



UConn

UNIVERSITY OF CONNECTICUT

UConn HEALTH

University of Connecticut Board of Trustees
University of Connecticut Health Center Board of Directors

Joint Audit & Compliance Committee
Virtual Meeting

June 25, 2026

PUBLIC SESSION

Public Streaming Link (with live captioning upon request): <https://its.uconn.edu/board-of-trustees-live-stream-meetings/>

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

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AGENDA

University of Connecticut Board of Trustees
University of Connecticut Health Center Board of Directors
Joint Audit & Compliance Committee
Virtual Meeting

Thursday, June 25, 2026

10:00 a.m. – 10:30 a.m. - Executive Session / 10:30 a.m. – 12:00 p.m. - Public Session

Public Streaming Link (with live captioning upon request):

<https://its.uconn.edu/board-of-trustees-live-stream-meetings/>

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

AGENDA		
CALL TO ORDER		
EXECUTIVE SESSION		
PUBLIC PARTICIPATION*		
*Individuals who wish to speak during the Public Participation portion of the Thursday, June 25, meeting must sign up no later than 10:00 a.m. on Wednesday, June 24, by emailing BoardCommittees@uconn.edu . Speaking requests must include a name, topic, and affiliation with the University (i.e., student, employee, member of the public). Per the University By-Laws, the Committee may limit the entirety of public comments to a maximum of 30 minutes. The sign-up list may be closed if, due to the number of people seeking to speak, the 30-minute allotment will be exceeded. As an alternative, individuals may submit written comments to the Committee via email BoardCommittees@uconn.edu , and all comments will be shared with the Committee.		
Agenda Items	Proposed Action	Attachment
MINUTES OF THE PRIOR MEETINGS		
Minutes of March 26, 2026, Meeting	Approval	1.1
Minutes of June 3, 2026, Special Meeting	Approval	1.2
EXTERNAL AUDIT ACTIVITIES		
Status of External Audit Engagements	Update	2.1
Pharmacy Consultants, Inc. (DBA 340B Compliance Partners) – UConn Health 340B Drug Pricing Program Audits for CY 2025	Presentation	2.2
SIGNIFICANT INTERNAL AUDIT ACTIVITIES		
AMAS Dashboard	Informational	3.1
Status of Audit Assignments	Update	3.2
Status of Audit Observations	Update	3.3
AMAS Organizational Chart/Staffing	Update	3.4
COMPLIANCE ACTIVITIES		
Office for Inclusion and Civil Rights Regulatory Update	Presentation	4.1
Office of University Compliance Significant Compliance Activities	Informational	4.2
HealthCare Compliance & Privacy Dashboard	Informational	4.3
Informational/Educational Items	Informational	4.4
INFORMATION TECHNOLOGY		
UConn	Update	5.1
UConn Health	Update	5.2
OTHER BUSINESS		
ADJOURNMENT		

NOTE: If you are an individual with a disability and require accommodations, please e-mail the Board of Trustees Office at boardoftrustees@uconn.edu prior to the meeting.

ATTACHMENT 1.1

ATTACHMENT 1.1

DRAFT MINUTES

University of Connecticut & UConn Health Joint Audit & Compliance Committee

March 26, 2026
Virtual Meeting

Committee Members	<u>Board of Trustees</u> Mark Boxer, Andrea Dennis-LaVigne, Daniel Toscano <u>UConn Health Board of Directors</u> Francis Archambault, Jr., Geoffrey Matous
University Staff	Andrew Agwunobi, Donald Babcock, Kimberly Fearney, Nicole Gelston, Jeffrey Geoghegan, Kimberly Hill, Philip Hunt, Andrea Keilty, Stacy Koehler, Eric Kruger, Ted Laskaris, Radenka Maric, Margaret McCarthy, Rick McCarthy, Stanley Nolan, Gregory Perrotti, Karen Preacher, Angelo Quaresima, Lesley Salafia, Janel Simpson, Scott Simpson, David Wallace, Reka Wrynn
External Invitees	Patrick Quinn, Brian Sullivan

Vice-Chair Boxer convened the Committee at 10:02 a.m.

1. Executive Session

On a motion by Director Archambault, seconded by Director Matous, the Committee voted unanimously to go into the Executive Session to discuss:

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

The entire Executive Session was attended by the following:

University Staff: Agwunobi, Fearney, Gelston, Geoghegan, Hill, Hunt, Keilty, Koehler, Maric, M. McCarthy, Perrotti, Preacher, Quaresima, J. Simpson, S. Simpson, and Wrynn.

Committee members: Archambault, Boxer, Dennis-LaVigne, Matous, and Toscano.

The following University staff were in attendance for part of the Executive Session: Babcock, Kruger, Laskaris, R. McCarthy, Nolan, Salafia, and Wallace.

The Executive Session ended at 11:08 a.m., and the Committee returned to the Open Session at 11:09 a.m.

2. Public Participation

No members of the public signed up to address the Committee.

3. Minutes of December 11, 2025, Meeting

On a motion by Director Archambault, seconded by Director Matous, the Committee voted to unanimously approve the minutes of the December 11, 2025, meeting.

4. External Audit Activities

Associate Vice President and Chief Audit Executive Quaresima provided an update on the status of external audit engagements.

Brian Sullivan from CBIZ CPAs P.C. presented the Committee with the UConn 2000 Infrastructure Program Agreed Upon Procedures Report for the Fiscal Year Ending June 30, 2025.

On a motion by Director Archambault, seconded by Director Matous, the Committee voted to unanimously approve the extension appointment of Clinton Larson Allen, LLP (CLA) for UCONN Health audit services for fiscal year ending June 30, 2026.

5. Significant Internal Audit Activities

Mr. Quaresima provided the Committee with updates on the status of audit assignments, the status of audit observations, AMAS Organizational Chart/Staffing and the AMAS Strategic plan. Mr. Quaresima also informed the Committee that AMAS is projected to finish fiscal year ended June 30, 2026 under budget.

The Committee reviewed and accepted five audit reports.

6. Compliance Activities

Associate Vice President and Chief Compliance Officer Fearney provided the Committee with updates on significant compliance activities, including updates on University HealthCare Compliance and Privacy Dashboard, CT 2026 workplan as well as several informational/educational items.

7. Information Technology Updates

Interim Vice President and Chief Information Officer Laskaris provided an update on the UConn information technology activities.

UConn Health Chief Information Officer R. McCarthy provided an update on UConn Health information technology activities.

8. Other Business

There was no Other Business.

9. Adjournment

On a motion by Trustee Dennis-LaVigne, seconded by Director Archambault, the Committee voted unanimously to adjourn the meeting. The Committee adjourned at 11:21 a.m.

Respectfully submitted,
Dorothy Del Valle
Secretary to the Committee

ATTACHMENT 1.2

ATTACHMENT 1.2

DRAFT MINUTES

University of Connecticut & UConn Health Joint Audit & Compliance Committee

**June 3, 2026
Special Virtual Meeting**

Committee Members	<u>Board of Trustees</u> Mark Boxer, George Barrios, Andrea Dennis-LaVigne, Daniel Toscano <u>UConn Health Board of Directors</u> Francis Archambault, Jr., Richard Carbray, Jr., Geoffrey Matous
University Staff	Andrew Agwunobi, Pamir Alpay, Kimberly Fearney, Nicole Gelston, Jeffrey Geoghegan, Kim Hill, Andrea Keilty, Stacy Koehler, Margaret McCarthy, Gregory Perrotti, Karen Preacher, Angelo Quaresima, Anthony Rini, Janel Simpson, Scott Simpson

Vice-Chair Boxer convened the Committee at 9:00 a.m.

1. Public Participation

No members of the public signed up to address the Committee.

2. External Audit Activities

Associate Vice President and Chief Audit Executive Quaresima provided the committee with the recommendation to appoint Clifton Larson Allen, LLP (CLA) to perform an audit of the School of Business expenditures.

On a motion by Director Archambault, seconded by Director Matous, the Committee voted to unanimously approve the appointment of Clinton Larson Allen, LLP (CLA) for audit services for the School of Business expenditures.

3. Adjournment

On a motion by Director Archambault, seconded by Director Carbray, the Committee voted unanimously to adjourn the meeting. The Committee adjourned at 9:05 a.m.

Respectfully submitted,
Dorothy Del Valle
Secretary to the Committee

ATTACHMENT 2.1

ATTACHMENT 2.1

University of Connecticut Board of Trustees
University of Connecticut Health Center Board of Directors
Joint Audit & Compliance Committee
June 25, 2026

Status of External Audit Engagements

Auditor	Area	Scope	Current Status of Audit	Recent Report Issued	Recent Report – Recommendations & Areas for Improvement		
					Total	No Further Action / Implemented	Open
Clifton Larson Allen, LLP	UConn Health	Audits of UConn Health's John Dempsey Hospital, UConn Medical Group, & Finance Corporation Financial Statements	FY 26 Underway	FY 25 Issued 11/20/25, 11/20/25 & 11/20/25	No Recommendations Reported		
Clifton Larson Allen, LLP	UConn	Audit of School of Business expenditures for fiscal years ended June 30, 2022, 2023, 2024 & 2025.	FYs 22, 23, 24 & 25 No Activity	N/A	N/A		
TBD	UConn Athletics	Annual NCAA agreed upon procedures performed on all revenues, expenses, and capital expenditures for the Athletics Program	RFP Underway	FY 25 Issued 12/1/25	No Recommendations Reported		
TBD	UConn & UConn Health	Annual agreed upon procedures on UConn 2000 Infrastructure Program as required by Section 10a-109z of the Connecticut General Statutes (CGS)	RFP Underway	FY 25 Issued 3/10/26	2	0	2
Pharmacy Consultants, Inc. (DBA 340B Compliance Partners)	UConn Health	Mock audits of UConn Health's 340B Drug Pricing Program covered entities recommended by Health Resources and Services Administration	CY 26 No Activity	CY 25 Issued 3/23/26, 3/24/26 & 3/24/26	4	4	0
State Auditors	UConn & UConn Health	Annual audit of Federal Funds required under the Federal Single Audit Act (SWSA)	FY 26 No Activity	FY 25 Issued 3/27/26	No Recommendations Reported		
State Auditors	UConn	Annual audit of financial statements included in the Annual Comprehensive Financial Report (ACFR)	FY 26 No Activity	FY 25 Issued 12/5/25	No Recommendations Reported		
State Auditors	UConn Health	Annual audit of financial statements included in the Annual Comprehensive Financial Report (ACFR)	FY 26 No Activity	FY 25 Issued 12/5/25	No Recommendations Reported		
State Auditors	UConn	Departmental statutory required audit (CGS Sec 2-90)	FYs 24 & 25 Underway	FYs 22 & 23 Issued 6/16/25	7	0	7
State Auditors	UConn Health	Departmental statutory required audit (CGS Sec 2-90)	FYs 23 & 24 Underway	FYs 21 & 22 Issued 11/9/23	12	2	10

ATTACHMENT 2.2

ATTACHMENT 2.2

UConn HEALTH

Connecticut Bleeding Disorders Center
Hemophilia Treatment Center [HM06030]

340B Program and Sample Data Analysis
June 1, 2025 through November 30, 2025

EXECUTIVE SUMMARY

Background

UConn Hemophilia Treatment Center is located in Farmington, CT and is registered as a Comprehensive Hemophilia Treatment Center on the OPAIS database as HM06030 with a start date of April 1, 2012, and last recertification date of February 9, 2026. UConn Hemophilia Treatment Center has registered contract pharmacies. Currently, EPIC is used as the facility EMR with Verity and Optum functioning as third-party administrators for the CE with additional manual replenishment tracking.

UConn Hemophilia Treatment Center contracted with 340B Compliance Partners to conduct the annual independent external audit of all functioning 340B universes for analysis of program compliance. This audit was conducted with an informational kick-off call on December 12, 2025, and remote portion was March 23, 2026. Auditors were Jennifer McElravey and Joshua Gue.

Scope and Methodology

340B Compliance Partners has completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the Health Resources and Services Administration's (HRSA) guidance for Covered Entities as of March 23, 2026. These procedures were agreed to by Senior Management of UConn Hemophilia Treatment Center. The primary areas of analysis for a HM Covered Entity type are meeting eligibility requirements to be in the 340B program, operating within scope of the grant, proper recertification, avoiding diversion by establishing and maintaining eligible patient definitions and only counting 340B drugs for those patients, accurate information on the OPAIS Medicaid Exclusion File with processes in place to avoid duplicate discounts, proper oversight of contract pharmacy relationships, and robust Policies and Procedures to ensure programmatic compliance. Contract pharmacy agreements should include 12 elements identified by HRSA as deemed necessary for compliance.

25 total samples were selected for testing from all universes used by UConn Hemophilia Treatment Center.

Analysis of the following has been completed:

- A. All requested data was provided
- B. Knowledge during pre-audit conference call
- C. Accuracy of OPAIS Database
- D. Verification of Eligibility
- E. Medicaid Carve-In/Carve-Out status
- F. Policy and Procedure Review
- G. Sample of dispensations tested for eligibility for 340B
- H. Accumulator review for eligibility and replenishment records, where applicable
- I. Diversion Tests
- J. Contract Pharmacy Registration Compliance
- K. Provider File Review
- L. Test staff knowledge of program (i.e., ordering processes, eligibility, etc.)
- M. Internal Audit Processes
- N. Multi-disciplinary oversight committee meetings
- O. 12 Essential Elements in PSAs for contract pharmacy relationships

PROCEDURE NOTES AND FINDINGS

A: All requested data was provided

B. Knowledge during pre-audit conference

Staff active and engaged in kick off call held December 12, 2025. We followed the agenda currently in use by Bizzell US (consulting group conducting audits on behalf of HRSA) along with Q&A from the UConn team. Appropriate questions asked to prepare for a HRSA audit in the future.

C: Accuracy of OPAIS database

Pharmacy Services Agreements were compared against registrations of contract pharmacies on the OPAIS database.

D: Verification of eligibility

The Notice of Award from HRSA for Icahn School of Medicine at Mount Sinai was submitted as well as the NOFO and the Subaward agreement for University of Connecticut Health Center.

E: Medicaid Carve-In/Carve-Out status

All contract pharmacy arrangements are Carve-Out. No instances of duplicate discounts were found during testing.

F: Policy and Procedure review

All essential elements noted in HRSA data request list are addressed in CE policies.

G: Sample of dispensations tested for 340B eligibility

Samples were selected from all identified universes, as reported by the CE, with a total of 25 samples tested. Thorough analysis was completed for all including:

- Ordering provider eligibility
- Location eligibility
- Review of payer
- Review of encounters for responsibility of care
- Review of accumulation and replenishment processes
- Prescription documentation in EHR to match hard copies supplied by contract pharmacies

H: Accumulator review

TPAs were reviewed for each sample to demonstrate accumulation of dispense and subsequent replenishment.

I: Diversion Tests

All claims were tested for diversion issues. No instances of diversion were identified during testing.

J: Contract pharmacy registration compliance

Contract pharmacy registrations were reviewed to ensure fully executed PSA prior to registration on OPAIS and a focus on documentation alignment and consistency across pharmacy records. Not all arrangements were supported by fully compliant written agreements. Strengthening contract standardization and oversight is recommended to reduce audit exposure.

K: Provider file review

Provider file was reviewed with no concerns noted. All samples were written by an eligible provider.

L: Staff knowledge of program

Processes in place of ordering on appropriate accounts, with key staff engaged and knowledgeable of program requirements.

M: Internal quality controls

Discussed on site with a review of elements tested. Audits were conducted in all universes, mimicking the HRSA audit process for each sample chosen. Process was well addressed in policy and procedure.

N: Multi-disciplinary committee meetings

Discussed onsite. Covered entity has this committee established and meets as indicated in policy and procedures. Minutes of meetings were produced to document as such.

O: 12 Essential Elements

All Pharmacy Services Agreements were reviewed for incorporation of 12 essential elements as identified in the Federal Register by HRSA. The review identified an opportunity to enhance consistency in pharmacy services agreement language across contract pharmacy relationships.

SUMMARY

Review above comments and determine if you would challenge any findings as you would have 30 days to do so. Next, develop a corrective action plan (CAP) within 60 days of receipt of report. Keep in mind with a HRSA audit, all CAPs would be expected to be fully implemented and attestation received within six months of approval of the CAP. The CAP would be expected for all Findings.

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

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

The Hemophilia Treatment Center 340B Program [HM06030] underwent an outside independent mock audit as required by Health Resources and Services Administration (HRSA) for the period of June 1, 2025 – November 30, 2025. This audit was conducted by 340B Compliance Partners, and it took place on March 23, 2026. 340B Compliance Partners completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the HRSA’s guidance for Covered Entities.

FINDINGS:

1. “OPAIS Database: Contract Pharmacy Compliance”

During the review of the Covered Entity’s (CE) contract pharmacy agreements, auditors noted not all arrangements were supported by fully compliant written agreements. The auditor specifically focused on dates next to signature lines within contracts.

340B Management Response:

The 340B Management team does not agree with this finding, as the documents in question are historical in nature and cannot be modified retrospectively. Additionally, alternative documentation and supporting records are available to demonstrate that the Covered Entity was compliant at the time the documents were executed. Nevertheless, the 340B team will collaborate with Procurement to help ensure future contracts consistently include dates alongside signatures to support documentation completeness and audit readiness.

Completion Date: 5/1/2026

AREAS FOR IMPROVEMENT:

(AFIs are recommendations for program enhancement and do not require a formal response to HRSA as part of the Corrective Action Plan (CAP) process.)

1. “12 Essential Elements in PSAs for Contract Pharmacy Relationships”

During the review of the CE’s contract pharmacy agreements, auditors identified opportunities to strengthen documentation related to the “Other Services,” “Patient Choice,” and “Duplicate discount prevention” provisions. These provisions are included within the 12 Essential Elements of Pharmacy Services Agreements (PSAs) for contract pharmacy relationships. Enhancing this documentation may further support audit readiness and compliance efforts.

340B Management Response:

The 340B Management team does not fully agree with this AFI, as these elements have not been identified as concerns in previous audits. Although audit processes are generally standardized, individual auditors may differ in their interpretation and review approach. Nevertheless, as contract pharmacy agreements are renewed, the 340B team will incorporate the recommended language and documentation enhancements to provide additional clarity and strengthen audit readiness.

UConn HEALTH

University of Connecticut Division of Infectious Diseases

Ryan White Part A [RWI06030]

340B Program and Sample Data Analysis
June 1, 2025 through November 20, 2025

EXECUTIVE SUMMARY

Background

University of Connecticut Division of Infectious Diseases Clinic is located in Farmington, CT and is registered as a Ryan White Part A on the OPAIS database as RWI06030 with a start date of January 1, 2012, and last recertification date of February 9, 2026. University of Connecticut Division of Infectious Diseases Clinic has registered contract pharmacies. Currently, EPIC is used as the facility EMR with WellPartner, Walgreens 340B Complete, Curant, and Verity functioning as third-party administrators for the CE. This is an additional manual universe, which had no claims data during the sample period.

University of Connecticut Division of Infectious Diseases Clinic contracted with 340B Compliance Partners to conduct the annual independent external audit of all functioning 340B universes for analysis of program compliance. The virtual MOCK HRSA audit was conducted March 24, 2026. Auditors were Jennifer McElravey and Joshua Gue.

Scope and Methodology

340B Compliance Partners has completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the Health Resources and Services Administration's (HRSA) guidance for Covered Entities as of March 24, 2026. These procedures were agreed to by Senior Management of UConn Health. The primary areas of analysis for a Ryan White Part A Covered Entity type are meeting eligibility requirements to be in the 340B program with proper recertification, avoiding diversion by establishing and maintaining eligible patient definitions and only counting 340B drugs for those patients, accurate information on the OPAIS Medicaid Exclusion File with processes in place to avoid duplicate discounts, proper oversight of contract pharmacy relationships, and robust Policies and Procedures to ensure programmatic compliance. Contract pharmacy agreements should include 12 elements identified by HRSA as deemed necessary for compliance.

65 total samples were selected for testing from all universes used by University of Connecticut Division of Infectious Diseases Clinic (RWI06030).

Analysis of the following has been completed:

- A. All requested data was provided
- B. Knowledge during pre-audit conference call
- C. Accuracy of OPAIS Database
- D. Verification of Eligibility
- E. Medicaid Carve-In/Carve-Out status
- F. Policy and Procedure Review
- G. Sample of dispensations tested for eligibility for 340B
- H. Accumulator review for eligibility and replenishment records, where applicable
- I. Diversion Tests
- J. Contract Pharmacy Registration Compliance
- K. Provider File Review
- L. Test staff knowledge of program (i.e., ordering processes, eligibility, etc.)
- M. Internal Audit Processes
- N. Multi-disciplinary oversight committee meetings
- O. 12 Essential Elements in PSAs for contract pharmacy relationships

PROCEDURE NOTES AND FINDINGS

A: All requested data was provided

B. Knowledge during pre-audit conference

Staff active and engaged in kick off call held December 12, 2025. We followed the agenda currently in use by Bizzell US (consulting group conducting audits on behalf of HRSA) along with Q&A from the UConn team. Appropriate questions asked to prepare for an HRSA audit in the future.

C: Accuracy of OPAIS database

Pharmacy Services Agreements were compared against registrations of contract pharmacies on the OPAIS database. A contract pharmacy address discrepancy was identified between executed agreements and OPAIS records.

D: Verification of eligibility

The covered entity demonstrated eligibility under the Ryan White HIV/AIDS Program Part A through its subrecipient relationship and funded services.

E: Medicaid Carve-In/Carve-Out status

All contract pharmacy arrangements are Carve-Out. No instances of duplicate discounts were found during testing.

F: Policy and Procedure review

All essential elements noted in HRSA data request list are addressed in CE policies. The covered entity conducts routine internal monitoring of 340B Program activity.

G: Sample of dispensations tested for 340B eligibility

Samples were selected from all identified universes, as reported by the CE, with a total of 65 samples tested. Thorough analysis was completed for all including:

- Ordering provider eligibility
- Location eligibility
- Review of payer
- Review of encounters for responsibility of care
- Review of patient status at the time of documented 340B eligibility
- Review of appropriate modifiers on claims, as required
- Review of accumulation and replenishment processes
- Prescription documentation in EHR to match hard copies supplied by contract pharmacies

H: Accumulator review

TPA was reviewed for each sample to demonstrate accumulation of dispense and subsequent replenishment.

I: Diversion Tests

No issues identified.

J: Contract pharmacy registration compliance

Contract pharmacy registrations were reviewed to ensure fully executed PSA prior to registration on OPAIS and a focus on documentation alignment and consistency across pharmacy records.

K: Provider file review

Provider file was reviewed with no concerns noted. All samples were written by an eligible provider.

L: Staff knowledge of program

Held discussions virtually with staff responsible for contract pharmacy oversight. Processes in place to ensure TPA(s) are functioning as intended, with key staff engaged and knowledgeable of program requirements.

M: Internal quality controls

Discussed on site with a review of elements tested. Audits were conducted in all universes, mimicking the HRSA audit process for each sample chosen. Process was well addressed in policy and procedure.

N: Multi-disciplinary committee meetings

Discussed onsite. Covered entity has this committee established and meets as indicated in policy and procedures. Minutes of meetings were produced to document as such.

O: 12 Essential Elements

All Pharmacy Services Agreements were reviewed for incorporation of 12 essential elements as identified in the Federal Register by HRSA. The review identified an opportunity to enhance consistency in pharmacy services agreement language across contract pharmacy relationships.

SUMMARY

Review above comments and determine if you would challenge any findings as you would have 30 days to do so. Next, develop a corrective action plan (CAP) within 60 days of receipt of report. Keep in mind with a HRSA audit, all CAPs would be expected to be fully implemented and attestation received within six months of approval of the CAP. The CAP would be expected for all Findings.

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

UConn HEALTH

University of Connecticut Division of Infectious Diseases

Ryan White Part A [RWI06030A]

340B Program and Sample Data Analysis
June 1, 2025 through November 20, 2025

EXECUTIVE SUMMARY

Background

University of Connecticut Division of Infectious Diseases Clinic is located in East Hartford, CT and is registered as a Ryan White Part A on the OPAIS database as RWI06030A with a start date of January 1, 2012, and last recertification date of February 9, 2026. University of Connecticut Division of Infectious Diseases Clinic has registered contract pharmacies. Currently, EPIC is used as the facility EMR with WellPartner, Walgreens 340B Complete, Curant, and Verity functioning as third-party administrators for the CE.

University of Connecticut Division of Infectious Diseases Clinic contracted with 340B Compliance Partners to conduct the annual independent external audit of all functioning 340B universes for analysis of program compliance. The virtual MOCK HRSA audit was conducted March 24, 2026. Auditors were Jennifer McElravey and Joshua Gue.

Scope and Methodology

340B Compliance Partners has completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the Health Resources and Services Administration's (HRSA) guidance for Covered Entities as of March 24, 2026. These procedures were agreed to by Senior Management of UConn Health. The primary areas of analysis for a Ryan White Part A Covered Entity type are meeting eligibility requirements to be in the 340B program with proper recertification, avoiding diversion by establishing and maintaining eligible patient definitions and only counting 340B drugs for those patients, accurate information on the OPAIS Medicaid Exclusion File with processes in place to avoid duplicate discounts, proper oversight of contract pharmacy relationships, and robust Policies and Procedures to ensure programmatic compliance. Contract pharmacy agreements should include 12 elements identified by HRSA as deemed necessary for compliance.

13 total samples were selected for testing from all universes used by University of Connecticut Division of Infectious Diseases Clinic (RWI06030A).

Analysis of the following has been completed:

- A. All requested data was provided
- B. Knowledge during pre-audit conference call
- C. Accuracy of OPAIS Database
- D. Verification of Eligibility
- E. Medicaid Carve-In/Carve-Out status
- F. Policy and Procedure Review
- G. Sample of dispensations tested for eligibility for 340B
- H. Accumulator review for eligibility and replenishment records, where applicable
- I. Diversion Tests
- J. Contract Pharmacy Registration Compliance
- K. Provider File Review
- L. Test staff knowledge of program (i.e., ordering processes, eligibility, etc.)
- M. Internal Audit Processes
- N. Multi-disciplinary oversight committee meetings
- O. 12 Essential Elements in PSAs for contract pharmacy relationships

PROCEDURE NOTES AND FINDINGS

A: All requested data was provided

B. Knowledge during pre-audit conference

Staff active and engaged in kick off call held December 12, 2025. We followed agenda currently in use by Bizzell US (consulting group conducting audits on behalf of HRSA) along with Q&A from the UConn team. Appropriate questions asked to prepare for an HRSA audit in the future.

C: Accuracy of OPAIS database

Pharmacy Services Agreements were compared against registrations of contract pharmacies on the OPAIS database.

D: Verification of eligibility

The covered entity demonstrated eligibility under the Ryan White HIV/AIDS Program Part A through its subrecipient relationship and funded services.

E: Medicaid Carve-In/Carve-Out status

All contract pharmacy arrangements are Carve-Out. No instances of duplicate discounts were found during testing.

F: Policy and Procedure review

All essential elements noted in HRSA data request list are addressed in CE policies. The covered entity conducts routine internal monitoring of 340B Program activity.

G: Sample of dispensations tested for 340B eligibility

Samples were selected from all identified universes, as reported by the CE, with a total of 65 samples tested. Thorough analysis was completed for all including:

- Ordering provider eligibility
- Location eligibility
- Review of payer
- Review of encounters for responsibility of care
- Review of patient status at the time of documented 340B eligibility
- Review of appropriate modifiers on claims, as required
- Review of accumulation and replenishment processes
- Prescription documentation in EHR to match hard copies supplied by contract pharmacies

H: Accumulator review

TPA was reviewed for each sample to demonstrate accumulation of dispense and subsequent replenishment.

I: Diversion Tests

No issues identified.

J: Contract pharmacy registration compliance

Contract pharmacy registrations were reviewed to ensure fully executed PSA prior to registration on OPAIS and a focus on documentation alignment and consistency across pharmacy records.

K: Provider file review

Provider file was reviewed with no concerns noted. All samples were written by an eligible provider.

L: Staff knowledge of program

Held discussions virtually with staff responsible for contract pharmacy oversight. Processes in place to ensure TPA(s) are functioning as intended, with key staff engaged and knowledgeable of program requirements.

M: Internal quality controls

Discussed on site with a review of elements tested. Audits were conducted in all universes, mimicking the HRSA audit process for each sample chosen. Process was well addressed in policy and procedure.

N: Multi-disciplinary committee meetings

Discussed onsite. Covered entity has this committee established and meets as indicated in policy and procedures. Minutes of meetings were produced to document as such.

O: 12 Essential Elements

All Pharmacy Services Agreements were reviewed for incorporation of 12 essential elements as identified in the Federal Register by HRSA. The review identified an opportunity to enhance consistency in pharmacy services agreement language across contract pharmacy relationships.

SUMMARY

Review above comments and determine if you would challenge any findings as you would have 30 days to do so. Next, develop a corrective action plan (CAP) within 60 days of receipt of report. Keep in mind with a HRSA audit, all CAPs would be expected to be fully implemented and attestation received within six months of approval of the CAP. The CAP would be expected for all Findings.

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

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

The Ryan White 340B programs (RWI06030 and RWI06030A) underwent an outside independent mock audit as required by Health Resources and Services Administration (HRSA) for the period of June 1, 2025 – November 30, 2025. This audit was conducted by 340B Compliance Partners, and it took place on March 24, 2026. 340B Compliance Partners completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the HRSA’s guidance for Covered Entities.

FINDINGS FOR RWI06030 (FARMINGTON):

1. *“OPAIS Database errors: A contract pharmacy address discrepancy was identified between executed agreements and OPAIS records.”*

During the review of the CE’s OPAIS database, the auditors identified an address discrepancy between OPAIS and the contract.

340B Management Response:

The 340B Management team agreed with this finding but were already aware and working on correcting it. The Honolulu, HI contract pharmacy (CP) closed and merged its licensure with another specialty pharmacy in Hawaii. The CP’s OPAIS registration was updated to reflect the new location. We were in the process of terminating the unused contract pharmacy, as it had no claims, as part of an effort to clean up OPAIS records and align contract documentation prior to the audit. The store has since been terminated in the CE’s OPAIS database.

Completion Date: 5/1/2026

FINDINGS FOR RWI06030A (EAST HARTFORD):

None on the final report.

AREAS FOR IMPROVEMENT FOR BOTH RWI06030 AND RWI06030-A:

(AFIs are recommendations for program enhancement and do not require a formal response to HRSA as part of the Corrective Action Plan (CAP) process.)

1. *“12 Essential Elements in PSAs for Contract Pharmacy Relationships”*

During the review of the CE’s contract pharmacy agreements, auditors identified opportunities to strengthen documentation related to the “Other Services,” “Patient Choice,” and “Reporting and Data Flow” provisions. These provisions are included within the 12 Essential Elements of Pharmacy Services Agreements (PSAs) for contract pharmacy relationships. Enhancing this documentation may further support audit readiness and compliance efforts.

340B Management Response:

The 340B Management team does not fully agree with this AFI, as these elements have not been identified as concerns in previous audits. Although audit processes are generally standardized, individual auditors may differ in their interpretation and review approach. Nevertheless, as contract pharmacy agreements are renewed, the 340B team will incorporate the recommended language and documentation enhancements to provide additional clarity and strengthen audit readiness.

ATTACHMENT 3.1

ATTACHMENT 3.1

Audit and Management Advisory Services — Joint Audit and Compliance Committee Dashboard
As of May 31, 2026

Audits & Projects Completed
13

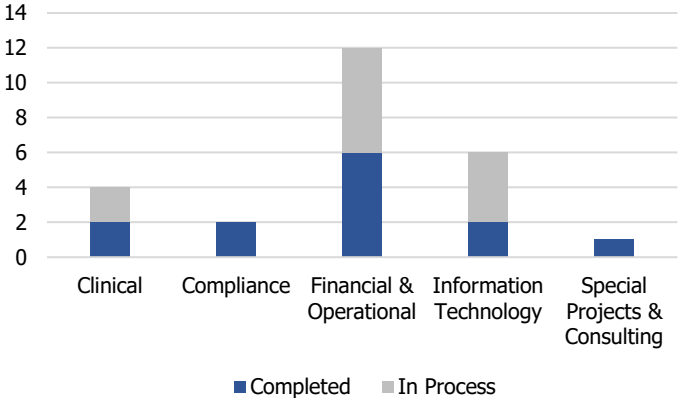
Reported Management Action Items
39

High Risk Management Action Items
33

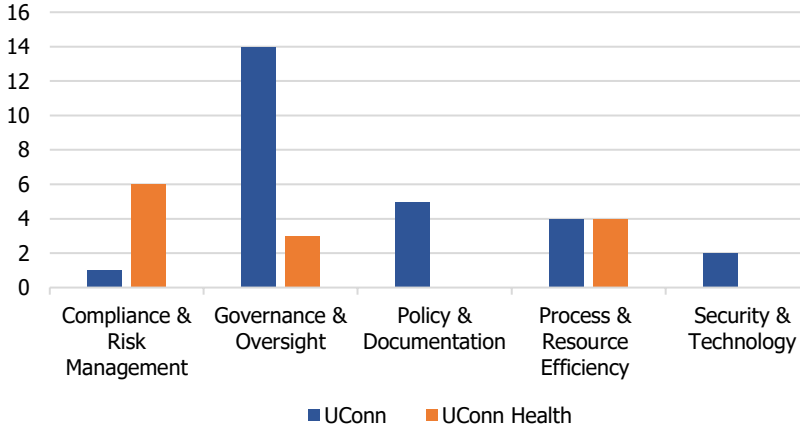
Staff Professional Certifications
16

Auditee Survey Average Rating
3.9

AUDITS AND PROJECTS COMPLETED



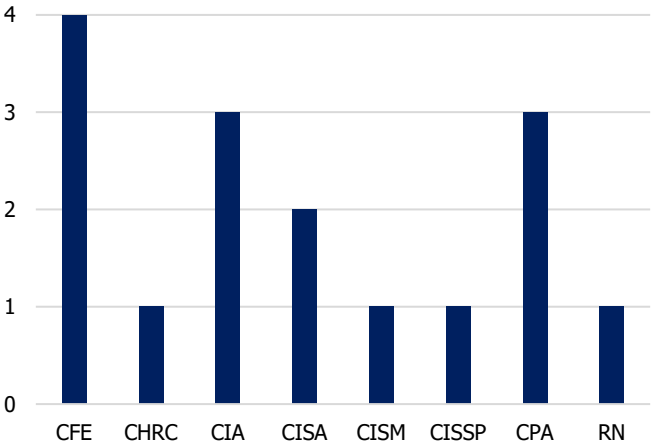
REPORTED MANAGEMENT ACTION ITEMS



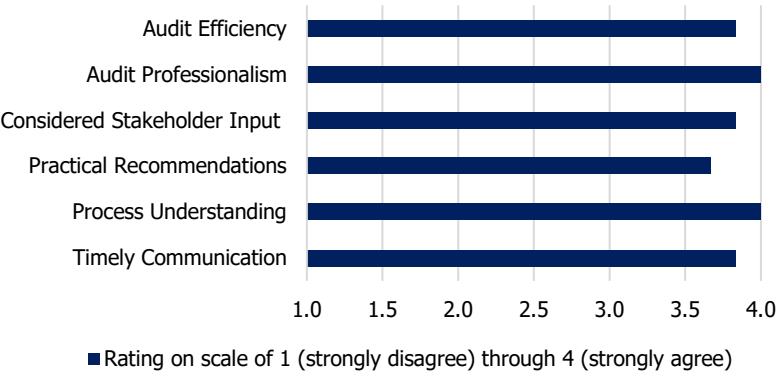
HIGH RISK MANAGEMENT ACTION ITEMS

Category	UConn	UConn Health
Compliance & Risk Management	-	-
Government & Oversight	-	2
Policy & Documentation	-	-
Process & Resource Efficiency	1	-
Security & Technology	18	12
Totals:	19	14

STAFF PROFESSIONAL CERTIFICATIONS



AUDITEE SURVEY RATINGS BY QUESTION
RESPONSE RATE 46% (6 of 13 Surveys)



ATTACHMENT 3.2

ATTACHMENT 3.2

University of Connecticut Board of Trustees
University of Connecticut Health Center Board of Directors
Joint Audit & Compliance Committee
June 25, 2026

Status of Audit Assignments
As of May 31, 2026

Audit Project	Campus	Current Status	Anticipated JACC Meeting			
			Jun 2026	Sep 2026	Dec 2026	Mar 2027
axiUm Application Controls	UH	Report				
Client Revenue Contracts	UH	Report				
Student Activities: Graduate Student Senate Operations	UC	Report				
UC Building Access	UC	Fieldwork				
UH Building Access	UH	Fieldwork				
Graduate Medical Education	UH	Fieldwork				
Legal Files Application Controls	UC	Fieldwork				
Wound Care and Hyperbaric Medicine	UH	Fieldwork				
Nephrology	UH	Planning				
UC Phishing Awareness and Response	UC	Planning				
UH Phishing Awareness and Response	UH	Planning				
Patient Account Credit Balances	UH	Fieldwork				

Special Projects/Consulting	Campus	Current Status	
		In Process	Project Final
Facilities Operations – Contract Review	UC		

ATTACHMENT 3.3

ATTACHMENT 3.3

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 25, 2026

Status of Audit Observations
Aging of Overdue Management Actions by Functional Area Based on Original Due Date
As of May 31, 2026

Functional Area	Not Due			0-3 Mos			3-6 Mos			6-12 Mos			1-2 Yrs			2-3 Yrs			> 3 Yrs			Total
	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	
UConn:																						
UC Athletics	1	3	1				1															6
UC Controller													1									1
UC Dean of Students				1																		1
UC Facilities Operations		4																		5		9
UC Foundation Administration	1				1																	2
UC Human Resources																				2		2
UC Information Technology Services												1		3	17		3					24
UC Office of the Provost	1	2								3												6
UC OVPR	1						1															2
UC Procurement		1																				1
UC Research Compliance Services																			2			2
UC Sponsored Program Services							1															1
UConn Total	4	10	1	1	1		1	2		3		1	1	3	17		3		2	7		57
UConn Health:																						
UCH Ambulatory Care										1												1
UCH CEO and EVP for Health Affairs																				2		2
UCH CFO							1															1
UCH Human Resources					1														2			3
UCH Information Technology Services						1		2	4								2	2		4	3	18
UCH JDH Administration								4		9	4		2			1	1			3		24
UCH JDH and UMG Revenue Cycle Management												1	2			1						4
UCH Procurement							1															1
UCH Sponsored Program Services	1				1																	2
UConn Health Total	1				2	1		8	4	10	4	1	4			1	4	2	2	9	3	56
UConn & UConn Health Total	5	10	1	1	3	1	1	10	4	3	10	5	2	7	17	1	7	2	4	16	3	113

Note: The net number of management open actions decreased by 20 from 133 to 113 from the prior reported quarter.

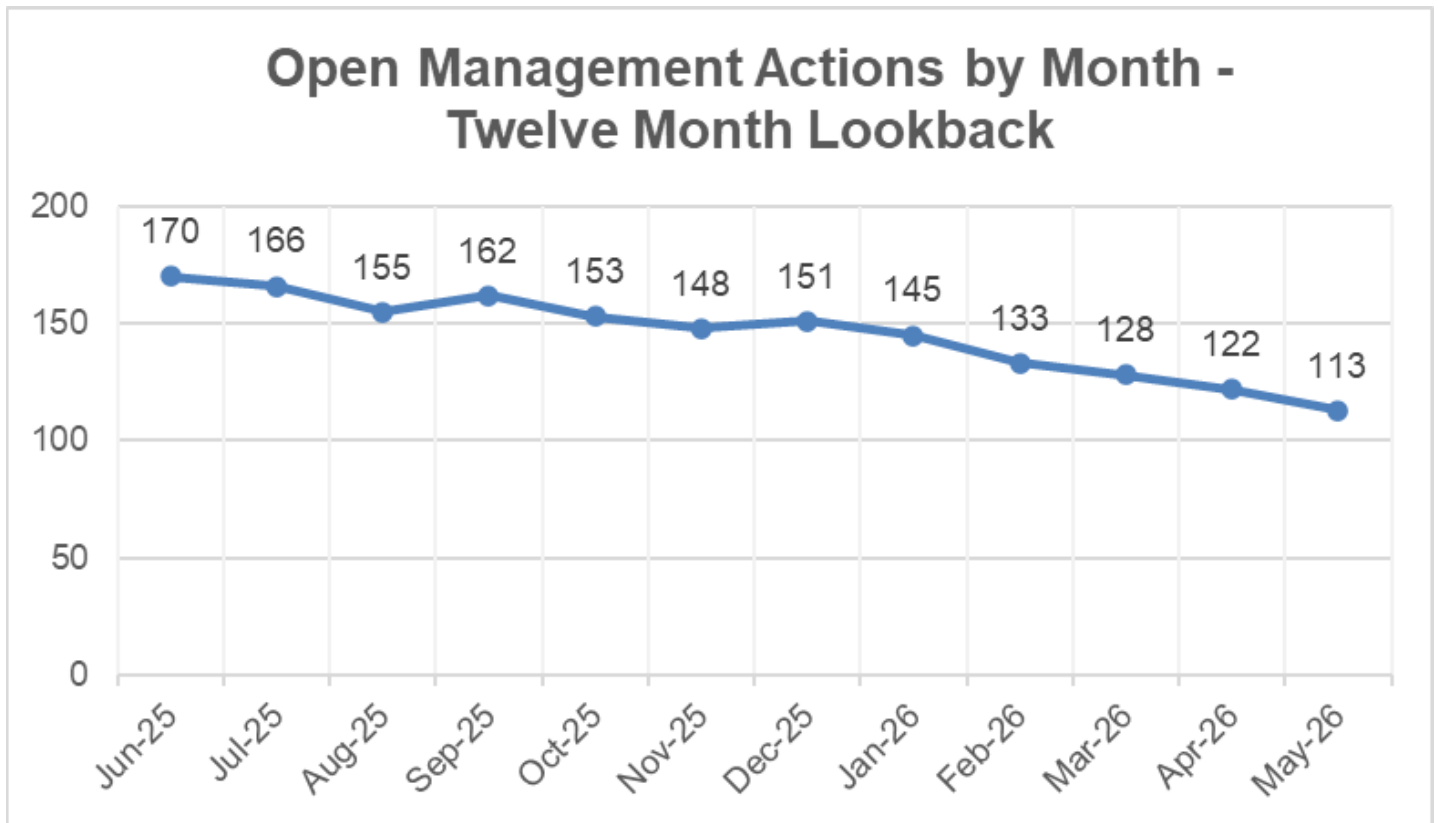
University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 25, 2026

Status of Audit Observations
Aging of Overdue Management Actions by Finding Category Based on Original Due Date
As of May 31, 2026

Finding Category	Not Due			0-3 Mos			3-6 Mos			6-12 Mos			1-2 Yrs			2-3 Yrs			> 3 Yrs			Total
	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	
UConn:																						
Compliance & Risk Management				1															1			2
Governance & Oversight	2	5			1			2		3				1			1					15
Policy & Documentation		4											1				1		1	1		8
Process & Resource Efficiency	1	1					1								1					1		5
Security & Technology	1		1									1		2	16		1			5		27
UConn Total	4	10	1	1	1		1	2		3		1	1	3	17		3		2	7		57
UConn Health:																						
Compliance & Risk Management											7									1		8
Governance & Oversight	1				1	1								3		1	2	1		4		14
Policy & Documentation								1						1			2		1	1		6
Process & Resource Efficiency					1			2					1						1	1		6
Security & Technology								5	4		3	4						1		2	3	22
UConn Health Total	1				2	1		8	4		10	4	1	4		1	4	2	2	9	3	56
UConn & UConn Health Total	5	10	1	1	3	1	1	10	4	3	10	5	2	7	17	1	7	2	4	16	3	113

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 25, 2026

Status of Audit Observations
Trend Analysis of Monthly Balances of Open Management Actions
As of May 31, 2026



Analysis:

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

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 25, 2026

Status of Audit Observations
Management Actions Closed by Functional Areas and Risk Level
For the Period March 1, 2026 to May 31, 2026

Functional Area	Implemented			Added to Subsequent Audit			No Longer Applicable			Total
	L	M	H	L	M	H	L	M	H	
UConn:										
UC Athletics		3								3
UC College of Liberal Arts and Sciences			2							2
UC Controller	1	3	1							5
UC Dean of Students	1									1
UC Human Resources		3								3
UC Office of the Provost				1	3		1			5
UC OVPR		1								1
UC Procurement	3	2								5
UConn Total	5	12	3	1	3		1			25
UConn Health:										
UCH CFO	1	3	1							5
UCH Information Technology Services		2								2
UCH JDH Administration		1								1
UCH JDH and UMG Revenue Cycle Management		3								3
UCH School of Medicine	1									1
UConn Health Total	2	9	1							12
UConn & UConn Health Total	7	21	4	1	3		1			37

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 25, 2026

Status of Audit Observations
Risk Level Descriptions

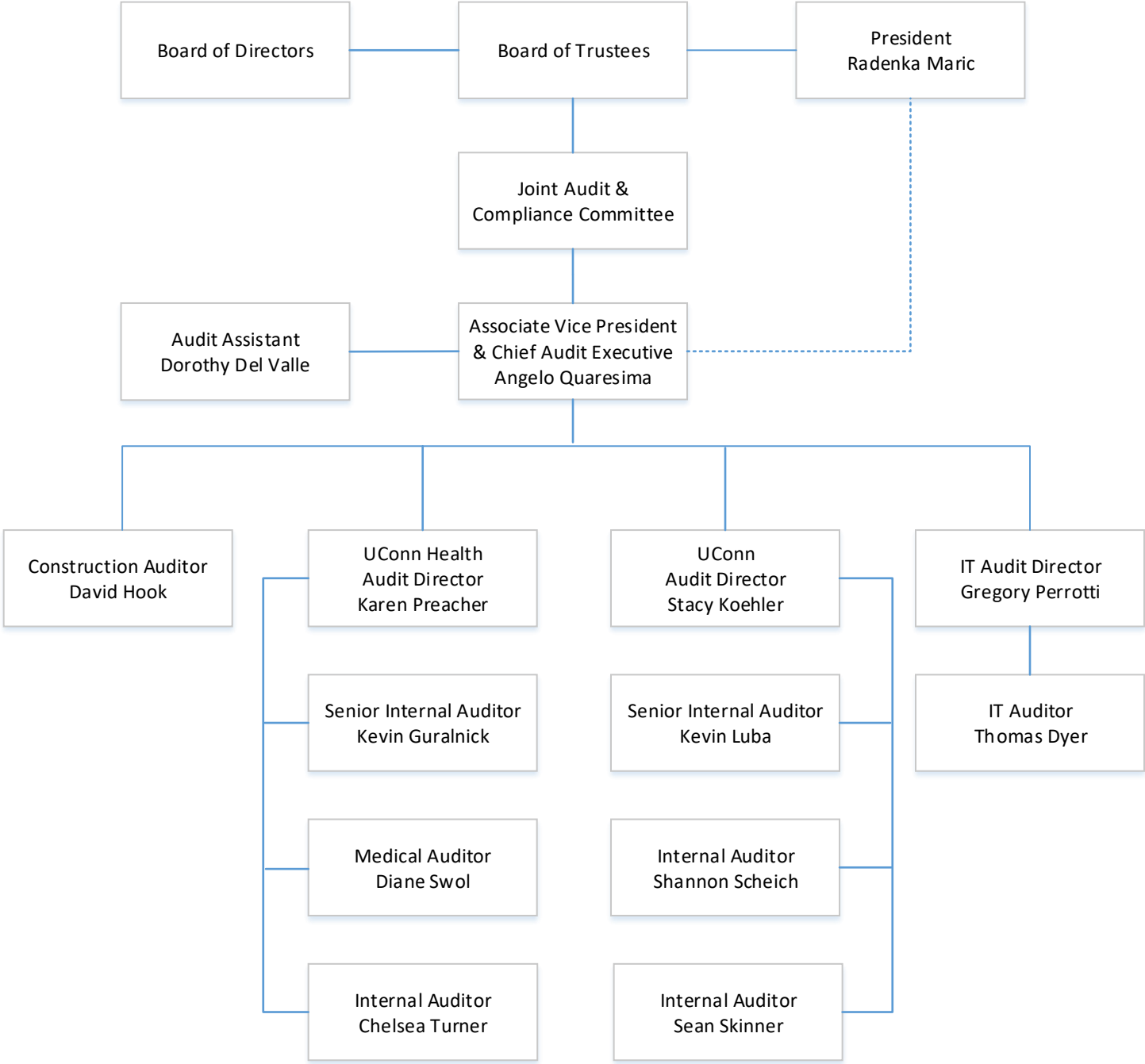
The description of the risk levels identified in this report is based on the following methodology. Observations are ranked based on an analysis of the likelihood and impact of a control or process failure. Considerable professional judgment is used to determine the risk ratings. Accordingly, others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

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

ATTACHMENT 3.4

ATTACHMENT 3.4

Office of Audit and Management Advisory Services
June 12, 2026



ATTACHMENT 4.1

ATTACHMENT 4.1

OICR's Civil Rights Compliance Role at UConn & UConn Health

Office for Inclusion and Civil Rights (OICR) (inclusioncivilrights.uconn.edu)

Administer the University's [*Policy Against Discrimination, Harassment and Related Interpersonal Violence*](#) and oversee system-wide compliance with state and federal civil rights and non-discrimination laws and regulations.¹ OICR also serves as the office of the University's ADA, Title VI, and Title IX Coordinator.

Sex-Based Discrimination and Related Harm (titleix.uconn.edu)

- Prevention and awareness programs
- Receive reports and ensure appropriate documentation and response
- Provide information and supportive measures
- Grievance Process
- Reasonable modifications for pregnancy/related conditions
- Other programs and tasks (e.g., student campus climate survey, Campus Resource Team, annual legislative report)

Identity-Based Discrimination and Harassment (equity.uconn.edu)

- Receive reports and ensure appropriate documentation and response
- Provide supportive measures and referrals
- Investigate alleged Policy violations
- Educate individuals and units/groups (both primary prevention/awareness education and tailored sessions)

Accessibility and Accommodations (accessibility.uconn.edu)

- Individualized interactive process to facilitate requests for reasonable accommodations
- Physical accessibility (e.g., buildings, exterior/landscape)
- Digital/communication accessibility (e.g., websites, course materials, captioning, interpreter services)

Equal Employment Opportunity (equity.uconn.edu/search-process/)

- Monitor and report on workforce equal employment opportunity efforts and activities (e.g., workforce demographics, search/hiring/promotion activities, policies and processes, education and information-sharing)
- Guide search committees and hiring managers on non-discriminatory search/hiring practices

¹ Such laws and regulations include but are not limited to Title IX of the Education Amendments of 1972; Titles VI and VII of the Civil Rights Act of 1964; Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973; and Connecticut General Statutes. These laws and regulations, as well as University policy, prohibit retaliation.

ATTACHMENT 4.2

ATTACHMENT 4.2

SIGNIFICANT COMPLIANCE ACTIVITIES

February 2026 – May 2026



Seven Elements of an Effective Compliance Program

Standards of
Conduct, Policies,
and Procedures

Leadership and
Authority

Education and
Development

Monitoring and
Auditing

Reporting and
Investigations

Reponse and
Prevention

Accountability
and incentives

Significant Compliance Activities: Office of University Compliance

As of May 31, 2026, OUC has received 93 reported concerns in 2026. This is consistent with the number of reports received this time in 2025; however, the percentage of reports from UConn Health have increased from 30% in 2025 to 40% in 2026.



Annual Compliance and Ethics Training concluded on May 1, 2026, for all UConn and UConn Health employees. At the deadline, training completion rates were 97.9% for UConn and 93.4% for UConn Health employees. Training was offered as an online, self-paced module. Additionally, OUC held 3 live trainings.



OUC implemented a centralized delivery model for Privacy and FERPA Training, improving access, consistency, and tracking compliance.



OUC modernized and upgraded its privacy program website with notable changes to education and training resources, and FERPA consent processes for staff and students.



OUC's Privacy Team coordinated the University's participation in a comprehensive data sharing project involving multiple state agencies to evaluate and inform efforts to offer institutional support to prospective and current students who may be eligible for SNAP and/or Medicaid benefits.



SIGNIFICANT COMPLIANCE ACTIVITIES

FEBRUARY 2026 – MAY 2026



Seven Elements of an Effective Compliance Program

Standards of
Conduct, Policies,
and Procedures

Leadership and
Authority

Education and
Development

Monitoring and
Auditing

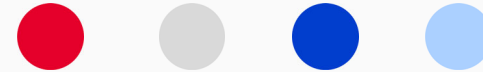
Reporting and
Investigations

Reponse and
Prevention

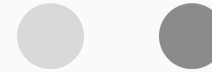
Accountability
and incentives

Significant Compliance Activities: Office of University Compliance (continued)

OUC's Privacy Team coordinated the University's management of two recent incidents of identity theft involving a University vendor and so-called "ghost students," who assume the identity of an actual student for purposes of receiving financial aid.



OUC's Policy Team supported the launch of a new UConn Health service line, the Blue Oak Retail Pharmacy, and supported two site visits from the Department of Public Health.



OUC's Policy Team developed a monthly policy governance report card for UConn Health with policy process data to inform leadership decisions and support accountability.



OUC's Policy Team led a cross-functional project regarding Specimens Management at UConn Health to enhance consistency in specimen processing and tracking and to clarify requirements outlined in policies and procedures. This resulted in coordinated oversight and reduced risks.



OUC's Minor Protection Program supported registration and compliance efforts for 200 University sponsored programs and activities that serve approximately 3,700 minors to as of May 31, 2026.



SIGNIFICANT COMPLIANCE ACTIVITIES

FEBRUARY 2026 – MAY 2026



Seven Elements of an Effective Compliance Program

Standards of
Conduct, Policies,
and Procedures

Leadership and
Authority

Education and
Development

Monitoring and
Auditing

Reporting and
Investigations

Reponse and
Prevention

Accountability
and incentives

Significant Compliance Activities: Office of University Compliance (continued)

As of May 31, 2026, the Senior Policy Council has approved 3 new policies, 20 revised policies, transferring 4 university policies to department-level policies, and decommissioned 2 policies in 2026. UConn Health approved 141 policies and decommissioned 41 standards documents.



OUC Policy Team developed the JDH-Solnit policy integration framework, including document disposition pathways, governance structures, resource guides, and standardized hybrid workflows integrating external stakeholders.



Additional Updates: Office of University Compliance

David Vargas, Jr. will join OUC as a Compliance Investigator on July 10, 2026. He brings seven years of experience in the United States Marine Corps, where he held the rank of Captain. Most recently, he served as a Site Commander and Inspector-Instructor, with responsibilities leading investigations, ensuring regulatory compliance, and managing large teams within his assigned duty station.

Hannah Cappello joined OUC part-time on March 9, 2026, working as the interim Compliance and Youth Protection Coordinator, supporting the Minor Protection Program across all campuses. Hannah has worked at UConn since 2021 and is currently a Human Resources Assistant in Human Resources. OUC thanks the leadership in Human Resources for collaboratively identifying an interim solution to an immediate program need.

ATTACHMENT 4.3

ATTACHMENT 4.3

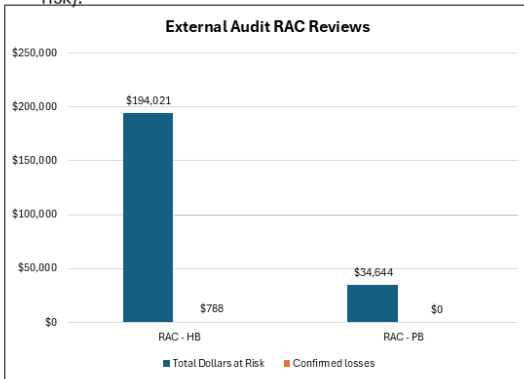
UConn Health – Healthcare Compliance & Privacy Dashboard Report

Fiscal Year 2026, Quarter 3 (January 1 – March 31, 2026)

External Reviews (Appendix A)

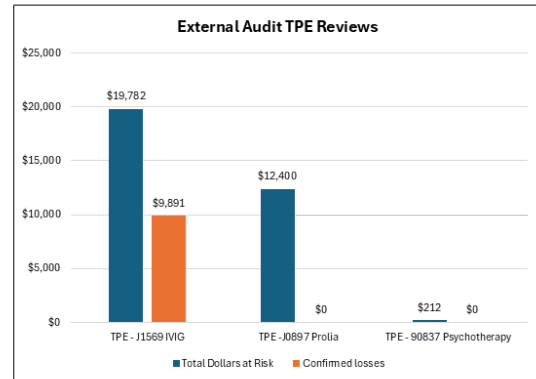
RAC

- \$228.7K total exposure identified.
- \$788 confirmed overpayments to date.
- 36% of records remain pending review (potential additional risk).



TPE

- \$32.4K total exposure identified.
- \$9.9K confirmed overpayments to date.
- 3 records resulted in partial denials.

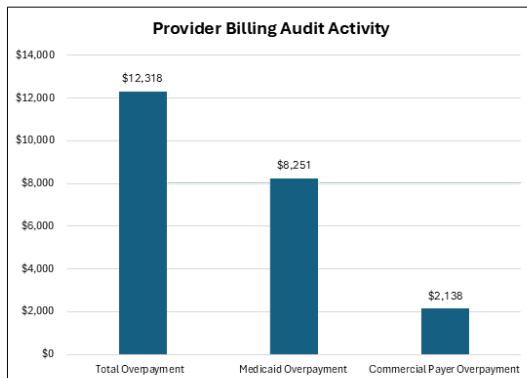


Internal Reviews (Government Overpayments, Coding, and Patient Rights)

Government Overpayments (Non-Recoupment)

HB & PB Activity

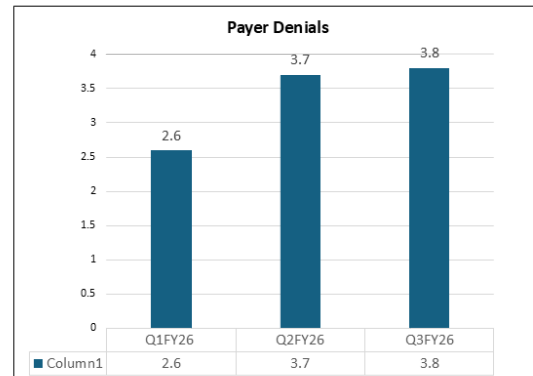
- QA review identified incorrect billing of specialty pharmacy-supplied Lupron, triggering a full impact assessment reported to GPOC.
- Review found 24 affected accounts with \$12.3K in overpayments.



Government Payer Denials (Appendix B)

School of Dental Medicine

- Government payer denials increased during FY26, rising from 2.6% in Q1 to 3.7% in Q2 and 3.8% in Q3.
- The most significant increase occurred between Q1 and Q2, with denial rates stabilizing in Q3.

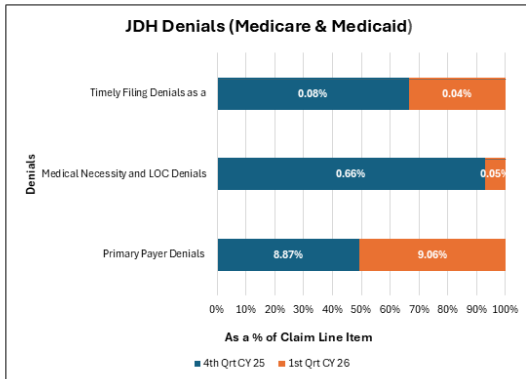


Internal Reviews (Government Overpayments, Coding, and Patient Rights) Cont'd

Government Payer Denials

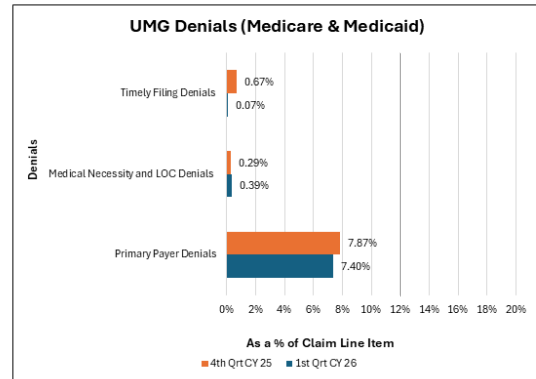
JDH Denials

- Primary Payer Denials increased slightly from 8.87% to 9.06%.
- Medical Necessity/LOC denials improved significantly, decreasing from 0.66% to 0.05%.
- Timely Filing denials were reduced from 0.08% to 0.04%.



UMG Denials

- Primary Payer Denials increased slightly and account for the majority of denials.
- Medical Necessity/LOC Denials remained very low.
- Timely Filing Denials remained negligible, indicating sustained performance in claims submission timeliness.

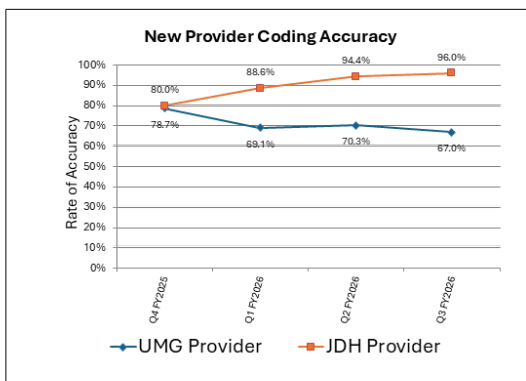


Internal Reviews (Government Overpayments, Coding, and Patient Rights) Cont'd

Coding (Appendix C)

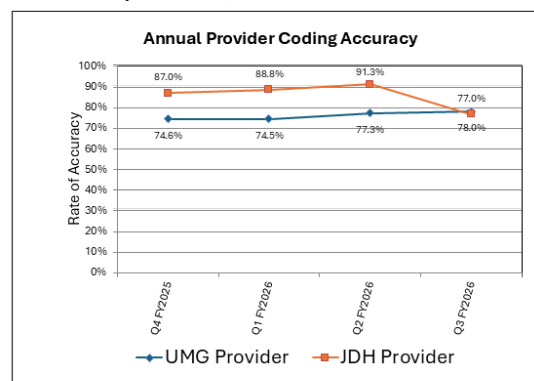
New Provider Coding Accuracy

- Both UMG and JDH providers started at the same coding accuracy rate but have since trended in opposite directions.
- JDH has shown steady improvement.
- UMG's accuracy has declined over time.



Annual Provider Coding Accuracy

- JDH Provider has consistently maintained coding accuracy above the ≥80% threshold throughout all quarters.
- UMG Provider has remained below the ≥80% accuracy. .
- UMG shows a gradual upward trend, reaching its highest accuracy of 78% in Q3 FY2026.

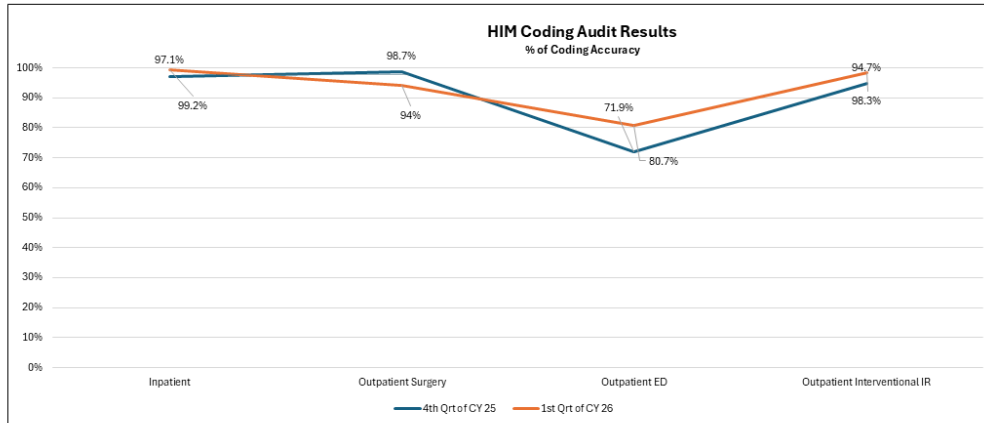


Internal Reviews (Government Overpayments, Coding, and Patient Rights) Cont'd

Coding (Appendix C)

HIM Coding Audit Results

- Strong overall coding audit performance, with accuracy rates remaining in the high 90% range.
- Mid-period decline identified, highlighting opportunities for targeted coding improvements.
- Performance recovered by period end, returning to near-target accuracy levels following corrective actions

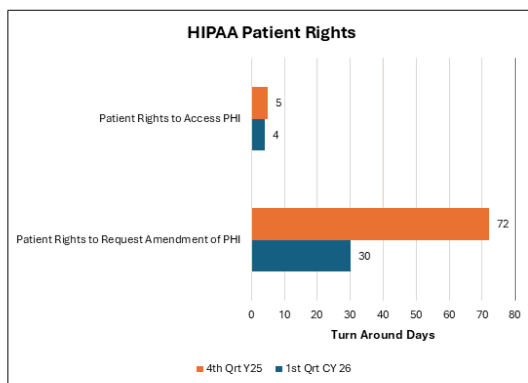


Internal Reviews (Government Overpayments, Coding, and Patient Rights) Cont'd

Patient Rights and Right to Access PHI

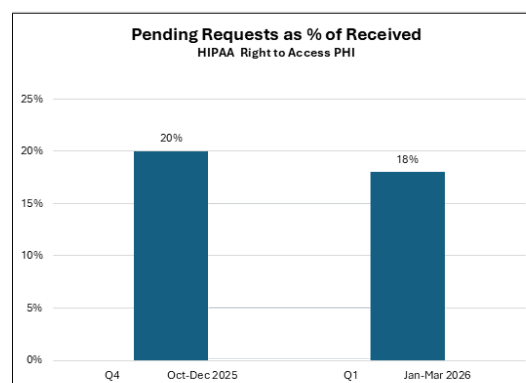
HIPAA – Patient Rights

- Quarterly performance metrics for patient requests to access Protected Health Information (PHI).
- Quarterly turnaround times for processing patient requests to amend Protected Health Information (PHI).



HIPAA – Right to Access PHI

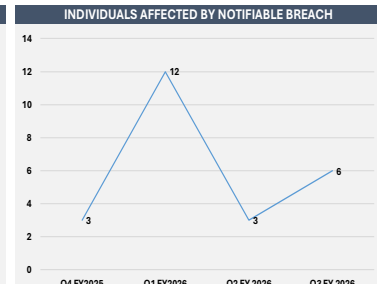
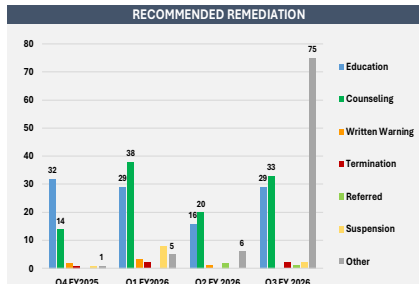
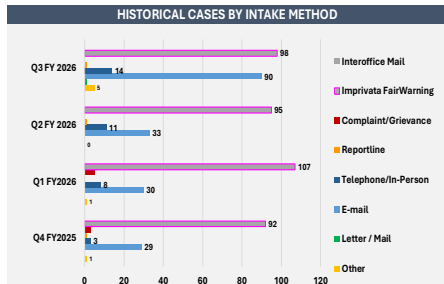
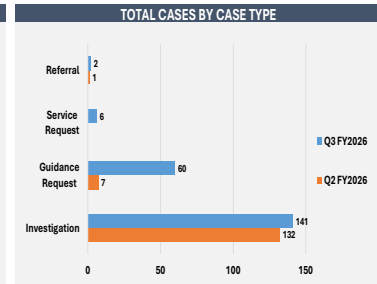
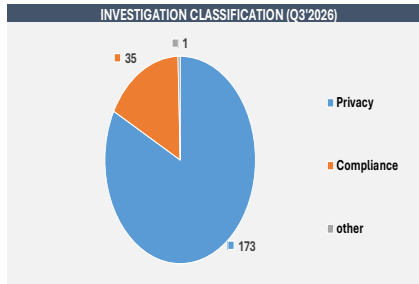
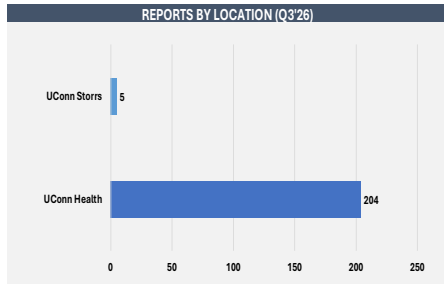
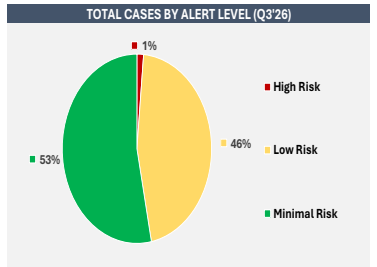
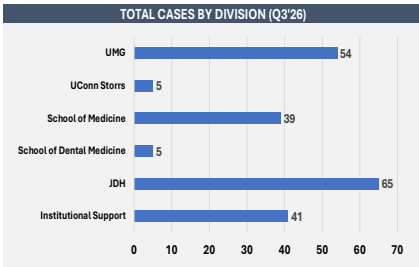
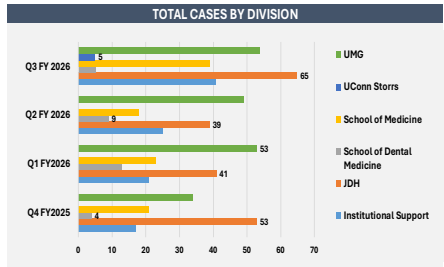
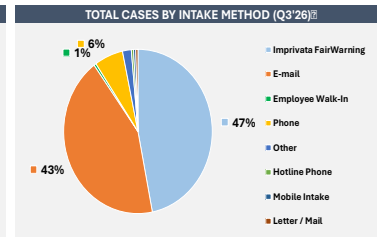
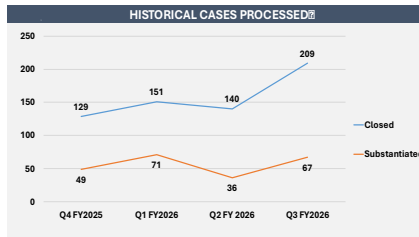
- Pending HIPAA Right of Access PHI Requests as a Percentage of Total Requests Received.
- Reduction in Pending HIPAA Right of Access PHI Requests from 20% in Q4 to 18% in Q1.



OFFICE OF HEALTHCARE COMPLIANCE & PRIVACY CASE STATUS REPORT

FY2025 Q4 through FY2026 Q3

TOTAL CASES PROCESSED (Q3'26)		
209		
Unsubstantiated	Substantiated	Partially Substantiated
74	67	0
Service Provided	Referred	Other
67	1	0



Healthcare Compliance & Privacy Program (cont'd)

Item	Status									
Education and Awareness (Appendix D)	Annual Training Launch: Jan 26, 2026 Deadline: May 1, 2026 Status as of May 19 95% Complete 5% Remaining. 95% Remaining non-completions were referred to HR for follow-up. OHCP and IT Security Matters – Monthly Compliance Matters <table><tr><th>Privacy</th><th>Financial</th><th>Cybersecurity</th></tr><tr><td>Updated Notice pf privacy Practices</td><td>Conflict of interest Disclosures</td><td>Wi-Fi Risks</td></tr><tr><td>Annual Training</td><td></td><td>Phishing Awareness</td></tr></table>	Privacy	Financial	Cybersecurity	Updated Notice pf privacy Practices	Conflict of interest Disclosures	Wi-Fi Risks	Annual Training		Phishing Awareness
Privacy	Financial	Cybersecurity								
Updated Notice pf privacy Practices	Conflict of interest Disclosures	Wi-Fi Risks								
Annual Training		Phishing Awareness								
Auditing and Monitoring Plan	10 projects planned for FY 2026. Projects are spanned across fiscal years, with the majority planned to begin in Q4.									
OHCP Work plan (Appendix E)	Please find the updated workplan on Appendix F.									
Sanctions and Exclusions	18 total individuals investigated and resolved.									

Pharmacy Healthcare Compliance & Privacy Program (cont'd) (Appendix F)

Item	Status
 Audit Status	HRSA audit completed (Feb 2026); final report pending. Program in good standing with only minor follow-up expected. Third-party audits completed; improvements in progress.
 Oversight and Governance	Active oversight in place. 340B Committee meets regularly (most recently in April 2026). Ongoing review of compliance, savings, and regulatory updates.
 Financials	Routine monitoring effective. \$6.8K identified in manufacturer reviews; majority recovered. No significant financial or audit issues.
 Regulatory	Rebate model on hold (federal ruling). 42 manufacturers are implementing restrictions. Duplicate discounts/rebate gaps identified. Exploring a vendor solution for tracking and recovery.
 Program Sustainability	DSH projected to remain >11.75% (FY2026). Strategies in place to maintain eligibility.
 Specialty Pharmacy (UHPSI)	Table operations; no major compliance concerns. Accreditations current (URAC, ACHC). No significant audit findings or takebacks. Retail pharmacy opening Dec 2026 (on track).
 Additional Compliance	No systemic issues. 3 minor PHI incidents were managed appropriately. Licensing and audits up to date

APPENDIX - Supporting documentation for the dashboard

Appendix A - External Reviews

Topic	Metrics	HB Activity	PB Activity
RAC			
	Number of Records Requested		
	Dollars at Risk	12,5537.00	106,106
	Number of No Findings		
	Number Pending		
	Number Denied		
	Activity Period Losses to Date	0.00	12,311
MAC			
	Audit Name	PERM	
	Number of Records Requested	0	
	Dollars at Risk		
	Number of No Findings		
	Number Pending		
	Number Denied		
	Activity Period Losses to Date		
TPE			
	Audit Name	J1569 IVIG	
	Number of Records Requested	6	
	Dollars at Risk	\$19,782	
	Number of No Findings	3	
	Number Pending		
	Number Denied	3 (partial denials)	
	Final Audit Loses	\$9,891	
TPE #2			
	Audit Name	Jo897 Prolia (Round 2)	
	Number of Records Requested	7	
	Dollars at Risk	\$12,400	
	Number of No Findings	7	

	Number Pending		
	Number Denied		
	Final Audit Loses		
TPE #3	Audit Name	90837 Psychotherapy	
	Number of Records Requested	1	
	Dollars at Risk	\$212	
	Number of No Findings	1	
	Number Pending		
	Number Denied		
	Final Audit Loses		
QIO			
	Audit Name		
	Number of Records Requested	0	
	Dollars at Risk		
	Number of No Findings		
	Number Pending		
	Number Denied		
	Audit Loses to Date		
CERT			
	Number of Records Requested	0	
	Dollars at Risk		
	Number of No Findings		
	Number Pending		
	Number Denied		
	Audit Loses to Date		

Appendix B – Government Overpayments

Topic	Metrics	Dental	HB Activity	PB Activity
Review 1	Audit Name and Description of Issue: HB Lupron Specialty Pharmacy Supplied Drug: Through QA request for PB review of stated drug, review found full billing on PB for specialty pharmacy. Concerns that there could be HB issues were brought forward and full review was done for HB. Delay in corrections due to clinical documentation updates/concerns that were ultimately handled by the pharmacy team.			
	Date Reported to GPOC	N/A	N/A	July 2025
	Time Period Reviewed	N/A	N/A	Full Review to Go Live
	Total Claims Impacted	N/A	N/A	24 Accounts
	Total Overpayment Amount	N/A	N/A	\$12,317.74
	Medicare Overpayment Amount	N/A	N/A	N/A
	Medicaid Overpayment Amount	N/A	N/A	\$8,251.03 (Includes 2 secondary claims)
	Self Pay Overpayment Amount	N/A	N/A	N/A
	Commercial Payer Overpayment Amount	N/A	N/A	\$2,138.08
	Date Refund(s) Completed	N/A	N/A	02/05/26 (adjustments submitted for correction/refunding)

Appendix C – Coding

Jan. Feb. March 2026	# of Providers Reviewed	# of records audited	Accuracy %	Accuracy Whole %	# of Providers that DIDN'T meet goal	# of Providers at or above 80% Accuracy	# of Providers at or above> 90% Accuracy	# of Providers 100%
PB New Provider Review	14	160	66.88%	67%	5	7	1	1
PB Department Review	149	1545	78.38%	78%	60	43	30	16
HB New Provider Review	1	28	96.43%	96%	0	0	1	0
HB Department Review	17	218	76.61%	77%	5	7	3	2

Appendix D– Education and Training

HEALTHCARE COMPLIANCE & PRIVACY AND IT SECURITY MATTERS



Coming Soon: Updated Notice of Privacy Practices

An updated UConn Health Notice of Privacy Practices will be available soon. Learn what's changing effective February 16, 2026

[Read More](#)



Coming Soon: 2026 Annual Compliance Training

The Annual Healthcare Compliance & Privacy and IT Security training will be assigned to all employees later this month. Please watch your email and Lifeline messages for more details.



IT SECURITY TIP



Keep Your Email Secure – Protect Yourself and our Patients

To help keep you and our patients safe, please remember that **personal email accounts** (such as Gmail, Yahoo, or Outlook.com) must not be connected to your UCH email account. This includes auto-forwarding, syncing messages, or adding personal accounts to Outlook.

Keeping work and personal email separate is essential for:

- Protecting sensitive patient information
- Maintaining HIPAA compliance
- Meeting UCH security standards
- Reducing the risk of accidental data exposure

Simple Ways to Stay Secure

- Use UCH-approved tools — Outlook, Teams, OneDrive, and SharePoint
- Avoid adding personal accounts to Outlook
- Do not set up auto-forward rules to personal email services
- Store and share files only in approved UCH platforms

Need Assistance?

Call the **Service Desk** at x4400. The team is happy to assist with email settings, security questions, and removing personal accounts from Outlook.

Thank you for doing your part to keep UCH safe, secure, and compliant!

HEALTHCARE COMPLIANCE & PRIVACY AND IT SECURITY MATTERS



2026 Annual Compliance Training

If you have not already completed the 2026 OHCP/IT Security Training module, please make sure to complete this mandatory training by May 1, 2026.

[Read More](#)



Updated Notice of Privacy Practices

Reminder: The revised UConn Health Notice of Privacy Practices is now in effect. Look for it in patient areas, in Epic, online, or in print via the Design & Document Production Center. Questions? Contact the [QHCP](#).



IT SECURITY TIP



Be Cautious with Unknown Wi-Fi Networks

Connecting to free or unfamiliar Wi-Fi networks, such as those at coffee shops, conferences, airports, or even some guest networks, can expose sensitive information to serious security threats. Connecting to these networks can put patient data, proprietary research, and organizational systems at risk of interception, hacking, or malware attacks.

Why it's dangerous:

- Hackers can secretly watch what you send and receive.
- They can steal your login passwords or trick you into sharing information.
- Your device could pick up harmful software that later spreads when you connect back to our network.
- Even a small slip could expose protected health information (PHI) and cause a serious breach.

Simple ways to stay safe:

- Avoid unknown Wi-Fi for anything work-related.
- Always use the UConn Health Cisco VPN client first, if you have to connect.
- Double-check the exact network name with staff or signs.
- Turn off "auto-join" for Wi-Fi networks on your phone/laptop.
- Use your phone's cellular data or personal hotspot instead.

A single connection to the wrong network can put patients, research, and our entire organization at risk.

Appendix D– Education and Training



Reminder: Financial Conflict of Interest (FCOI) Disclosure Due June 7, 2026

To help you prepare for the upcoming FCOI disclosure deadline, please review the guidance to ensure your disclosure is submitted on time.

[Read More](#)



IT SECURITY TIP



Pause Before You Share: Internal Requests Need Verification Too

Even messages that look internal can be part of a scam. Attackers increasingly compromise real employee accounts and then request sensitive information, wire transfers, password resets, or urgent help—often using familiar names and internal language.

How to stay secure:

- Treat unexpected requests for sensitive information as suspicious, even if they come from a known colleague.
- Verify requests using a second method (phone call, Teams message, or in-person).
- Be extra cautious with requests involving PHI, credentials, financial actions, or system access.
- When in doubt, report it to IT Security or the Service Desk and don't respond.

Why this matters:

Many recent breaches start with trusted internal access rather than external phishing. Taking a moment to verify can prevent a major incident.

Appendix E – OHCP Workplan

Activity		Responsible Area	Complete By	Notes	Status
<i>Element # 1 of an Effective Compliance Program - Implement written policies, procedures, and standards of conduct</i>					
1.a.	Perform Annual Review & Update Healthcare Compliance Policies	Healthcare Compliance	12/31/2026		Ongoing
1.b.	Perform Annual Review & Update Healthcare Privacy Policies	Healthcare Privacy	12/31/2026		Ongoing
1.c.	Assess, Adapt, and Implement Healthcare Compliance & Privacy Policies to UConn Healthcare Covered Components as applicable	Healthcare Compliance & Healthcare Privacy	4/30/2026		In process
1.d.	Develop and implement a Recruitment of Patients for Research Policy	Healthcare Privacy	2/28/2026		In process
1.e.	Assess and/or implement Healthcare Compliance Policies for Waterbury Health and other new affiliates if/as applicable	Healthcare Compliance	TBD		Not Started
1.f.	Assess and/or implement Healthcare Privacy Policies for Waterbury Health and other new affiliates if/as applicable	Healthcare Privacy	TBD	Conducted initial review of Waterbury Privacy policies 12/31/25 and determined no immediate action needed. Further review and refinement will be ongoing.	In Process
<i>Element # 2 of an Effective Compliance Program - Designate a compliance officer and a compliance committee</i>					
2.a.	Staff the Quarterly Healthcare Compliance and Privacy Committee (HCPC), including development of agenda, materials, and meeting minutes	Healthcare Compliance & Healthcare Privacy	Ongoing		Ongoing

2.b.	Collaborate with AMAS & University Compliance to support preparation of healthcare compliance meeting materials and related items for Joint Audit & Compliance Committee (JACC)	Healthcare Compliance & Healthcare Privacy	Ongoing		Ongoing
2.c.	Provide support for healthcare compliance and privacy governance if/as needed for Waterbury Health and other new affiliates if/as applicable	Healthcare Compliance & Healthcare Privacy	TBD		Not Started
<i>Element # 3 of an Effective Compliance Program - Conduct effective training and education</i>					
3.a.	Review & update New Hire Healthcare Compliance, Healthcare Privacy trainings that are provided as part of the orientation of new workforce members	Healthcare Compliance & Healthcare Privacy	3/31/2026		Completed
3.b.	Review, update, and launch the annual required Healthcare Compliance, Healthcare Privacy, and Information Security trainings that are provided to all workforce members	Healthcare Compliance & Healthcare Privacy	6/30/2026		In process
3.c.	Assess, Adapt & Implement Healthcare Compliance, and Healthcare Privacy trainings for UConn Healthcare Covered Components as applicable	Healthcare Compliance & Healthcare Privacy	4/30/2026		Completed
3.d.	Implement New Hire and Annual Healthcare Compliance and Privacy Trainings for Waterbury Health and other new affiliates if/as applicable	Healthcare Compliance & Healthcare Privacy			Ongoing

3.e.	Implement Onboarding/Annual Healthcare Compliance and Privacy Training for Solnit	Healthcare Compliance & Healthcare Privacy	4/30/2026		Completed
Element # 4 of an Effective Compliance Program - Develop effective lines of communication					
4.a.	Develop and send monthly healthcare compliance, privacy and information security matters to workforce members to educate and update on related matters	Healthcare Compliance & Healthcare Privacy	12/31/2026	In addition to Monthly Matters, provide in-person briefs to departments upon request. Provided 2 briefings as of 2/18/26. Develop topic-specific materials to address noted trends in privacy cases.	In process
4.b.	Collaborate with Office of General Counsel (OGC) to review, update, and implement updated UConn Health Notice of Privacy Practices including updates to address new privacy protections for substance use disorder (SUD) records.	Healthcare Privacy	2/16/2026	Updated NoPP finalized and posted	Completed
4.c.	Collaborate with Office of General Counsel (OGC) to draft & implement a Notice of Privacy Practices for Waterbury Health and other new affiliates if/as applicable	Healthcare Privacy	TBD	Current NoPP has been reviewed.	Not Started
4.d.	Promote awareness of OHCP and related resources and reporting mechanisms through planning & implementing annual "National Compliance Week" activities	Healthcare Compliance & Healthcare Privacy	11/30/2026		Not Started
Element # 5 of an Effective Compliance Program - Conduct internal monitoring and auditing					
5.a.	Perform "Destruction of Premalignant Lesions" audit/review	Healthcare Compliance	12/31/2026	Looking for excessive units. CPT codes 17000 and 17004 may be billed only once and CPT code 1700 may be billed up to 13 times	Not Started Target Start: July

5.b.	Perform audit/review of "Evaluation and Monitoring (E/M) Same Day as Nursing Facility Admission"	Healthcare Compliance	12/31/2026	Watch for improper unbundling. CMS does not pay for an emergency department visit or an office E/M services and a comprehensive nursing facility assessment when both are performed on the same day by the same physician. Applies to CPT codes 99201-99215, 99281-99285	In progress
5.c.	Perform audit/review of "Vitamin D Assay Testing"	Healthcare Compliance	12/31/2026	Verify medical necessity and documentation requirements, as Vitamin D assay testing for routine screening is not covered by Medicare	In progress
5.d.	Perform audit/review of "Computerized Tomography (CT) Coronary Angiography"	Healthcare Compliance	12/31/2026	Verify medical necessity and documentation requirements, as RACs are reviewing documentation for coronary angiography CT claims to determine coverage criteria and coding guidelines are met, and service is medically necessary	Not Started Target Start: July
5.e.	Perform audit/review of "Immunosuppressive Drugs"	Healthcare Compliance	12/31/2026	RACs are reviewing claims for medical necessity & documentation requirements for claims with HCPCS Level II code J7507. This drug is used to prevent transplanted organ rejection. MACs report excessive use of this code	Completed No impact to organization. Closed
5.f.	Perform audit/review for "Spinal Cord Neurostimulation"	Healthcare Compliance	12/31/2026	RACs are checking claims for medical necessity and documentation requirements for claims with CPT code 63685	In progress
5.g.	Perform audit/review of "Modifiers TC and 26"	Healthcare Compliance	12/31/2026	MACs are seeing incorrect use of technical and professional component modifiers leading to overpayments	Not Started Target Start: July
5.h.	Perform review/audit of documentation and related billing/coding for providers using DAX copilot ambient listening AI tool	Healthcare Compliance	6/30/2026	Review to ensure that documentation is complete and appropriate and billing/coding is appropriately supported by documentation	Not Started Target Start: July

5.i.	Review, and develop and implement compliance review of new procedures or service lines implemented during 2026 if/as applicable	Healthcare Compliance	TBD	Perform compliance review for new procedures or service lines that may be added to ensure compliance	Not Started
5.j.	Implement periodic healthcare privacy rounding program for UConn Health	Healthcare Privacy	6/30/2026	Implement a process to round JDH, UMG, and other UConn Health locations to assess privacy risks and provide brief privacy education & sharing of best practices	Not Started
5.k.	Perform Epic access review of New England Donor Services (NEDS) employees	Healthcare Privacy	Ongoing	Initial review of all active NEDS users (54 users) completed 4/16/26. A sample of NEDS employees will be reviewed quarterly beginning 7/1/26.	Ongoing
<i>Element # 6 of an Effective Compliance Program - Enforce standards through well-publicized disciplinary guidelines</i>					
6.a.	Collaborate with Human Resources/Labor Relations (HR) to develop and implement a Sanctions for Privacy and Security Violations policy & procedure	Healthcare Privacy	6/30/2026	Provided new LR Director with current drafts of Policy and Procedures after incorporating input from LR staff	In process
6.b.	Collaborate and Support HR to ensure appropriate sanctions or corrective actions are taken with workforce members responsible for healthcare compliance or privacy violations	Healthcare Compliance & Healthcare Privacy	Ongoing	Consistently meet with HR and LR to discuss workforce violations. Provide audit logs and professional guidance upon request related to Privacy and Compliance issues.	Ongoing
<i>Element # 7 of an Effective Compliance Program - Respond promptly to detected offenses and undertake corrective action</i>					
7.a.	Perform daily access monitoring to UConn Health electronic medical record, and perform necessary investigation & corrective action for instances of non-compliance	Healthcare Privacy	Ongoing	Perform daily reviews of potential impermissible access and investigate as necessary. Follow through with HR/LR and workforce management to ensure corrective actions are taken.	Ongoing

7.b.	Investigate reported or identified healthcare privacy concerns, performing risk assessment and breach notification procedures and mitigation and corrective action if/as necessary	Healthcare Privacy	Ongoing	Daily monitoring of all sources of contact that receive privacy issue. Perform investigations, conduct risk assessments, provide breach notifications when necessary and ensure mitigations and correctives actions as indicated.	Ongoing
7.c.	Investigation reported or identified healthcare compliance concerns and perform mitigation and corrective action if/as necessary	Healthcare Compliance	Ongoing		Ongoing

Appendix F - Pharmacy

340B Review:

- Audits:
 - HRSA Audit: In December, the 340B Program was notified that our DSH Covered Entity had been selected for a HRSA audit. The audit was conducted remotely on February 18 and 19, 2026. While specific findings were not shared at the conclusion of the audit, we anticipate the final HRSA-OPA report will confirm the program remains in good standing, with only minor items potentially identified for follow-up. Based on prior experience, final determinations are typically issued within 60-90 days, although no official timeline was provided.
 - Third-Party Audit: Independent external mock audits of the HTC and RWI Grantee programs are scheduled to occur on March 23 and March 24, respectively. The DSH program mock audit was conducted on February 16–17 using HRSA-selected sample data in preparation for the official HRSA audit.

340B Oversight Committee activity:

- The Committee meets at least 4 times a year and has a typical cadence of every other month. During the meetings internal quality assurance monitoring data for different compliance requirements with HRSA is presented and discussed along with net-savings data, contracting, accumulator monitoring as well as pertinent legislative updates. The most recent meeting was held on 2/27/2026.
 - Walgreens Self-disclosures: Per our usual process, we have extracted from our Walgreens portal those claims that have been reversed in the previous FY25 due to being slow movers and not reaching a full package size or being reversed due to incorrect qualification and not netting out. Thirteen manufacturer disclosures were identified for JDH (none for RWI), totaling \$6,860.40. Letters were sent to all manufacturers, and nine out of thirteen manufacturers responded and have been reimbursed totaling \$6542.19
 - Third-Party Audit reviews- as stated above.
 - DSH percentage: Dr. Agwunobi's workgroup continues to work on preserving our DSH percentage so that it will remain above 11.75% for FY2026. The 2025 Reconciliation law reduces federal funding related to Medicaid and therefore less patients are expected to qualify for Medicaid negatively impacting our DSH percentage. The workgroup has implemented multiple different strategies so far and continues to work on additional strategies.

- **Legislative updates:**

The implementation of the IRA's first 9 out of 10 drugs prompted HRSA to introduce a 340B rebate model through the Beacon platform, originally scheduled to go live on January 1, 2026. On December 31, 2025, HRSA announced it was pausing implementation of the 340B Rebate Model Pilot Program in response to a federal court decision that temporarily blocked the program. On February 13, HRSA released a Request for Information (RFI) seeking extensive data from Covered Entities, including detailed operational information, contract terms, and other inputs related to potential costs under a 340B rebate model. The RFI was initially due March 19 but has since been extended to April 20, 2026. Additionally, on February 25, HRSA published a new Information Collection Request (ICR) related to a potential 340B

rebate model pilot program. Our collaborative believes this action is likely intended to address concerns raised by the Court in the litigation associated with the previously approved and subsequently withdrawn rebate pilot. The collaborative is currently seeking Covered Entity feedback, and we will need to consider whether to participate.

In the interim, Eli Lilly and Novo Nordisk announced a new policy that conditions access to 340B pricing on the submission of claims data for drugs dispensed through hospital in-house pharmacies, including both retail and mixed-use locations. Stakeholders have raised concerns that this policy may unlawfully restrict access to 340B pricing.

Separately, Congress enacted new attestation and identifier requirements for off-campus hospital outpatient departments. Under this policy, hospitals must obtain a location-specific National Provider Identifier (NPI) for each off-campus outpatient department and use it when billing Medicare. Hospitals must also submit provider-based attestations for each off-campus outpatient department. These requirements must be implemented by January 1, 2028; otherwise, no Medicare payment under the Outpatient Prospective Payment System (OPPS) will be made for items or services furnished at those locations. The rule also establishes that off-campus provider-based departments must be located within a 35-mile radius of the main provider's campus to qualify for provider-based status. We will continue to monitor developments and provide updates as additional guidance becomes available.

UHPSI (Specialty Pharmacy):

-Accreditations are up to date for both URAC and the Accreditation Commission for Health Care (ACHC)

- Next Accreditation cycle is FY 2026-27
- Submitting annual audited clinical metrics to URAC as required for specialty pharmacy accreditation

-No known audits of scale (anticipated next Medicaid audit to occur 2025/2026 with a 3-year window of scope (e.g., 2023-2026)

- Next anticipated Medicaid Audit to cover the dates February 1, 2023- January 31, 2026

-We continue to have routine desk audits from PBM's of individual Rx claims on a weekly/daily basis; no takebacks have been assessed

DEA visit on 7/31/25 resulted in a letter of admonition being issued on October 23 ,2025. All points raised were addressed by UHPSI and resolved before final response to LOA on November 7, 2025. SOP's were updated after the July visit and staff have been retrained on impacted areas. Next anticipated DEA visit is in three years.

Other related known issues

- Any cases of PHI shared with the incorrect patients were reported to compliance and reported as SE events
- One documented SE events for FY26 involved PHI shared with incorrect patients
- Renewal of all licenses completed and up-to-date; do not anticipate any issues
 - Applying for non-resident retail license for the state of Maine – expected to submit March 2026
- Likely Drug Control for unannounced visits for wholesale (summer 2027) or retail (spring 2026) standard site visits in the next 12-24 months

UHPSI - UHIPS (Infusion Pharmacy):

- No updates; suspended infusion services on September 30,2025

MTM:

- No updates

UHPSI-Retail

- Retail pharmacy be presented to CT Commission of Pharmacy for design approval March/April 2026
- Targeted opening date: November 1, 2026

ATTACHMENT 4.4

ATTACHMENT 4.4

AI Governance Profession Report 2025

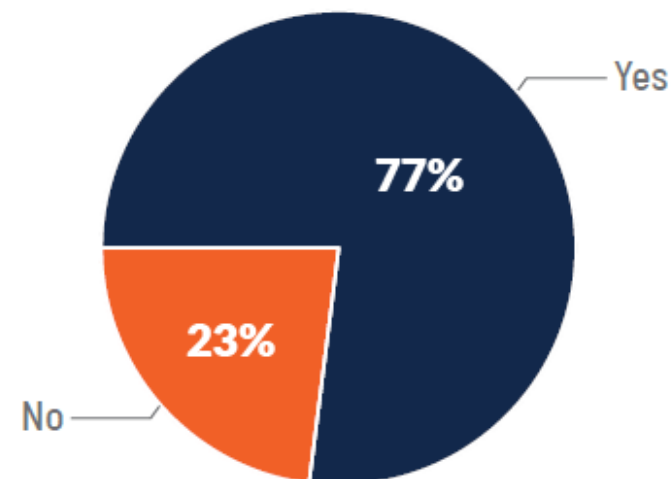
Executive summary

AI governance has proved its value to organizations.

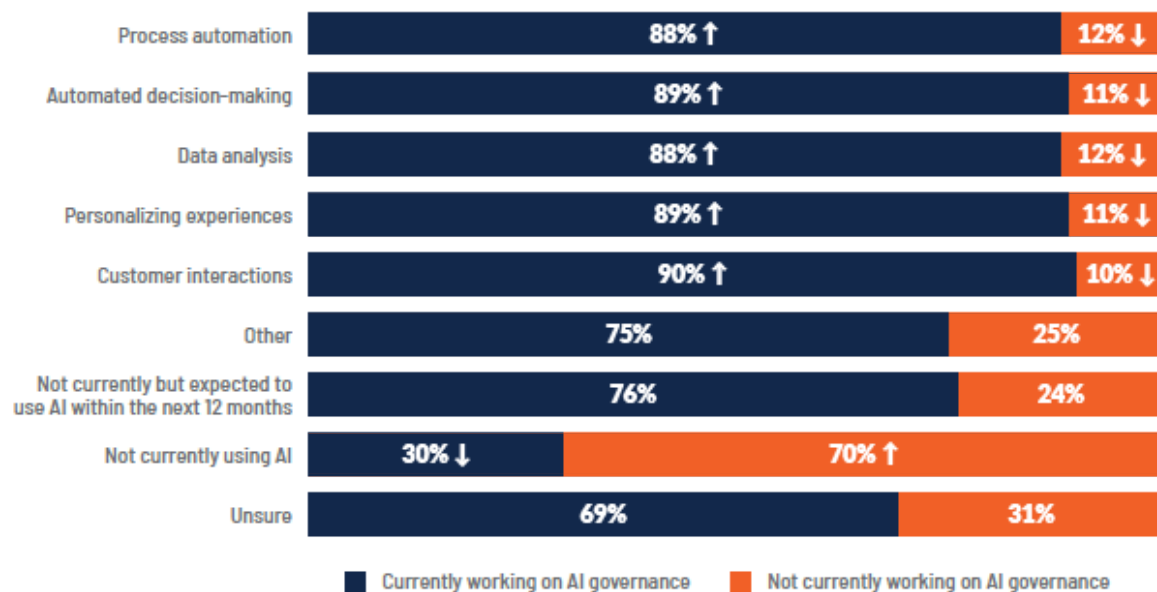
The promulgation of AI governance legislation, regulations and standards combined with increasingly complex and demanding sociotechnical pressures have organizations prioritizing the building and implementation of AI governance programs.

This report, and the data within it, profiles the extent to which organizations are implementing AI governance programs, and how they are doing so. Indeed, survey data shows how the development and deployment of AI by organizations very often goes hand in hand with AI governance.

Is your organization currently working on AI governance?



AI governance use in different groups of AI users



Of surveyed organizations, 77% are currently working on AI governance, with a jump to near 90% for those organizations already using AI. Importantly, 30% of organizations not yet using AI reported working on AI governance, perhaps revealing a prevailing "governance first" prioritization of ensuring good governance is in place before AI use. This is supported by some of the case studies, which indicate organizations are implementing formal AI governance programs after using AI for smaller use cases but before embracing AI as a strategic imperative.

Starting an AI governance program involves hiring new or dedicating existing employees to an AI governance team. Companies are building these teams incrementally, starting with tasking the existing workforce and then hiring and empowering senior managers and executives, which the data suggests leads to fewer issues using AI and reporting on AI governance, among other positive outcomes. Many of the case studies illustrate how newer AI governance programs hire managers with prior experience in a digital governance discipline, like privacy.

Importantly, 30% of organizations not yet using AI reported working on AI governance, perhaps revealing a prevailing "governance first" prioritization of ensuring good governance is in place before AI use.



**Many organizations with mature
AI governance programs
are drawing in specialists
from several departments,
regardless of the main
AI governance function.**

A significant challenge identified by respondents was access to appropriate AI governance talent and skills in the workforce. Of respondents, 23.5% said finding qualified AI professionals was part of the challenge delivering AI. Another part of the challenge is the host of skills qualified AI governance professionals need. They should, of course, understand AI but also have experience in governance, risk and compliance, and they should be able to translate legislative requirements into actionable policies, for example. While larger companies can split these tasks into several roles, smaller companies will look for AI governance professionals who can cover all these areas. Respondents indicated AI governance skills will continue to evolve alongside the development of new types of AI technologies and policies. Certain skills, such as red teaming, will be increasingly necessary.

There is no clear best practice for how to build and organize an AI governance team, including the location of those directly responsible for AI governance, for example as a separate team or integrated into a broader team responsible for other digital portfolios. From an organizational structure perspective, the data shows 50% of AI governance professionals are typically assigned to ethics, compliance, privacy or legal teams. Many organizations with mature AI governance programs are drawing in specialists from several departments, regardless of the main AI governance function. Over 50% of respondents indicated the following disciplines would gain additional responsibility: privacy, IT, security, and legal and compliance.

Disciplines already involved in digital responsibility are relevant as either the main function or as a collaborating function in AI governance. Organizations often share joint responsibility with privacy and other disciplines, such as cybersecurity or data governance. Respondents indicated AI governance professionals come from different disciplines and areas of expertise, and a strong number of privacy professionals are continually asked to take on AI governance roles.

Organizations building their AI governance programs out of or in conjunction with their privacy programs are likely to adapt those structures, processes and tools. One common example is the AI risk impact assessment process, in which relevant questions about AI are added to existing privacy governance documentation and processes.

AI governance is still evolving, and mature AI governance programs continue to find room to innovate. As new guidance and compliance burdens emerge, alongside new and greater commercial opportunities associated with good governance, a mature AI governance program will look different in 2025 or 2026 than it did in 2024 at the same organization. Nevertheless, patterns have already emerged, especially related to the integrated nature of diverse digital teams, what governance looks like at different-sized organizations and each organization's approach for AI governance.

Research approach

Two data sources were employed in the making of this report. In the spring of 2024, the IAPP conducted its annual governance survey. The survey contained broad demographic questions, such as the size and revenue of the organization, as well as 25 questions related to AI governance. More than 670 individuals from 45 countries and territories responded. In the survey, a few questions revealed if the respondents are confident in their approach to AI governance: "Are you confident in your compliance with the EU AI Act?" and "Is your AI governance budget adequate?" Other questions were more basic: "Are you actively working on AI governance?" and "What are your challenges in reporting on or using AI?" Through these questions, we teased out subjective understanding of the maturity of an AI governance program. Some questions, like if the organization has an AI governance committee, are a sign of a mature AI governance program for a larger company but might be irrelevant for a smaller company.

A note on statistical significance: Throughout this piece, the term "significant" is only used to denote figures that are statistically significant at a 95% confidence interval ($p=0.05$). ↑ denotes a figure that is significantly higher than the rest of the sample, and ↓ denotes a figure that is significantly lower than the rest of the sample.



Currently, there is no clear best practice for structuring AI governance teams. Some companies embed AI governance in compliance or ethics teams, while others create stand-alone AI governance functions. AI governance is often split between multiple teams, including privacy, legal, security and risk management. As a result, AI risk impact assessments are inconsistent across organizations.

Navrina Singh
Founder & CEO, Credo AI

To complement the survey data, seven private companies with headquarters spread across North America and Europe and with business and governance practices distributed across the globe provided case studies to highlight examples of AI governance programs. The case studies describe how organizations make decisions relating to their AI governance programs, including the team's composition, their cross-functional cooperation and the tools employed. These case studies complement the insights gained from the survey data by providing individual and specific context to provide insight into the decisions made in each AI governance program. The variety of companies and their respective use of AI mirrors the diversity of approaches to governing AI, while highlighting commonalities among similar institutions.

The survey data can be used to group organizations by type and size, as well as by which AI technologies an organization uses and for what purpose.



Richard Sentinella
IAPP AI Governance Center
Research Fellow



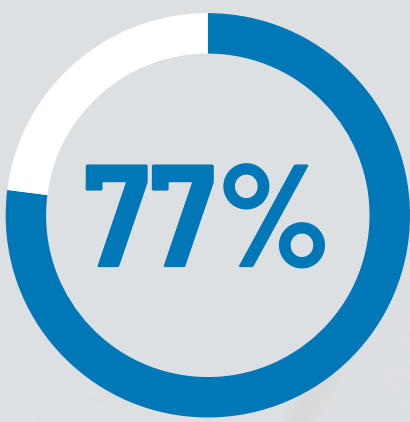
Evi Fuelle
Global Policy Director,
Credo AI



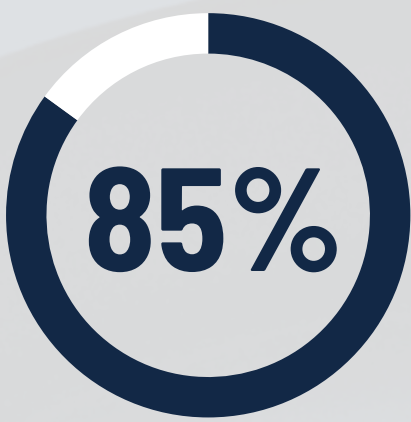
AT-A-GLANCE

AI Governance Profession Report 2025

AI governance is no longer a nice-to-have but increasingly a business imperative. Learn in IAPP and Credo AI's latest report about how your peers are implementing AI governance.

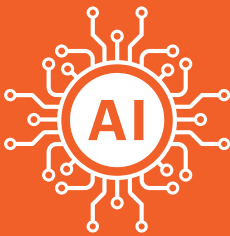


77% of organizations are currently working on AI governance and this number increases significantly to over 85% if they are also using AI.



30%

of organizations not yet using AI reported as working on AI governance, revealing “governance first” prioritization.

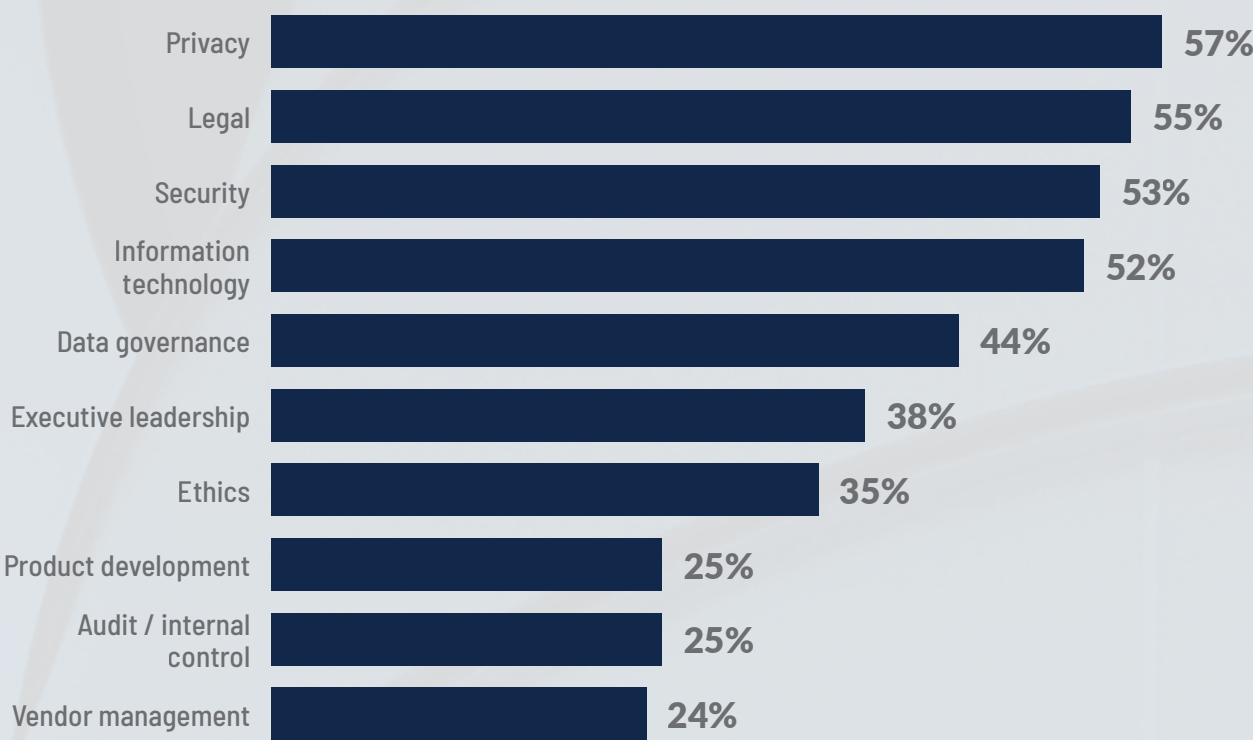


98% anticipate needing additional employees. On average, organizations anticipate needing to task 9.8 people with AI governance over the next 12 months but only 8% of organizations were recruiting.

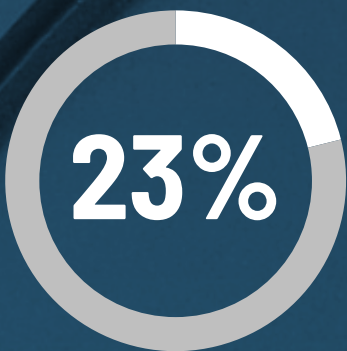
23.5% reported finding qualified AI professionals as a significant challenge of delivering AI.



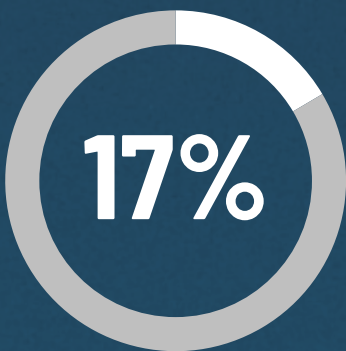
Which organizational functions have or will have additional responsibility for AI governance?



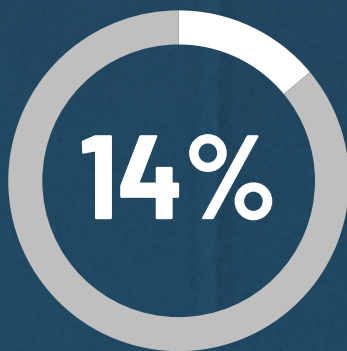
Most AI governance departments report to the general counsel or head of legal (23%), the CEO (17%) or the CIO (14%).



General counsel or head of legal



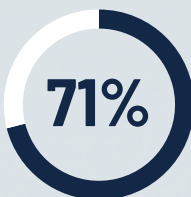
CEO



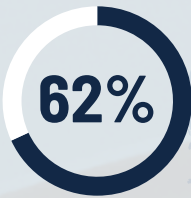
CIO

39%

of organizations report having an AI governance committee.



for organizations using AI for personalizing experiences



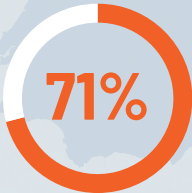
for organizations using AI for process automation



for organizations using AI for automated decision-making



where **primary responsibility** for AI governance rests with the **privacy function**



when the **most senior AI governance professional** in the organization is **at least a senior vice president** in the organization

HuskyCT FERPA Training for Everyone Decommissioning

EFFECTIVE JULY 1, 2026

Earlier this spring, the UConn Privacy Program launched updated FERPA and Privacy training modules for professional employees and students. As part of this transition, the original FERPA Training for Everyone modules hosted in HuskyCT will be **permanently retired on July 1, 2026**. All official University training links now direct users to the updated modules on the Privacy website. However, some internal materials may still reference the legacy training during this transition.

REQUIRED ACTIONS

1

Review Department Training Materials

Check onboarding documents, SharePoint pages, and printed guides for any links to the legacy HuskyCT FERPA Training for Everyone modules.

2

Update Links By July 1

Replace any outdated links with the current training available on the [UConn Privacy training website](#). After July 1, the legacy links will no longer function.

3

Accessing Legacy Completion Records

Completion records will remain available in HuskyCT under the “Useful Links” section after the module is retired.

QUESTIONS?

For questions about training access, completion records, or updated training links, please contact the UConn Privacy Office at: [UConn Privacy](#).

Compliance Chatter

Spring 2026 University Policy Updates

The following policies were approved by the Senior Policy Council and the President.

Hazardous Materials Donations Policy

(New)

Applies to: All UConn campuses, except UConn Health

Effective: June 1, 2026

Establishes a requirement that all donations of hazardous materials be reviewed and approved by Environmental Health & Safety prior to acceptance to ensure safety, regulatory compliance, and cost control.

[VIEW THE POLICY](#)

Consumable Stores and Supplies Inventory Policy

(Revised)

Applies to: All UConn campuses, except UConn Health

Effective: April 30, 2026

Clarifies policy language, definitions, and inventory concepts and updates references and links.

[VIEW THE POLICY](#)

Service Center Policy

(Revised)

Applies to: All UConn campuses, except UConn Health

Effective: April 30, 2026

Updated as part of a scheduled review to align University requirements with current federal regulations (2 CFR Part 200).

[VIEW THE POLICY](#)

Pre-Employment Background Check Policy (Revised)

Applies to: All UConn campuses, except UConn Health

Effective: April 30, 2026

Expands background check requirements to all special payroll positions, aligning them with regular payroll requirements.

[VIEW THE POLICY](#)

Are you a University policy owner who needs to submit a new or revised policy for Senior Policy Council (SPC) approval?

Be sure to engage the Office of University Compliance early in the policy development process and submit final drafts before the policy submission deadline.

Next SPC Meeting

June 15, 2026

(The submission deadline has passed.)

Next Policy Submission Deadline for August SPC Meeting

July 20, 2026

If a proposed new or revised policy applies to UConn Health, the policy must first be approved by the appropriate UConn Health policy committee. This will affect the policy submission deadline. Check the SPC website below for more information.

[LEARN MORE ABOUT SPC](#)

[REPORT A CONCERN](#)

[CONTACT US](#)

[CONNECT ON LINKEDIN](#)

UConn
UNIVERSITY COMPLIANCE

ATTACHMENT 5.1

ATTACHMENT 5.1

University of Connecticut
Joint Audit & Compliance Committee Meeting
Public Session
June 25th, 2026

UConn – Information Technology Services

ITS Outreach

ITS hosted a conference-style professional development event for UConn staff called Tech Day on June 2nd. Presenters from multiple University departments and trainers from Microsoft and Nitro delivered practical sessions on how to use the major IT systems, services, and apps at UConn and leverage new features and technology, such as AI and automation, for greater workplace efficiency. Sessions on cybersecurity, brand standards, and accessibility increased awareness of institutional guidelines and policies. Over 250 staff joined in-person; many more watched the livestreamed sessions.

Major Outages (as of 6/4/2026)

<u>Outage Taxonomy</u>	<u># of Issues</u>	<u>Systems Affected</u>
Network Issue - Software	0	
Network Issue – Hardware	1	Core routing blade failed, requiring replacement. Reduced overall throughput during replacement. Redundancy resulted in limited user impact.
System Issue - Hardware	0	
System Issue - Software	0	
Third Party	1	Cisco User VPN Degradation We identified an issue that the vendor fixed. Redundancy prevented user impact

ATTACHMENT 5.2

ATTACHMENT 5.2

University of Connecticut
Joint Audit & Compliance Committee Meeting
Public Session
June 25th, 2026

UConn Heath – Information Technology Update

Major Projects Completed since March 2026

- Aetna, Cigna and Optum Behavioral Health payer contracts
- DocPanel – remote radiologist reading
- Epic - AI Text Assist
- Inpatient Stroke Service
- New Torrington Location go live
- CMS Telehealth Visit Restoration
- Bone Marrow Transplant Epic Enhancements for Front and Back End Billing
- Epic Lab Critical Result Closed Loop Communication
- System upgrades:
 - Epic
 - OnBase
 - EEG/EMG
 - Ellucian Banner

Major Outages (as of 6/4/2026)

<u>Outage Taxonomy</u>	<u># of Issues</u>	<u>Systems Affected</u>
Network Issue -	1	UT 6 computers, phones offline due to switch issue.
System Issue – Hardware	0	
System Issue – Software	2	CITRIX desktop issues on two separate occasions
Third Party	1	Talcott Notch lost network connectivity due to service provider issues.

Total # of Major Outages: 4