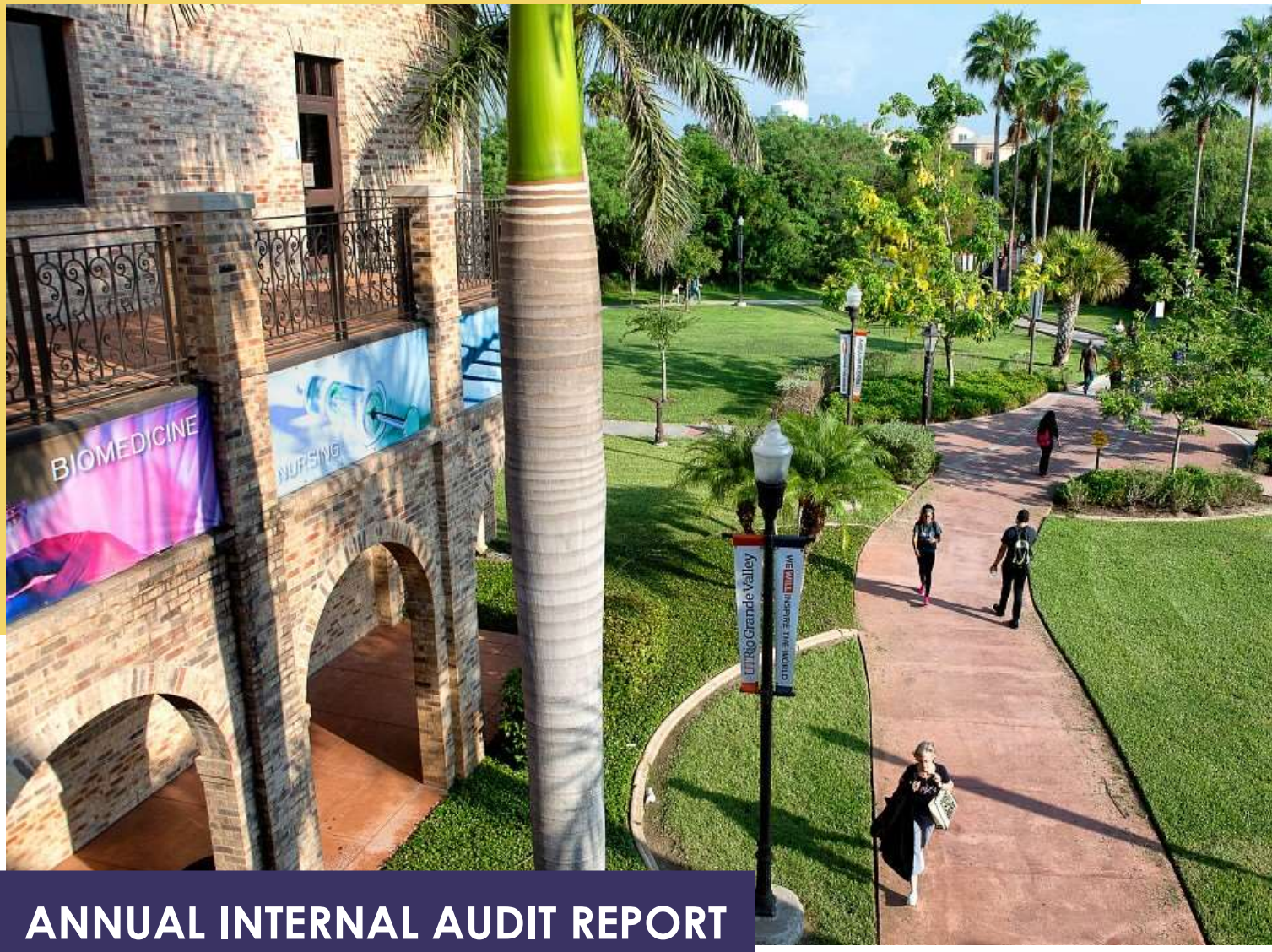

ANNUAL INTERNAL AUDIT REPORT FISCAL YEAR 2022

OFFICE OF AUDITS AND CONSULTING SERVICES

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SECTION I
Compliance with Texas Government Code, Section 2102.015: Website Postings

Compliance with Texas Government Code, Section 2102.015: Posting the Internal Audit Plan, Internal Audit Report, and Other Audit Information on Internet Website

Texas Government Code, Section 2102.015, requires state agencies and higher education institutions, as defined in the statute, to post certain information on their internet websites. Accordingly, an entity should post its final audit plan and annual report on its Internet website within 30 days after the audit plan and annual report are approved by an entity's governing board or chief executive.

In accordance with Texas Government Code, Section 2102.01, submitting and posting the fiscal year 2023 Internal Audit Plan and fiscal year 2022 Internal Audit Annual Report is due November 1, 2022. Agencies and higher education institutions are also required to post a summary of actions taken to address issues raised by the audit plan or annual report. In addition, all periodic internal audit reports should be submitted "not later than the 30th day after the date the report is submitted to the state agency's governing board or the administrator of the state agency if the state agency does not have a governing board."

To comply with the requirements of the Texas Government Code, Section 2102.015, the FY 2022 Annual Internal Audit Report is posted on the home page of the UTRGV website under the link https://www.utrgv.edu/audits/tools-and-resources/index.htm.

FY 2023 Internal Audit Plan is posted under the Office of Audits & Consulting Services' website link https://www.utrgv.edu/audits/tools-and-resources/index.htm.

All periodic internal audit reports were submitted to the Governor's Office of Budget, Planning & Policy, State Auditor's Office, Legislative Budget Board, and the Sunset Advisory Commission within 30 days of submitting these reports to UT Rio Grande Valley's Internal Audit Committee. In addition, the periodic internal audit reports were posted to the Office of Audits & Consulting Services' website link https://www.utrgv.edu/audits/tools-and-resources/index.htm

SECTION II
Internal Audit Plan for Fiscal Year 2022

Explanation of Deviations from Audit Plan

The FY 2022 Audit Plan Status Report indicates that the Office of Audits & Consulting Services did not complete all engagements on its budgeted audit plan. While not all audits/projects on the plan were completed, two engagements were in progress at year-end and initially carried forward to the FY 2023 Audit Plan. In addition, other engagements that were not started during the fiscal year were reassessed during the annual audit plan development process and added to the FY 2023 Audit Plan.

The FY 2022 original plan was revised to include four projects as additional carryforwards that were not completed in FY 2022: UT Health RGV Surgery and Women's Specialty Clinic Audit, MSRDP Audit, South Texas Diabetes & Obesity Institute Audit, and Fees and Other Charges Audit.

Refer to the FY 2022 Annual Audit Plan Status Report for details.

Audit Plan Status Report as of August 31, 2022

Engagement Name	Original Budget	Additions/ Deletions	Revised Budget	Actual Hours	Variance - Revised Budget to Actual	Percent of Total Revised Budget	Status as of August 31, 2022	Report/Memo Issued Date
Assurance Engagements								
Fixed Costs Contracts Audit	0.00	0.00	0.00	0.00	0.00		Report Issued #20CF-AEN-03	11/8/2021
FY21 Carryforward - UT Health RGV Surgery & Women's Specialty Clinic	75.00	0.00	75.00	45.50	29.50		Report Issued #21-AEN-02	11/22/2021
FY21 Carryforward - MSRDP (Faculty Practice Plan) Audit	75.00	0.00	75.00	59.00	16.00		Report Issued #21CF-AEN-04	2/22/2022
FY21 Carryforward - South Texas Diabetes & Obesity Institute	50.00	0.00	50.00	132.50	(82.50)		Report Issued #21-AEN-05	8/30/2022
FY21 Carryforward - ePHI Audit	100.00	0.00	100.00	488.00	(388.00)		Draft Report - Mgmt. Response	
FY21 Carryforward - Cloud/3rd Party Security Management Audit	100.00	0.00	100.00	462.00	(362.00)		Report Issued #21CF-AEN-09	8/31/2022
FY21 Carryforward - Fees and Other Charges Audit	200.00	0.00	200.00	270.50	(70.50)		Report Issued #21-AEN-12	4/7/2022
UTS 142.1 - Monitoring Plan & Account Reconciliations Audit	100.00	0.00	100.00	216.50	(116.50)		Report Issued #22-AEN-01	8/5/2022
Conflict of Interest Audit	250.00	0.00	250.00	0.00	250.00		Not Started; Included on FY2023 Audit Plan	
Cost Transfers Audit	250.00	0.00	250.00	0.00	250.00		Not Started; Included on FY2023 Audit Plan	
Institutional Review Board (IRB) Audit	300.00	0.00	300.00	0.00	300.00		Not Started; Included on FY2023 Audit Plan	
Patch Management Audit	300.00	0.00	300.00	0.00	300.00		Not Started; Included on FY2023 Audit Plan	
Denials Management Audit	250.00	0.00	250.00	109.00	141.00		Addressed - External Engagement by PWC	
Payment Card Industry Data Security Standards (PCI) Audit	300.00	(300.00)	0.00	0.00	0.00		Audit was postponed till FY2023	
UT Health RGV Orthopedics & Sports Medicine Audit (Weslaco)	300.00	0.00	300.00	168.00	132.00		In Progress - Draft Report	
UT Health RGV Behavioral Health Audit (Harlingen)	300.00	0.00	300.00	161.00	139.00		In Progress - Fieldwork	
NCAA Compliance - Financial Aid Audit	300.00	0.00	300.00	0.00	300.00		Not Started; Included on FY2023 Audit Plan	
School of Medicine IT Controls Audit	300.00	0.00	300.00	0.00	300.00		Not Started; Included on FY2023 Audit Plan	
Change in Personnel Action Form Audit	300.00	0.00	300.00	307.00	(7.00)		In Progress - Draft Report	
Assurance Engagements Subtotal	**3,850.00**	**(300.00)**	**3,550.00**	**2,419.00**	**1,131.00**	**36.21 %**		
Advisory and Consulting Engagements								
Data Analytics - Research Expenditures	250.00	0.00	250.00	0.00	250.00		Not Started; Included on FY2023 Audit Plan	
Data Analytics - Cost of Attendance	50.00	0.00	50.00	180.00	(130.00)		Completed	
Data Analytics - Procurement and Travel Cards	150.00	0.00	150.00	53.50	96.50		Completed	
Data Analytics - Enrollment Reporting	50.00	0.00	50.00	162.50	(112.50)		Completed	
Institutional Committee Meetings and Adhoc Workgroups	300.00	0.00	300.00	238.00	62.00		Ongoing	
Education, Training, and Advice to Institutional Departments	300.00	0.00	300.00	250.50	49.50		Ongoing	
Executive Leadership Meetings and Others	300.00	0.00	300.00	76.00	224.00		Ongoing	
Math & Science Academy Consulting	0.00	300.00	300.00	429.00	(129.00)		Internal Memo Issued 7/20/2022	7/20/2022
Advisory and Consulting Engagements Subtotal	**1,400.00**	**300.00**	**1,700.00**	**1,389.50**	**310.50**	**17.34 %**		
Required Engagements								
NCAA Agreed Upon Procedures	350.00	0.00	350.00	382.50	(32.50)		Completed and Report Issued	1/18/2022
Joint Admission Medical Program - School of Medicine	150.00	0.00	150.00	125.50	24.50		Report Issued 10/29/2021; #22-REQ-27	10/29/2021
McAllen Family Practice Residency Program Audit	100.00	0.00	100.00	108.00	(8.00)		Report Issued 12/24/2021; #22-REQ-28	12/24/2021
DHR Family Practice Residency Program Audit	100.00	0.00	100.00	110.00	(10.00)		Report Issued 12/24/2021; #22-REQ-29	12/24/2021
Knapp Family Practice Residency Program Audit	100.00	0.00	100.00	111.50	(11.50)		Report Issued 12/24/2021; #22-REQ-30	12/24/2021
Benefits Proportionality Audit	200.00	0.00	200.00	259.50	(59.50)		Report Issued 8/31/2022; #22-REQ-31	8/31/2022

Audit Plan Status Report as of August 31, 2022

Engagement Name	Original Budget	Additions/ Deletions	Revised Budget	Actual Hours	Variance - Revised Budget to Actual	Percent of Total Revised Budget	Status as of August 31, 2022	Report/Memo Issued Date
FY 2021 Financial Audit - Final	20.00	0.00	20.00	0.00	20.00		No Assistance Provided	
FY 2022 Financial Audit - Interim	10.00	0.00	10.00	0.00	10.00		No Assistance Provided	
Audits/Reviews by External Agencies	100.00	(25.00)	75.00	34.50	40.50		Participated in Entrance & Exit Conference	
TEC 51.9337 Compliance Assessment Audit	100.00	0.00	100.00	24.00	76.00		Completed; Annual Internal Auditors Report	
Required Engagements Subtotal	**1,230.00**	**(25.00)**	**1,205.00**	**1,155.50**	**49.50**	**12.29 %**		
Investigations								
Reserve Hours for Investigations	100.00	(100.00)	0.00	0.00	0.00			
Investigation-School of Medicine Contracts	0.00	100.00	100.00	160.50	(60.50)		Internal Memo Issued 11/8/2021	11/8/2021
UT System Anonymous Complaint	0.00	200.00	200.00	270.00	(70.00)		Memo Issued 1/31/2022	1/31/2022
General Surgery Residency Program	0.00	150.00	150.00	244.00	(94.00)		In Progress	
Investigations Subtotal	**100.00**	**350.00**	**450.00**	**674.50**	**(224.50)**	**4.59 %**		
Reserve								
Reserve Hours for Unanticipated Projects	300.00	(300.00)	0.00	0.00	0.00			
Reserve Subtotal	**300.00**	**(300.00)**	**0.00**	**0.00**	**0.00**	**0.00 %**		
Follow-Up								
1st Quarter	50.00	0.00	50.00	62.00	(12.00)		Completed	
2nd Quarter	50.00	0.00	50.00	91.00	(41.00)		Completed	
3rd Quarter	50.00	0.00	50.00	18.50	31.50		Completed	
4th Quarter	50.00	0.00	50.00	15.00	35.00		Completed	
Follow-Up Subtotal	**200.00**	**0.00**	**200.00**	**186.50**	**13.50**	**2.04 %**		
Development - Operations								
UT System Meetings and Reporting	100.00	0.00	100.00	134.00	(34.00)			
Annual Audit Plan and Risk Assessments	350.00	0.00	350.00	455.00	(105.00)		FY2023 Plan Approved 6/29/2022	
Internal Quality Assurance Review	125.00	0.00	125.00	13.50	111.50			
Internal Audit Committee Meetings	250.00	0.00	250.00	263.00	(13.00)			
Annual Internal Audit Report	100.00	0.00	100.00	9.00	91.00		Report Issued	11/1/2021
Development/Maintenance of Technologies	100.00	0.00	100.00	191.50	(91.50)			
Management of Audit Activity	700.00	0.00	700.00	1,232.50	(532.50)			
Development - Operations Subtotal	**1,725.00**	**0.00**	**1,725.00**	**2,298.50**	**(573.50)**	**17.59 %**		
Development - Initiatives and Education								
UT System Audit Office Initiatives	100.00	0.00	100.00	47.50	52.50			
Professional Development	700.00	0.00	700.00	693.00	7.00			
Internal Audit Office Organization and Strategic Initiatives	100.00	0.00	100.00	81.50	18.50			
Professional Organizations	100.00	(25.00)	75.00	34.50	40.50			
Development - Initiatives and Education Subtotal	**1,000.00**	**(25.00)**	**975.00**	**856.50**	**118.50**	**9.94 %**		
Total Audit Hours	**9,805.00**	**0.00**	**9,805.00**	**8,980.00**	**825.00**	**100.00 %**		

TEC Section 51.9337(h) Assessment & Benefits Proportionality Audit

Senate Bill 20 (86th Legislative Session) made several modifications and additions to Texas Government Code and Texas Education Code (TEC) related to purchasing and contracting. Effective September 1, 2015, TEC §51.9337 requires that "The chief auditor of an institution of higher education shall annually assess whether the institution has adopted the rules and policies required by this section and shall submit a report of findings to the state auditor."

The UTRGV Office of Audits & Consulting Services conducted this required compliance assessment for the fiscal year 2022, and our conclusion is as follows:

> Based on our review of current institutional policies, the UT System policies, and the UT System Board of Regents Rules and Regulations, UTRGV has generally adopted all the rules and policies required by TEC §51.9337. The review and revision of institutional policies are an ongoing process. These rules and policies will continue to be assessed annually to ensure continued compliance with TEC 51.9337.

In addition, Rider 8, of the General Appropriations Act (87th Legislature, Conference Committee Report) requires each higher education institution to conduct an internal audit of benefits proportional by fund using a methodology approved by the State Auditor's Office. A compliance audit of Benefits Proportionality Funding was included in the FY 2022 audit plan with a scope of Appropriation Years 2020 and 2021.

FY 2022 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-20-AEN-03	11/8/2021	Fixed Costs Contracts Audit	Contracts at UTRGV are maintained by three departments, with each department responsible for maintaining different types of agreements. There is no central repository for executed agreements at UTRGV. Currently, the new Contract + is not a mandatory process.	The Procurement Office will recommend that Contract+ be utilized for all contracts, agreements, and campus leases following the UTRGV Delegation of Authority Chart . Implement Contracts+ as campus-wide repository of contracts and train the campus users. Update the following Contract related trainings for users: 1. Contract Requestor 2. Contract Approver. Update instructions for the Contract Request process submittal in iShop to include a list and link to Special contracts as per UTS 145. Work on updates to the Contracts Administrator role. The Procurement Office is not responsible for funding sources selected for the contract including receiving of payments, tracking, and managing balances.	In Progress
UTRGV-20-AEN-03	11/8/2021	Fixed Costs Contracts Audit	There are no formal UTRGV policies and procedures to provide uniform guidance for formulating, monitoring, and closing-out non-sponsored fixed-price contracts. Additionally, there were no defined methodologies to maintain active agreements, and no formal reporting requirements were observed.	The Senior Vice President for Finance and Planning agrees to lead the development to align UTRGV's formal policies and procedures that provide guidance and accountability for adherence to formulating, monitoring, and closing-out non-sponsored revenue contracts. To that end, the ownership of that process should fall to those areas overseeing these procedures, and therefore the appropriate departmental managers should be recognized as key stakeholders (i.e., owners) of the process.	In Progress
UTRGV-20-AEN-03	11/8/2021	Fixed Costs Contracts Audit	Residual balances from negotiated contracts are addressed in a document in the Division of Finance and Administration. It documents definitions, provisions, distribution, and transfer process of residual balances as it relates to projects routed and processed by the Office of Sponsored Programs and the Office of Grants and Contracts. We observed the following: Although the document refers that it is policy, process, and procedures have not been adopted in UTRGV's Handbook of Operating Procedures. Guidance is only provided for projects routed and processed by the Office of Sponsored Programs and the Office of Grants and Contracts. The guidance does not address fixed-cost contracts that are processed outside of these two areas (departments). The document does not address the code of Federal Regulations. CFR-Title 2 Vol 1-Sec 200-45CFR-Title 2 Vol 1-Sec 200-201 Although not required, its good business practice to reference applicable policies and procedures.	The Executive VP of Research, Graduate Students and New Program Development, and Associate VP for Planning & Analysis will meet to initiate conversations on revising existing residual balance documents. In addition, Research will follow up with each EVP's office and ensure cost centers are created to deposit residual balances. Once the residual balance document is finalized and approved by both divisions, a draft HOP policy for residual balance will be submitted for review and approval.	In Progress
UTRGV-20-AEN-03	11/8/2021	Fixed Costs Contracts Audit	We found that 2 out of the 6 Executive Vice President's unrestricted designated fund accounts had not been created as of fieldwork.	The Executive VP of Research, Graduate Students and New Program Development and Associate VP for Planning & Analysis will meet to initiate conversations on revising the existing residual balance documents. In addition, Research will follow up with each EVP's office and ensure cost centers are created to deposit residual balances. Once the residual balance document is finalized and approved by both divisions, a draft HOP policy for residual balance will be submitted for review and approval.	In Progress

FY 2022 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-20-AEN-03	11/8/2021	Fixed Costs Contracts Audit	We reviewed three program accounts and found no evidence that residual balance account from negotiated contracts is monitored or evaluated for the risk of other institutional resources used for operations.	The Senior Vice President for Finance and Planning agrees to lead the development to align UTRGV's formal policies and procedures that provide guidance and accountability for adherence to formulating, monitoring, and closing-out non-sponsored revenue contracts. To that end, the ownership of that process should fall to those areas overseeing these procedures, and therefore the appropriate departmental managers should be recognized as key stakeholders (i.e., owners) of the process.	In Progress
UTRGV-20-AEN-03	11/8/2021	Fixed Costs Contracts Audit	Three program accounts selected had operating fund balances with no oversight.	The Senior Vice President for Finance and Planning agrees to lead the development to align UTRGV's formal policies and procedures that provide guidance and accountability for adherence to formulating, monitoring, and closing-out non-sponsored revenue contracts. To that end, the ownership of that process should fall to those areas overseeing these procedures, and therefore the appropriate departmental managers should be recognized as key stakeholders (i.e., owners) of the process.	In Progress
UTRGV-20-AEN-03	11/8/2021	Fixed Costs Contracts Audit	29 different revenue contracts were deposited into one cost center.	The Senior Vice President for Finance and Planning agrees to lead the development to align UTRGV's formal policies and procedures that provide guidance and accountability for adherence to formulating, monitoring, and closing-out non-sponsored revenue contracts. To that end, the ownership of that process should fall to those areas overseeing these procedures, and therefore the appropriate departmental managers should be recognized as key stakeholders (i.e., owners) of the process.	In Progress
UTRGV-21-AEN-02	11/22/2021	UT Health RGV Surgery & Women's Specialty Clinic	Seven out of fifteen (46%) sampled patient files contained incorrectly completed Advanced Beneficiary Notice of Non-coverage forms.	This has been added to new hire training. Evidence of Coverage (EOC) has been added for all patients who have added services. PSR's and Managers have been provided with the CMS.gov ABN instruction guides and the location of the ABN form in Athena, along with instructions on when to provide this to the patient. The training guide was also provided to the managers via OneDrive.	Implemented
UTRGV-21-AEN-02	11/22/2021	UT Health RGV Surgery & Women's Specialty Clinic	Thirty-one out of 570 encounters completed in April 2021 remained open as of May 10, 2021, due to missing provider signoffs or incomplete notes. The encounters ranged from 12 to 32 days outstanding.	Revenue cycle and office managers send email reminders to the providers. Medical Assistants are helping with reminding providers as well. We have begun a reconfiguration of the Athena system as a whole. An Athena rep is scheduled to come on-site the week of October 17th in order to visit with providers, examine their workflow, and provide feedback with recommended changes to improve efficiency, and functionality and increase provider participation. We strongly believe that with training, we will see a significant increase in providers meeting documentation deadlines.	In Progress
UTRGV-21-AEN-02	11/22/2021	UT Health RGV Surgery & Women's Specialty Clinic	Appointment scheduling statics are not tracked and trended.	Reports in Athena are available for this. Patient Access is in the process of designing reports and metrics to measure and track these statistics.	In Progress

FY 2022 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-21-AEN-04	2/22/2022	MSRDP (Faculty Practice Plan) Audit	We received the Financial Assistance and Self-Pay policy, which addresses the fee schedule. The policy became effective on March 07, 2017 and is the responsibility of the senior director of clinical administration. The policy was last revised on February 26, 2021, and approved by the senior director of clinical administration, assistant vice president of clinical affairs, and the executive vice dean, of finance & administration. Additionally, the policy was reviewed by the Medical Executive & Professional Affairs Committee. However, there is no evidence of a fee schedule approved by the president, the president's designee, or consultation with the board.	Initiate Budget and Finance Committee meetings in the Fall of 2022. The budget and Finance Committee will review the current UT Health RGV fee schedule and update as needed. Fee schedule will then be approved by the Board for submission to the president or president's designee for final approval. In consultation with the Board, the Budget and Finance Committee will review and approve the UT Health RGV discount policy and submit it to the president or president's designee for approval. The document above actions is in the committee minutes.	In Progress
UTRGV-21-AEN-04	2/22/2022	MSRDP (Faculty Practice Plan) Audit	The School of Medicine has an Interaction with Industry/Conflict of Interest policy, which is the responsibility of the "Executive Vice President for Health Affairs". The policy became effective November 04, 2018. While the policy was approved by the president and executive vice president for health affairs and disseminated to all faculty, residents, students, and staff, we found no evidence that the Interaction with Industry/Conflict of Interest policy was approved by the executive vice chancellor for health affairs and the executive vice chancellor for academic affairs. The SOM policy also states that interests should be disclosed as required under the UTRGV policies on Conflict of Interest and Commitment. However, UTRGV does not have a formal HOP policy on Conflict of Interest and Commitment.	The current policy has been approved by Dean and President. Will re-visit with new Dean SOM by 3/1/2022. Upon approval by the Dean and President, the policy will go to UT System for approval by May 1, 2022. President or designee to present policy for approval by UT System to the following: John M. Zerwas, M.D, UTS Executive Vice Chancellor for Health Affairs Archie L. Holmes Jr., Ph.D., UTS Executive Vice Chancellor for Academic Affair	In Progress
UTRGV-21-AEN-04	2/22/2022	MSRDP (Faculty Practice Plan) Audit	A comprehensive faculty compensation plan is not adopted by the School of Medicine. The deputy chief legal officer stated that a committee, chaired by the chief medical officer, was working on a compensation plan during the past academic year.	The president or president's designee should ensure that a faculty compensation plan is developed and adopted.	In Progress
UTRGV-21-AEN-04	2/22/2022	MSRDP (Faculty Practice Plan) Audit	Agreements are executed at the initial appointment, but Agreements of Participation are not executed annually.	SOM Operations team will work with SOM legal to ensure appropriate language is added to Faculty contracts, both new and renewals agreements to document reaffirmation of MSRDP agreement. The new MOA format submitted to UTS for approval by May 1, 2022. President or designee to present policy for approval by UTS. John M. Zerwas, M.D, UTS Executive Vice Chancellor for Health Affairs	In Progress

FY 2022 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-21-AEN-04	2/22/2022	MSRDP (Faculty Practice Plan) Audit	The Bylaws outline committees and their structure. We found some committees of the plan are not in place and/or functioning as intended. The following committees/subcommittees are not part of UTRGV's Practice Plan governance structure. Executive Committee Budget and Finance Subcommittee Audit Subcommittee Faculty Compensation Advisory Subcommittee Although a compliance subcommittee is part of the governance structure, the subcommittee is not active and not functioning as intended.	Initiate standing committee and subcommittee member selection with President or assigned designee for each committee and subcommittee. Schedule first committee meetings by Fall of 2022 with each committee meeting at least quarterly as required.	In Progress
UTRGV-21-AEN-04	2/22/2022	MSRDP (Faculty Practice Plan) Audit	Duties and responsibilities as chair of the board have not been executed per the Bylaws. UTRGV's practice plan committee structure identifies the president as the chair of the Board.	Initiate a plan with President and Sr. VP office to formally appoint officers and directors to the Board who will meet quarterly starting in June 2022 and begin planning for the annual meeting. Schedule an annual in-person meeting with Members of Plan in the Fall of 2022. Review budget with members during annual meeting. Initiate Budget and Finance Committee meetings after annual meeting in Fall 2022; begin budget review and budget approval process during FY2023. Budget and Finance Committee will ensure financial information is sent to Board for approval.	In Progress
UTRGV-21-AEN-12	4/7/2022	Fees and Other Charges Audit	A lab fee is a charge to generally cover the cost of laboratory materials and supplies used by a student. Lab fee revenue can only be used to cover the cost of materials and supplies. The revenue can not be used for equipment, maintenance, and salaries. The fee revenue should be used and not be accumulated.	Prior year and current year laboratory material and supplies expenses are being identified. Expense corrections will be processed as needed. Moving forward, laboratory materials and supplies will be charged to the cost center.	In Progress
UTRGV-21-AEN-12	4/7/2022	Fees and Other Charges Audit	Large unexpended fee cost center balances are not being monitored.	Planning & Analysis will create formal guidance to establish an annual fee cost center balance monitoring process. The guidance will be posted on the Planning & Analysis website to be followed by a notification sent to fee cost center managers and respective finance/budget contacts. Responsibility for monitoring will reside with the primary finance/budget contact for each division and/or college. These individuals currently monitor balances within their units. Documentation of the monitoring process, including justifications/action plans for large balances, will remain on file in the division and college offices. Planning and Analysis will remain available to assist with any questions which arise during annual monitoring.	In Progress
UTRGV-21-AEN-12	4/7/2022	Fees and Other Charges Audit	The fee revenue was inappropriately used.	Expense corrections posted in February. The SOM is submitting a proposed adjustment to the fee description to include wording on recruitment, promotional related efforts and activities. In addition, staff associated with processing applications for admission to the School of Medicine are being identified along with effort to have payroll costs funded by cost center.	In Progress

FY 2022 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-21-AEN-12	4/7/2022	Fees and Other Charges Audit	Incidental fees are being commingled.	Planning & Analysis will avoid combining incidental fees in cases where different activities are supported (e.g., the late payment processing and late registration processing activities described). For this reason, the Late Registration Fee revenue will be applied to Registrar operations which are more directly impacted by late registration than the Bursar's operation. Step 1: Necessary changes will be incorporated for FY 2023 operating budget development. Step 2: The same changes will be applied when funding FY 2022 activities prior to FYE close.	In Progress
UTRGV-22-AEN-01	8/5/2022	UTS 142.1 - Monitoring Plan & Account Reconciliations Audit	The Monitoring Plan does not reflect the controls currently in place which address training, communication, and ownership/accountability. The Financial Services/Comptroller conducts monthly financial reconciliation training for all cost center/project managers. For FY2021, 90% of the targeted audience attended the required training. While many cost center/project managers attended the required training, many of those managers certified their cost center and projects at year-end but did not complete all period reconciliations as indicated in the SAHARA section of this report.	Management concurs with the recommendation, where the monitoring plan will be revised to align with the recommendation.	In Progress
UTRGV-22-AEN-01	8/5/2022	UTS 142.1 - Monitoring Plan & Account Reconciliations Audit	Inspections performed by Accounting & Reporting do not address the accuracy of the reconciliation of accounts.	Management agrees with the recommendation and will implement the following updates to the monitoring plan and implement the following activities/processes: The monitoring plan controls in section 3, Monitoring Controls, will be updated to rephrase the statement "The inspections will not audit or inspect the methodology…" to refer to the Financial Reconciliation Inspection checklist we currently use that addresses the validity, reasonableness, and compliance with university policies and procedures. The Annual Certification Inspection Procedures document and Financial Reconciliation Inspection checklist will be updated to include procedures currently conducted that address the validity, reasonableness, and compliance with university policies and procedures.	In Progress

FY 2022 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-22-AEN-01	8/5/2022	UTS 142.1 - Monitoring Plan & Account Reconciliations Audit	The SAHARA system allows annual certifications without completion of monthly reconciliations. Through data analytics, we compared annual certifications with the completed monthly reconciliations and determined that 40% did not follow the certification process.	Management agrees with the recommendations and will implement the following activities / processes: A process that includes 'compliance language' will be implemented to ensure all monthly reconciliations for cost center/projects are completed timely, including a process to notify management for those areas that are in non-compliance with the policy. We currently send quarterly notifications to all reconcilers that have outstanding monthly reconciliations. Beginning in April 2022, we will notify the cost center/project managers and subsequently notify the Dean/Director and Divisional Executives to take corrective action to bring all non-compliant cost center/project managers in compliance with policy. Effective fiscal year 2023, we will conduct semi-annual financial reconciliation inspections to monitor the timely completion of monthly reconciliations to provide accurate annual financial certifications.	In Progress
UTRGV-22-AEN-01	8/5/2022	UTS 142.1 - Monitoring Plan & Account Reconciliations Audit	We evaluated 20 cost centers/projects, and all completed their monthly reconciliations and submitted their annual certifications. However, we observed the following: • Eight cost centers/projects' monthly reconciliations were not completed timely, ranging between one month to five months past due. • One reconciler did not have a clear understanding of the new reconciliation process. • One cost center in the School of Medicine (SOM) did not segregate its payroll-related functions. Cost center manager has the ability to make changes to Personnel Action Forms and sign off on cPAFs. In addition, the cost center mangers perform payroll reconciliations and has the reconciler acknowledge reconciling the entire cost center in SAHARA. • Reconciliations were incomplete due to: oSeven cost centers lacked a review of reconciling items. oTwo cost centers did not reconcile wage expenses.	Management agrees with the recommendations and will implement the following activities/processes: Implement the activities/processes noted above in Management Action Plan #3. Send on a quarterly basis a notification reminder to reconcilers that are pending to attend Monthly Financial Reconciliation (MFR) training. By attending MFR training, reconcilers will learn how to complete monthly reconciliations and have an opportunity to ask any questions they may have regarding the reconciliation process. Notify School of Medicine (SOM) Finance and Administration staff (SOM Assistant VP for Finance and Administration, and Financial Manager) of this audit finding and remind them to maintain adequate segregation of duties with payroll expenditures and update their procedures to provide all required payroll information to reconcilers to complete the monthly reconciliations for approval by cost center/project managers.	In Progress
UTRGV-21-AEN-09	8/30/2022	Cloud/3rd Party Security Management Audit	Although the University has policies and procedures that address protection of data and cloud services, the procedure outlined in the Acceptable Use Policy (AUP) does not offer enough guidance to University employees.	Management Action Plan. The ISO has a list of approved storge location which indicates the approved Cloud storage solutions. The ISO also maintains a Security Exception list for limited approved uses of technology, including Cloud storage. IT maintains a list of approved applications, including Cloud applications and storage solutions. This list will be improved upon and make it easier to locate and review to reduce the burden on consumers users who are searching for approved Cloud hosting options. Additionally, the Data Governance Committee is developing a new website that will make finding policies, procedures, and tools easier for our consumer users.	In Progress

FY 2022 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-21-AEN-09	8/30/2022	Cloud/3rd Party Security Management Audit	The Information Security Office does not monitor network traffic for unauthorized cloud storage services.	Management Action Plan The components of this area are currently under development. Access Control is a part of the Identity Governance Project, which is a three-phase project to identify the current state of identity and access management (IAM), the future state of IAM, and then implementation of the future state vison for IAM. Currently Phase 1 is complete and phase II is beginning. Network segmentation is a part of the Network-Core redesign project. Currently we have high level segments in place and are working on a plan to set-up and deploy micro-segmentation where appropriate. Alert response monitoring is currently performed at a basic level. The ISO has plans to improve this, as well as begin to conduct active threat hunting and State Operations Center (SOC) operations. These are both dependent on future budget requests, the first from the institution and the second from the State legislature if our proposed regional SOC is funded. In addition to the work in these areas the ISO currently has a multi-year security plan documented and is in the process of formalizing a continuous quality improvement (CQI) plan.	In Progress
UTRGV-21-AEN-09	8/30/2022	Cloud/3rd Party Security Management Audit	Unauthorized cloud services purchased with procurement cards.	Management Action Plan Review Internal Audit's transaction monitoring process Review Process and partner with Internal Audit and Procurement to implement a process Work with Procurement to identify pertinent account codes to include Build a BI dashboard in Power BI to provide insight into monitored transactions Implement a quarterly transition monitoring process based on Internal Audits process.	In Progress
UTRGV-21-AEN-05	8/31/2022	South Texas Diabetes and Obesity Institute Audit	Effort statements certified inaccurately	Certifications of Time & Effort statements will be done in a timely manner and have been certified within the required time periods since Fall 2020. Certifications for effort over-the-cap salaries are being certified accurately and have been since the issue was discussed with the Audit group in 2021 (coinciding with certification of the 1st Semester of FY2021 for September 2020 through December 2020).	In Progress
UTRGV-21-AEN-05	8/31/2022	South Texas Diabetes and Obesity Institute Audit	Cost transfer not completed timely	Subaward monitoring currently occurs and will continue to occur. Within monthly financial reporting, the last month requested for reimbursement by a subcontract is listed. Subcontracts do have some flexibility, and some subcontracts, with the approval of UTRGV Research, bill quarterly. Therefore, a subcontract's expenses for month X may be billed for and paid more than 90 days later. STDOI will request Grants & Contracts modify their iShop cart naming to include the period being billed for by the subcontract.	In Progress
UTRGV-21-AEN-05	8/31/2022	South Texas Diabetes and Obesity Institute Audit	Expenses not allowed on grant.	Expenditures are monitored and will continue to be monitored. Travelers will continue to be reminded of the limited time period for the submission of receipts.	In Progress

FY 2022 Observations and Action Plans

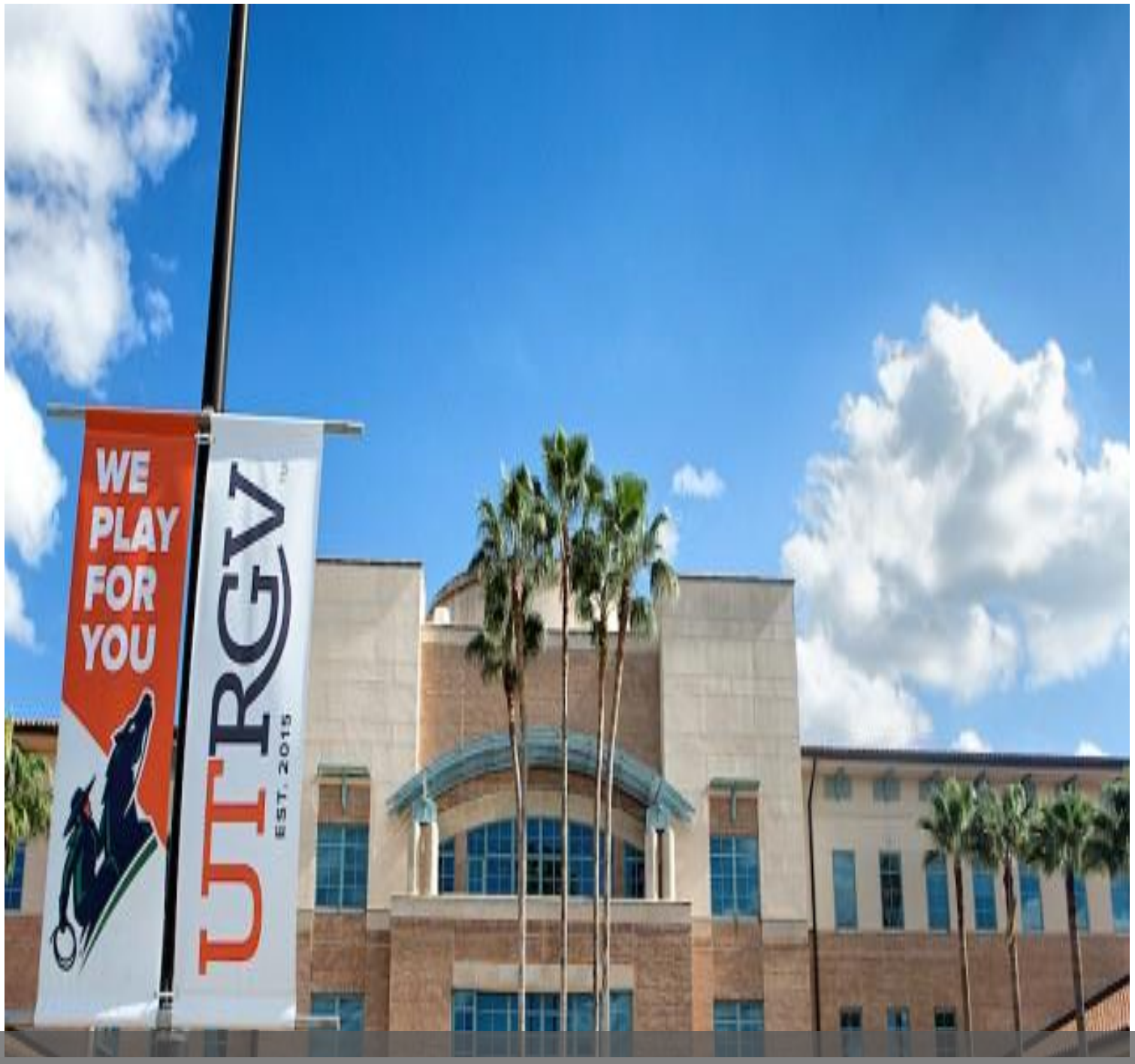
REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV-21-AEN-05	8/31/2022	South Texas Diabetes and Obesity Institute Audit	Expenses not allowed on grant.	The questioned costs are allowable on the grant. They were approved by Grant and Contracts and were documented. Although not specifically budgeted, these expenses are allowable; NIH policy dictates that grantees have flexibility in rebudgeting. Per NIH policy, "NIH prior approval is not required to rebudget funds for any direct cost item that the applicable cost principles identify as requiring the Federal awarding agency's prior approval, unless the incurrence of costs is associated with or is considered to be a change in scope." The expenses were not a change of scope. STDOI will take additional steps to review expenditure types during expense submission and review. We will reach out to UTRGV to request general training and more detailed examples of expenditures that should be coded within each category.	In Progress
UTRGV-21-AEN-05	8/31/2022	South Texas Diabetes and Obesity Institute Audit	Funding, lack of proper approval	STDOI will continue to follow the UT System and UTRGV policies for reporting outside activities. Outside activities must be reported on an annual basis.	In Progress
UTRGV-22-REQ-27	10/29/2021	Joint Admission Medical Program School of Medicine	No Findings	Not Applicable	Not Applicable
UTRGV-22-REQ-28	12/23/2021	McAllen Family Practice Residency Program Audit	No Findings	Not Applicable	Not Applicable
UTRGV-22-REQ-29	12/23/2021	DHR Family Practice Residency Program Audit	No Findings	Not Applicable	Not Applicable
UTRGV-22-REQ-30	12/23/2021	Knapp Family Practice Residency Program Audit	No Findings	Not Applicable	Not Applicable
UTRGV-22-REQ-31	8/31/2022	Benefit Proportionality Audit	No Findings	Not Applicable	Not Applicable

SECTION III
Consulting Services and Nonaudit Services Completed

CONSULTING SERVICES AND NON-AUDIT SERVICES COMPLETED

Date Completed	Name of Engagement	High-Level Non-Audit Services Objective(s)	Observation/Findings and Recommendations	Fiscal Impact/Other Impact
7/20/2022	Math & Science Academy (MSA)	To assess specific MSA Operations. (Recruiting, Admissions, Curriculum, Reporting, Enrollment, Records, Transcripts, Funding, and Expenses)	Management is using this memo to improve efficiency and MSA operations.	Compliance
Ongoing	Procurement and Travel Card Program Data Analysis	To provide monthly custom data analytic reports to the procurement and travel card administrator to identify procurement and travel card transactions that may require further review.	Management is using these reports as a monitoring tool to increase compliance throughout the institution.	Compliance
Ongoing	Financial Aid Data Analysis – Cost of Attendance	To provide custom data analytic reports to the Financial Aid Office to identify the Cost of Attendance transactions that may require further review.	Management is using these reports as a monitoring tool to increase financial aid compliance.	Compliance
Ongoing	Enrollment Reporting Data Analysis	To provide custom data analytic reports to the Registrar's Office to identify enrollment reporting transactions that may require further review.	Management is using these reports as a monitoring tool to increase financial aid compliance.	Compliance
11/8/2021	School of Medicine Physician Contract – Investigation	To evaluate the accuracy of payments to physician based on contract terms.	Overpayment identified and recommendation to seek reimbursement	Fiscal
1/17/2022	Complaint – Allegation of Nepotism and Conflict of Interest - Investigation	Evaluate whether nepotism and conflict of interest were present in employment and advancement of employee.	Not substantiated	Ethics/Compliance
1/31/2022	Complaint – UTRGV Appointment of Provost and EVP – Investigation	Evaluate whether Provost was hired not in accordance with hiring policies and procedures.	Not substantiated	Ethics/Compliance

SECTION IV
External Quality Assurance Review
(Peer Review)



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Report of the Independent Validation of the Quality Assessment Review of The University of Texas at Rio Grande Valley Office of Audits and Consulting Services

August 7, 2020

August 7, 2020

Ms. Eloy R. Alaniz, Jr., Chief Audit Officer
The University of Texas at Rio Grande Valley

In August 2020, The University of Texas at Rio Grande Valley (UT Rio Grande Valley or UTRGV) internal audit (IA) function, the Office of Audits and Consulting Services (OACS), completed a self-assessment of internal audit activities in accordance with guidelines published by the Institute of Internal Auditors (IIA) for the performance of a quality assessment review (QAR). UT Rio Grande Valley OACS engaged an independent review team consisting of internal audit professionals with extensive higher education and healthcare experience to perform an independent validation of OACS' QAR self-assessment. The primary objective of the validation was to verify the assertions made in the QAR report concerning IA's conformity to the IIA's *International Standards for the Professional Practice of Internal Auditing* (the IIA *Standards*) and Code of Ethics, Generally Accepted Government Auditing Standards (GAGAS), and the relevant requirements of the Texas Internal Auditing Act (TIAA).

The IIA's *Quality Assessment Manual* suggests a scale of three ratings, "generally conforms," "partially conforms," and "does not conform." "Generally conforms" is the top rating and means that an internal audit activity has a charter, policies, and processes that are judged to be in conformance with the *Standards*. "Partially conforms" means deficiencies in practice are noted that are judged to deviate from the *Standards*, but these deficiencies did not preclude the IA activity from performing its responsibilities in an acceptable manner. "Does not conform" means deficiencies are judged to be so significant as to seriously impair or preclude the IA activity from performing adequately in all or in significant areas of its responsibilities.

Based on our independent validation of the QAR performed by OACS, we agree with OACS' overall conclusion that the internal audit function **"Generally Conforms"** with the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing* and Code of Ethics, as well as with OACS' conclusions regarding GAGAS and TIAA requirements. Our review noted strengths as well as opportunities for enhancing the internal audit function.

This information has been prepared pursuant to a client relationship exclusively with, and solely for the use and benefit of, The University of Texas System Administration and UT Rio Grande Valley and is subject to the terms and conditions of our related contract. Baker Tilly disclaims any contractual or other responsibility to others based on its use and, accordingly, this information may not be relied upon by anyone other than The University of Texas System Administration and The University of Texas at Rio Grande Valley.

The review team appreciates the cooperation, time, and candid feedback of executive leadership, stakeholders, and OACS personnel.

Very truly yours,

Baker Tilly Virchow Krause, LLP

Baker Tilly Virchow Krause, LLP

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Summary

Background

Baker Tilly was engaged to conduct an independent validation of The University of Texas at Rio Grande Valley Office of Audits and Consulting Services' self-assessment with the assistance of an internal audit executive from a peer institution. The primary objective of the validation was to verify the assertions noted in the attached self-assessment report concerning adequate fulfillment of the organization's expectation of the internal audit activity and its conformity to the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing* and Code of Ethics, Generally Accepted Government Auditing Standards, and relevant requirements of the Texas Internal Auditing Act.

The scope and approach for the independent validation included:

- Interviewing stakeholders of the IA function, including the President and other members of UT Rio Grande Valley's leadership team, Institutional Audit Committee (IAC) members, and OACS personnel.
- Reviewing the self-assessment report and a sample of IA documents related to fiscal years 2018, 2019, and 2020.
- Considering current internal audit activities in relation to the *Standards* promulgated by the IIA as well as GAGAS and TIAA requirements.
- Identifying opportunities to enhance the internal audit function and other institution-wide considerations.

Conclusions of the Independent Review Team

Based on our independent validation of the QAR performed by OACS, it is our overall opinion that the internal audit function **"Generally Conforms"** with the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing* and Code of Ethics. The IIA's *Quality Assessment Manual* suggests a scale of three ratings, "generally conforms," "partially conforms," and "does not conform." "Generally conforms" is the top rating and means that an internal audit activity has a charter, policies, and processes that are judged to be in conformance with the *Standards*. "Partially conforms" means deficiencies in practice are noted that are judged to deviate from the *Standards*, but these deficiencies did not preclude the IA activity from performing its responsibilities in an acceptable manner. "Does not conform" means deficiencies are judged to be so significant as to seriously impair or preclude the IA activity from performing adequately in all or in significant areas of its responsibilities.

We agree with OACS' conclusions regarding its adherence to GAGAS and TIAA requirements.

Our review noted strengths as well as opportunities for enhancing the internal audit function and processes that affect OACS' effectiveness, as further detailed on the following pages.

Observations

Strengths

During our review we noted a number of strengths, including the following:

- **IA trusted advisor role:** IA's strong, ongoing advisory approach enables it to support change and evolution across the institution. The President and others describe the IA function as a trusted advisor.
- **IA team and culture:** IA's strong, cohesive team and culture, seamlessly bringing together professionals from the legacy institutions, result in high team member retention rates, consistent IA leadership, and the longevity of the function. Team members possess industry certifications and expertise in specialized areas. The CAE introduces his team to stakeholders, acknowledging their contributions on IA engagements and intentionally developing the team as leaders who can interact directly with stakeholders.
- **Foothold in healthcare skills:** IA hired a team member with a background in IA healthcare to expand the function's expertise and has intentionally begun to develop other team members' skills in this area, as well.
- **Collaboration between IA and Institutional Compliance (Compliance):** The IA and Compliance perform joint risk assessments, participate in regular, joint stakeholder meetings to enable ongoing risk assessment, and demonstrate an ongoing, intentional collaboration.

For a further sense of the positive feedback from stakeholder interviews, see **Appendix E** for key words captured.

"Looking at areas causing concern...the first person we call is IA."

"They go the extra mile to help us to identify issues informally and prepare for what to change in policies and processes before an [external] audit happens."

"When they…look at something, they do the deep dive. They understand and look at what can be helpful. They bring the controls AND the efficiency perspective every time. [Their work] benefits us every time."

Opportunities for Enhancement

Internal Audit-Specific Observations

The review team agrees with the *Standards* assessment and opportunities for enhancement identified in OACS' August 2020 self-assessment report, included in **Appendix D**. We offer the following observations and recommendations to build on IA's strong performance:

- **Communicating with leadership** – Share final reports directly with leaders with institution-wide responsibilities, even when those leaders are not directly involved in specific engagements. As the focus on the health care enterprise continues to increase, schedule regular meetings with key health care leaders throughout the year to provide transparency into overall progress, results, and potential risks or trends.
- **Accelerating project cycle times** – Enhance IA project turnaround times by clearly defining and communicating to process owners the timelines for each engagement. Consider sharing a report of potential issues early during each project's fieldwork phase to support confirmation of observations as the project progresses. Proactively communicate expectations at the beginning of engagements for the format and timing of management's responses in final reports and follow-up to support adherence to report timelines. Establish and report to the IAC on anticipated and actual project completion time frames.
- **Enhancing the professional growth of IA team members** – Define a career path for IA personnel at the University. Consider developing a rotational program that matches auditors with interim roles within the institution to enhance professional growth opportunities.

Institution-wide Considerations

Although our assessment was of the IA function, the IIA *Standards* require review teams to consider the intersection of IA activities with risk management and compliance activities across the institution. Addressing these observations will help to optimize the performance of IA:

- **Supporting the IAC** – Expand IAC educational opportunities to discuss periodically with the committee in an interactive format the roles and expectations of the committee and its members. Hold an annual working session to review with, and incorporate IAC external member feedback into, the risk assessment and IA plan. Hold regular closed sessions with the CAE to discuss sensitive topics. Consider streamlining the number of management participants in the IAC and adding external members with healthcare and technology backgrounds.
- **Expanding UTRGV's risk-related resources for the healthcare enterprise** – Review UTRGV's capacity for oversight and monitoring of its growing healthcare enterprise. Assess the sufficiency of resources dedicated to oversight and monitoring of billing compliance, the overall revenue cycle, clinical operations, and clinical trials. Further define and rationalize the key roles that IA, Institutional Compliance, the Director of Quality Assurance, and Accounting each play in these areas.
- **Continuing the collaboration between IA and Institutional Compliance** – Stakeholders note that IA and Institutional Compliance work well together. As Institutional Compliance undergoes a leadership change, maintain this strong collaboration, including the existing joint effort for annual risk assessment.

Appendix A: Work Performed

In completing our review, the independent review team:

- Conducted interviews with 22 individuals from positions across UT Rio Grande Valley and from the UT System Administration Audit Office (see list in **Appendix B**) to understand their views of the current internal audit function in relation to strategic goals, major initiatives, and challenges
- Reviewed documentation, including:
  - Internal audit charter
  - Organizational charts
  - Recent annual audit plans
  - Recent annual risk assessments
  - Departmental policies and procedures
  - Staff training plans and qualifications
  - Reports to the Audit Committee
  - Sample internal audit reports
  - Quality assurance and improvement plan (QAIP) documentation
  - QAR program guides
  - GAGAS self-assessment guides
  - Work papers for IA projects performed during the past two fiscal years
- Considered the current internal audit function in relation to the *Standards* promulgated by the IIA in the areas of:
  - Structure and reporting relationships
  - Roles and responsibilities
  - Degree of independence and objectivity
  - Education, training, qualifications, and experience of personnel
  - Management of the IA activity
  - Quality of IA deliverables
- Assessed additional materials, as necessary, to further validate the self-assessment completed

Appendix B: Interviews Conducted

Institutional Audit Committee Members

Kenneth Everhard, CPA, Chair, External IAC Member
Elias Longoria, External IAC Member
Gregg McCumber, CPA, External IAC Member

Executive and Senior Leadership

Rick Anderson, Executive Vice President (EVP) for Finance & Administration
Janna Arney, PhD, Deputy President and Interim EVP for Academic Affairs
Doug Arney, Vice President (VP) of Campus Operations
Guy Bailey, PhD, President
Chasse Conque, VP and Director of Athletics
Jeff Graham, Chief Information Officer
Parwinder Grewal, PhD, EVP of Research, Graduate Studies, & New Program Development
Magdalena Hinojosa, PhD VP for Strategic Enrollment
Melba Sanchez, Associate Dean for Finance, School of Medicine
Diane Sheppard, Chief Compliance Officer

Internal Audit

Eloy R. Alaniz, Jr., Chief Audit Officer, CPA, CIA, CISA
Isabel Benavides, Assistant Director
Angelica Coello-Pineda, Auditor
Jose Gomez, Senior IT Auditor
Paul Plata, Senior Auditor
Norma Ramos, Director
Cecilia Sanchez, Senior Auditor

System Audit Office

Moshmee Kalamkar, Director of Operations
J. Michael Peppers, UT System Chief Audit Executive

Appendix C: Independent Review Team Member Information

Raina Rose Tagle, CPA, CISA, CIA — Review Team Leader

Partner, Baker Tilly

Raina Rose Tagle is a Partner with Baker Tilly, an accounting and advisory firm with more than 4,000 personnel nationwide. Raina serves on Baker Tilly's governing Board of Partners and leads global Governance, Risk, Compliance, and Cybersecurity Services for Baker Tilly International. Raina previously led Baker Tilly's national higher education and research institutions industry practice, as well as its national risk, internal audit, and cybersecurity services practice. In addition to her extensive work with higher education and academic medical center clients, Raina's practice serves the healthcare, financial services, real estate, manufacturing, not-for-profit, government contracting, and professional services industries. Raina started her career with Arthur Andersen. Prior to joining Baker Tilly, she led her own consulting firm that offered strategic planning facilitation, executive coaching, and organizational development for not-for-profits and growing companies. Raina holds a bachelor of science in accounting from Oklahoma State University and is a Certified Public Accountant, Certified Information System Auditor, and Certified Internal Auditor. Raina frequently presents at conferences of the Association of College and University Auditors, the Association of Governing Boards of University and College Trustees, the National Council of University Research Administrators, and the National Association of College and University Business Officers. In addition to her work across The University of Texas System, Raina's clients include the University of California System, the University of Wisconsin System, the University of Washington, the University of Michigan, Iowa Regents' Institutions, Cornell University, Princeton University, Stanford University, the University of Pennsylvania, Massachusetts Institute of Technology, Harvard University, and the Virginia Polytechnic Institute and State University (and, among other work, she has led reviews of the internal audit, institutional compliance, and/or enterprise risk management programs of all of these institutions).

Brian Daniels, CIA, CISA, GCFA

Chief Audit and Compliance Officer, University of Tennessee System

As Chief Audit and Compliance Officer, Brian and the internal audit team perform audits focused on internal controls, fraud prevention and detection, information technology, and effectiveness and efficiency, as well as fraud investigations, among others. He also oversees the institutional compliance team which is responsible for designing, implementing, and monitoring the systemwide compliance program, and promoting the university's code of conduct. Brian began his career as the auditor of public accounts for the Commonwealth of Virginia, conducting external audits of state entities, including colleges and universities. He then worked at the University of Virginia as assistant director of information technology audits from 2005 to 2011. Brian received his bachelor's degree in business information technology from Virginia Tech and an MBA from James Madison University. He is a certified internal auditor, a certified information systems auditor, and a certified forensic analyst.

Appendix D: Office of Audits and Consulting Services Quality Self-Assessment Report

DATE: August 7, 2020

TO: Kenneth Everhard, UTRGV Institutional Audit Committee Chair

SUBJECT: Internal Audit Self-Assessment – Internal Audit Activity

Dear Mr. Everhard,

The Office of Audits & Consulting Services (Office) completed a quality self-assessment of the Internal Audit (IA) activity in preparation for validation by an independent assessor. The principal objective of the review was to assess the IA activity's conformance to The Institute of Internal Auditors' (IIA) *International Standards for the Professional Practice of Internal Auditing* (*Standards*), the IIA's Code of Ethics, Generally Accepted Government Auditing Standards (GAGAS), and the relevant requirements of the Texas Internal Auditing Act (TIAA). The scope of the review was of the current and prior fiscal years (FY 2020 and 2019), with an emphasis on current practices, and the methodology used was based on the IIA's *Quality Assessment Manual*.

The IIA's *Quality Assessment Manual* suggests a scale of three ratings, "generally conforms," "partially conforms," and "does not conform.*"* "Generally Conforms" is the top rating and means that an IA activity has a charter, policies, and processes that are judged to be in conformance with the *Standards.* "Partially Conforms" means deficiencies in practice that are judged to deviate from the *Standards* are noted, but these deficiencies did not preclude IA from performing its responsibilities in an acceptable manner. "Does Not Conform" means deficiencies in practice are judged to be so significant as to seriously impair or preclude the IA activity from performing adequately in all or in significant areas of its responsibilities.

It is our overall opinion that our internal audit program Generally Conforms to the *Standards* and Code of Ethics. In addition, it is our overall opinion that the internal audit program is in conformance with *the TIAA,* and as applicable, to *GAGAS.* The internal assessment identified opportunities for further improvement, of which details are provided below.

We appreciate your support for the internal audit function.

Sincerely,

Eloy R. Alaniz, Jr., CPA, CIA, CISA
Chief Audit Officer

cc: Guy Bailey, PhD, President
The University of Texas Rio Grande Valley Institutional Audit Committee
J. Michael Peppers, Chief Audit Executive, The University of Texas System Administration

Background

The University of Texas System Institutions and System Internal Audit groups comply with the Texas Internal Auditing Act to have independent quality assessment reviews performed every three years. During this Quality Assurance cycle, each institution conducted a self-assessment with independent validation. The national accounting and advisory firm of Baker Tilly was contracted to perform the independent validation for each institution separately. Recommendations included in this report were presented to Baker Tilly and a representative from an internal audit group of a peer institution to review and confirm.

Scope and Methodology

This was a comprehensive self-assessment in which each institution in the University of Texas System reviewed information about its respective IA practices and policies, including risk assessment and audit planning processes, audit tools and methodologies, engagement and staff management processes, a review of a representative sample of work papers and reports, and interviews with audit staff and campus audit clients and leadership. The results of this review resulted in the following report with recommendations for improvement along with our internal assessment of conformance with the *Standards* that was then validated by Baker Tilly and the peer internal auditor.

Overall Opinion

It is our overall opinion that our internal audit program Generally Conforms to the *Standards* and Code of Ethics. In addition, it is our overall opinion that the internal audit program is in conformance with the *TIAA,* and as applicable, to *GAGAS.*

Strengths

We identified the following points of pride:

Audit Report Format Change

The Office recently changed its audit report format to enhance reporting process and quality. We presented the new format to the audit committee and received positive feedback. The new report format was adopted.

Staff Experience and Competencies

The audit staff has an average of 20 years of internal auditing experience. The staff consists of highly skilled and qualified professionals with 86% certified as either Certified Internal Auditors, Certified Public Accountants, Certified Information Systems Auditors, Certified Healthcare Internal Audit Professionals or Certified Fraud Examiners. Additionally, 71% of the staff hold multiple certifications. This knowledge base serves as a unique resource. The staff is located on two campuses, and they are well acquainted with the UTRGV processes.

Relationships with University Leadership and Collaboration

The Office has established collaborative relationships with university leadership. Auditors attend Audit Committee meetings and interact with leadership. The Executive Leadership have requested that the Office conduct special audits/engagements. Members of the audit staff provide advisory services through their participation in various institutional committees such as the Handbook of Operating Procedures Committee, Operational Information Technology and Data Governance Committee, Athletics Council, and Clery Compliance Committee.

The Office collaborates with Institutional Compliance and Legal Affairs Offices in its annual risk assessment process and audit plan development. This eliminates duplication of effort and utilizes combined expertise to evaluate the universities risks. University management calls upon the Office for advice on internal controls, compliance issues, policy interpretation, and operational best practices. The Office has provided individualized internal control trainings for areas upon request as well.

Training

All auditors receive on average 40 hours of continuing professional education annually. Auditors are members of various associations and receive specialized training offered by the Institute of Internal Auditors, Information Systems Audit and Controls Association, Association of Certified Fraud Examiners, Association of Healthcare Internal Auditors, American Institute of Certified Public Accountants, Association of College and University Auditors, Texas Association of College and University Auditors, National Council of University of Research Administrators, Society of Corporate Compliance and Ethics, and HealthCare Compliance Association.

Members of a University System

As members of the UT System, the Office has access to a knowledge base with subject matter experts who can provide guidance and information when needed in areas such as Healthcare, Information Technology, Financials, Research and Compliance. In addition, the UT System Audit Office schedules biannual Internal Audit Council meetings bringing together fellow UT institution Chief Audit Executives to discuss current audit issues, risks, and best practices.

Recommendations: We identified several opportunities for improvement in the following areas:

Ongoing Evaluation of Risk Assessments

The internal audit function is facilitating the institutions risk assessment process and using that assessment to develop its audit plan. This risk assessment process is performed annually, and risks are not evaluated throughout the audit plan year.

Recommendation: The Chief Audit Officer should evaluate risks more frequently throughout the fiscal year and discuss changes in risk profiles.

Internal Quality Assessment

Audit management is conducting ongoing internal assessments at the end of each audit. These assessments, including audit engagement survey results are not presented to the Audit Committee annually. In addition, perform annual Audit Committee surveys. These internal assessments are ongoing monitoring activities to improve the performance of the internal audit function.

Recommendation: The Chief Audit Officer should present results of the internal assessments annually to the Audit Committee.

Engagement Review

In one of three audits tested, the review of the engagement work papers was not conducted timely. Timely review could help the auditor complete the work in a more efficient and effective manner improving audit cycle time.

Recommendation: The CAE should ensure that reviews of engagement work papers is conducted timely.

Audit Manual

The Audit Office has policies and procedures, but the Audit Manual has not been reviewed or updated to include information on recent changes such as the new PeopleSoft system.

> Recommendation: The Chief Audit Officer should review and update the Audit Manual incorporating information to assist auditors in performing their audits efficiently.

***Standards* Assessment**

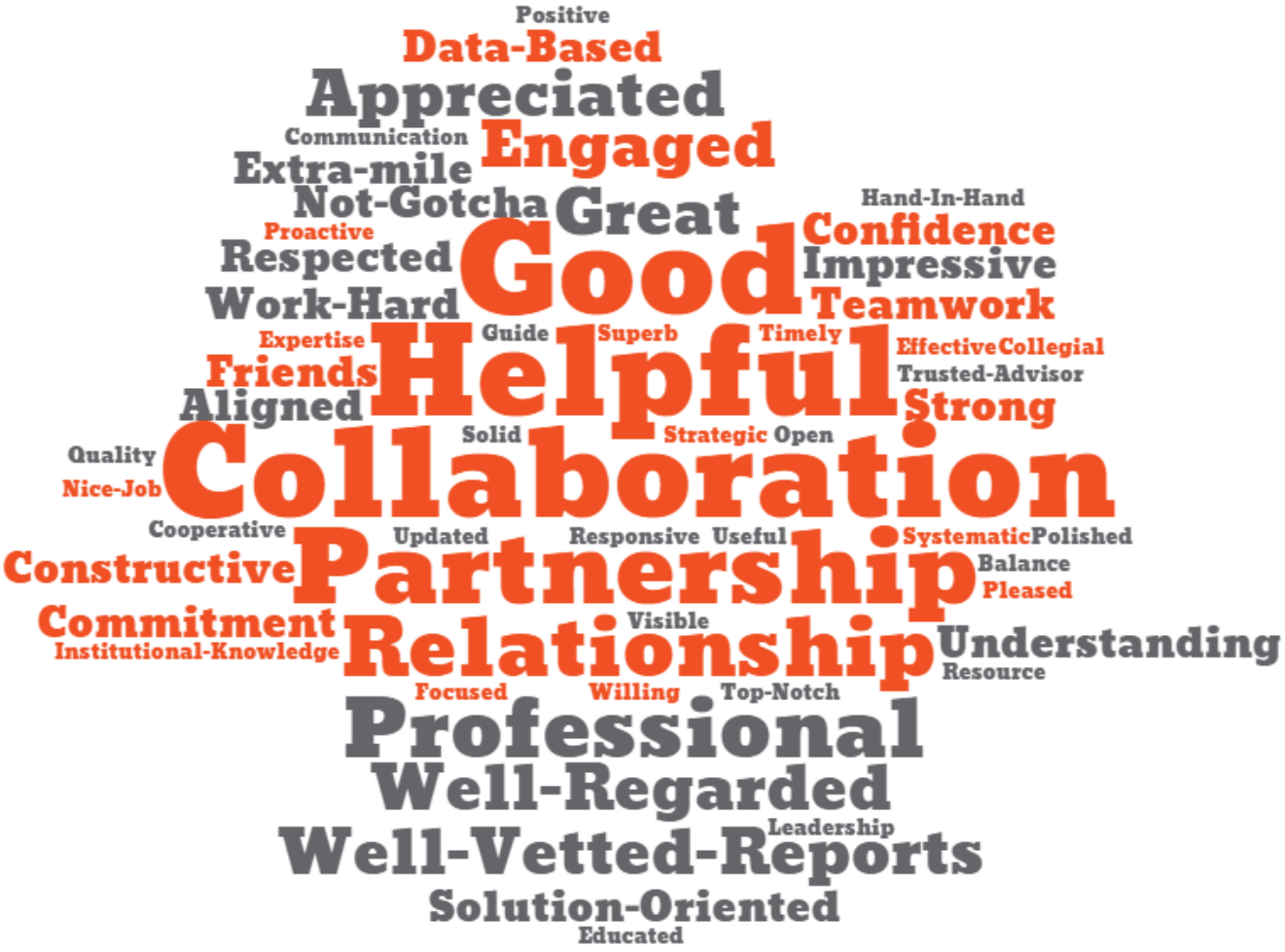
Quality Assessment Evaluation Summary—Overall Evaluation	GC	PC	DNC
OVERALL EVALUATION	✔		

Quality Assessment Evaluation Summary—Major/Supporting *Standards*		GC	PC	DNC
1000	**Purpose, Authority, and Responsibility**	✔		
	1010 Recognition of the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework (the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the *Standards*, and the Definition of Internal Auditing)	✔		
1100	**Independence and Objectivity**	✔		
	1110 Organizational Independence	✔		
	1111 Direct Interaction with the Board	✔		
	1112 Chief Audit Executive Roles Beyond Internal Auditing	✔		
	1120 Individual Objectivity	✔		
	1130 Impairment to Independence or Objectivity	✔		
1200	**Proficiency and Due Professional Care**	✔		
	1210 Proficiency	✔		
	1220 Due Professional Care	✔		
	1230 Continuing Professional Development	✔		
1300	**Quality Assurance and Improvement Program**	✔		
	1310 Requirements of the Quality Assurance and Improvement Program	✔		
	1311 Internal Assessments	✔		
	1312 External Assessments	✔		
	1320 Reporting on the Quality Assurance and Improvement Program	✔		
	1321 Use of “Conforms with the International Standards for the Professional Practice of Internal Auditing”	✔		
	1322 Disclosure of Nonconformance	✔		
2000	**Managing the Internal Audit Activity**	✔		
	2010 Planning	✔		
	2020 Communication and Approval	✔		
	2030 Resource Management	✔		
	2040 Policies and Procedures	✔		
	2050 Coordination and Reliance	✔		

Quality Assessment Evaluation Summary—Major/Supporting *Standards*		GC	PC	DNC
	2060 Reporting to Senior Management and the Board	✔		
	2070 External Service Provider and Organizational Responsibility for Internal Auditing	✔		
2100	**Nature of Work**	✔		
	2110 Governance	✔		
	2120 Risk Management	✔		
	2130 Control	✔		
2200	**Engagement Planning**	✔		
	2201 Planning Considerations	✔		
	2210 Engagement Objectives	✔		
	2220 Engagement Scope	✔		
	2230 Engagement Resource Allocation	✔		
	2240 Engagement Work Program	✔		
2300	**Performing the Engagement**	✔		
	2310 Identifying Information	✔		
	2320 Analysis and Evaluation	✔		
	2330 Documenting Information	✔		
	2340 Engagement Supervision	✔		
2400	**Communicating Results**	✔		
	2410 Criteria for Communicating	✔		
	2420 Quality of Communications	✔		
	2421 Errors and Omissions	✔		
	2430 Use of “Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing”	✔		
	2431 Engagement Disclosure of Nonconformance	✔		
	2440 Disseminating Results	✔		
	2450 Overall Opinions	✔		
2500	**Monitoring Progress**	✔		
2600	**Communicating the Acceptance of Risks**	✔		
	The IIA’s Code of Ethics	✔		

GC = Generally Conforms
PC = Partially Conforms
DC = Does not Conform

Appendix E: Positive Words from Interviews



Note: The relative size of the words correlates to their occurrence/use by interviewees

SECTION V
Internal Audit Plan for Fiscal Year 2023

Texas Government Code, Section 2102.005(b) Compliance

The Texas Internal Auditing Act Sec. 2102.005(b) requires that a state agency's internal audit program shall consider methods for ensuring compliance with contract processes and controls and for monitoring agency contracts.

The UTRGV Office of Audits & Consulting Services considers risks related to contracting processes and monitoring controls as well as information technology annually through its risk assessment process when developing its internal audit plan (**Refer to Internal Audit Plan FY 2023**).

In addition, in accordance with the Texas Education Code (TEC) §51.9337 related to purchasing and contracting, the Office of Audits & Consulting Services is required to annually assess whether the institution has adopted the rules and policies required by this section and shall submit a report of findings in the annual auditor's report or in a separate report to the state auditor (**Refer to TEC §51.9337 Compliance in Section II**).

FISCAL YEAR 2023 AUDIT PLAN

UTRGV

Office of Audits and Consulting Services

Approved by: Internal Audit Committee
June 29, 2022

Table of Contents

Background

In accordance with Texas Government Code, *Chapter 2102*, referred to as the Texas Internal Auditing Act, The University of Texas System Administration Policy 129, The Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing, Standard 2010 – Planning,* and Generally Accepted Government Auditing Standards, a formal Audit Plan was prepared for fiscal year (FY) 2023. This Audit Plan allows the chief audit executive to carry out the responsibilities of the Office of Audits & Consulting Services. The Office of Audits & Consulting Services is responsible for providing the president of the University of Texas Rio Grande Valley (UTRGV) with information about the adequacy and effectiveness of the institution's system of internal administrative and accounting controls and the quality of operating performance when compared with established standards. Therefore, the overall objective was to develop a standardized Audit Plan which addresses the highest risks of UTRGV.

The Audit Plan is based on risk assessments performed, management input and available current audit resources. The chief audit executive sought input on the annual plan from the president and executive management. In addition, the chief audit executive reviewed major goals and institutional priorities to identify those areas where value-added audit services could be provided. The methodology used in assessing risk is described below.

Since the Texas State Auditor's Office, the Texas State Comptroller's Office, and The University of Texas System Audit Office audit UTRGV, we will coordinate our audit work to eliminate any duplication of effort. Consequently, we may limit or supplement our work as deemed necessary. Additionally, due to changing circumstances, any additions or deletions to the FY 2023 Audit Plan are communicated to, and approved by, the UTRGV Internal Audit Committee.

Audit Universe and Risk Assessment Methodology

The plan **(Appendix A)** is prepared using a risk-based approach to ensure that areas and activities specific to UT Rio Grande Valley with the greatest risk are identified for audit consideration.

As part of the FY 2023 Audit Plan process, a risk assessment was conducted based on a top-down process that included conversations and requests for input with risk collaborators, executives, and managers from the various operating areas on campus. The goal for this risk assessment approach was to start at the top with an awareness of critical initiatives and objectives to ensure the risks assessed were the most relevant. The assessment process was standardized by creating common terms and criteria, enabling the trending of risks and UT System-wide comparisons. An emphasis was placed on collaboration with other functions that assess or address risks such as Institutional Compliance and the Legal Office.

We developed a Risk List through the evaluation of the twenty-one (21) major processes applicable to UTRGV. These twenty-one processes are as follows:

1. Governance
2. Finance
3. Information Technology
4. Research
5. Human Resources
6. Facilities Management
7. Property Management
8. Purchasing/Supply Chain
9. Legal
10. Risk Management
11. Public Services
12. Auxiliary Services
13. University Relations
14. University Development
15. Enrollment Management
16. Student Services
17. Academic Support
18. Instruction
19. Medical Practice Plan
20. Medical Training
21. Medical Services Revenue Cycle

For all critical (red) or high (orange) risks identified on the risk list, either an audit or project was included in the Annual Audit Plan (Appendix A), or an explanation/mitigation strategy was provided on the risk list for those, not on the Audit Plan.

The 84th Legislature passed Senate Bill 20 which requires consideration of risks related to contract management, procurement contracting, sole source agreements, and procurement functions. These risks were considered in our risk assessment process described above.

Scope Of Audits

The Standards for the Professional Practice of Internal Auditing addresses the engagement scope of work as follows:

"The established scope must be sufficient to achieve the objectives of the engagement.
2220.A1 – The scope of the engagement must include consideration of relevant systems, records, personnel, and physical properties, including those under the control of third parties.

2220.A2 – If significant consulting opportunities arise during an assurance engagement, a specific written understanding as to the objectives, scope, respective responsibilities, and other expectations should be reached and the results of the consulting engagement communicated in accordance with consulting standards.
2220.C1 – In performing consulting engagements, internal auditors must ensure that the scope of the engagement is sufficient to address the agreed-upon objectives. If internal auditors develop reservations about the scope during the engagement, these reservations must be discussed with the client to determine whether to continue with the engagement.
2220.C2 – During consulting engagements, internal auditors must address controls consistent with the engagement's objectives and be alert to significant control issues."

The planned scope of each of the audits is described in **Appendix A**.

Risk Based Audits

The risk assessment process identified areas that are critical or high risk to UTRGV, resulting in audits or projects. A few of those audits include the Conflict of Interest, Cost Transfers, Institutional Review Board, UT Health RGV Multispecialty Clinic and UT Health RGV Surgical Specialty Clinic, Graduate Medical Education, Patch Management and Payment Card Industry Data Security Standards, which covers TAC 202 requirements.

Required Audits (Externally and Internally)

The UT System Board of Regents approved an independent CPA firm to conduct the FY 2022 UT System-wide Consolidated Financial Audit. Interim procedures will be conducted during the months of July 2022, and year-end procedures will be conducted in November 2022. The NCAA Agreed-Upon Procedures is an annual requirement in accordance with NCAA regulations and is conducted in November and December. The Texas Higher Education Coordinating Board (CB) awarded operational grants to the McAllen Family Practice Residency Program, the Doctors Hospital at Renaissance Family Practice Residency Program, and the Knapp Medical Center Family Practice Residency Program. These audits will determine whether the funds were utilized in accordance with program guidelines. In addition, the CB is requiring a facilities audit.

In accordance with the Texas Education Code §51.9337(h) – "The chief auditor of an institution of higher education shall annually assess whether the institution has adopted the rules and policies required by this section and shall submit a report of findings to the state auditor." This compliance assessment will be conducted in September/October 2022 and the certification will be included in the Annual Internal Audit Report.

Advisory and Consulting Engagements

Advisory and Consulting engagements will primarily include data analysis in the following areas: financial aid cost of attendance and enrollment reporting. We will also assist UT Health RGV to conduct an inventory of electronic medical devices. Internal controls training and other advisory services to institutional departments are also planned.

Investigations

Hours have been reserved for any investigations that may arise during the year.

Follow up

Professional standards require that follow-up audits be conducted to ensure that management has taken corrective action on previously reported findings. Reporting to the Institutional Audit Committee on the status of the implementation of the recommendations will continue.

Reserve for Unanticipated Projects

Hours reserved for engagements that may arise during the fiscal year will be captured in the following categories: financial, operational, and special requests.

Development-Operations

The Operations section includes activities necessary to conduct the internal audit function and serve management and governance such as hours allocated for attending the Institutional Audit Committee meetings as well as hours devoted to performing internal quality assurance assessments. It also includes hours towards developing the annual audit plan.

Development-Initiatives and Education

The Initiatives & Education section includes activities that improve the strategic initiatives of the internal audit function and/or its internal leadership and staff.

Budget And Staffing

The budget for this Audit Plan was prepared in accordance with the *FY 2023 UT System Annual Audit Plan Guidelines*. The Office is budgeted for seven (7) auditors. The internal audit staff consists of highly qualified and skilled audit professionals with 86% (6 out of 7) certified. The UTRGV president provides institutional oversight over the chief audit executive (CAE) and the chief audit executive of the UT System Audit Office provides professional oversight of the UTRGV internal audit function. The Institutional Audit Committee provides strategic oversight and direction of all internal audit activities.

The CAE is a Certified Public Accountant (CPA), Certified Internal Auditor (CIA), and Certified Information Systems Auditor (CISA) and has over 25 years of audit experience. The director has 28 years of audit experience and is a CIA and a Certified Government Auditing Professional (CGAP). The assistant director has over 25 years of audit experience and is a CIA, CGAP, and Certified Fraud Examiner. Three senior staff auditors have many years of auditing experience, two are CIAs, and one is Certified in Healthcare Auditing and a CISA. Our senior IT auditor is also a CISA.

Career development for the staff is a strategic goal of the Office of Audits & Consulting Services, and it is the CAE's practice to create a working environment that facilitates career opportunities for the audit staff within and outside the office. Currently, a staff auditor is pursuing professional certification. The CAE continues to seek low-cost training for its staff and provides them with the opportunity to perform a wide range of audit activities and provide exposure to high levels of management.

Calculation Of FY 2023 Audit Hours

The number of audit hours available for FY 2023 was calculated using 2,080 hours per auditor. There are 7.0 budgeted audit positions for the fiscal year. Estimated hours associated with administrative tasks, holidays, training, and other types of leave were deducted to arrive at the available hours for audits and special projects. The Audit Plan includes **10,245** hours for audits and consulting engagements as well as audit staff and management development hours. The FY 2023 Budget Hours are included in **Appendix B**.

Approval of the Audit Plan

The Audit Plan is reviewed and approved as follows:

- The UT System Audit Office – Audit plan presented on June 23, 2022.
- The UTRGV Audit Committee – Audit plan was approved on June 29, 2022.
- The UT System Board of Regents – Audit plan provided on August 24, 2022.

FY 2023 Internal Audit Estimated Budget $996,727

Appendix A – FY 2023 Audit Plan (Budgeted Hours)

FY 2023 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
Assurance Engagements						
FY22 Carryforward - Patch Management Audit	150		High	Information Technology	IT	Review controls over timely patching of workstations, servers, and other IT infrastructure equipment. Meets requirements for TAC 202
NCAA Compliance - Financial Aid Audit	300		High	Auxiliary Services	N/A	Determine whether policies and procedures are in place to administer and monitor the awarding of financial aid to student-athletes in accordance with NCAA legislation.
UT Health RGV Multispecialty Clinic (Edinburg)	300		Critical	Revenue Cycle related to medical services	Data Analytics	Assess the efficiency and effectiveness of front-end revenue processes as well as internal controls over clinical operations.
UT Health RGV Surgical Specialty Clinic (Harlingen)	300		Critical	Revenue Cycle related to medical services	Data Analytics	Assess the efficiency and effectiveness of front-end revenue processes as well as internal controls over clinical operations.
Graduate Medical Education Audit	300		High	Patient Care Operations	N/A	Determine whether UTRGV is adhering to the Accreditation Council for Graduate Medical Education requirements.
Cost Transfers Audit	200		High	Research	Data Analytics	Determine whether UTRGV developed and implemented adequate procedures and controls relating to cost transfers and that cost transfers are justified and supported in accordance with Federal regulations and UTRGV's policies and procedures. This engagement will be conducted under GAGAS.
Institutional Review Board (IRB) Audit	300		High	Research	N/A	Evaluate key activities of the IRB in the protection of human subjects in research.
Conflicts of Interest Audit	250		High	Governance	N/A	Assess the effectiveness of controls for ensuring the identification, communication, and management of conflicts of interest.
Student Housing & Residence Life Audit	300		High	Auxiliary Services	N/A	Assess the effectiveness of selected financial and operating controls related to Student Housing and Residence Life.
Small Business Development Center (SBDC) Audit	250		High	University Relations	N/A	Evaluate SBDC operations.
Payment Card Industry Data Security Standards (PCI) Audit	300		Critical	Information Technology	IT	Evaluate payment card controls in accordance with data security standards. Meets TAC 202 requirements.
School of Medicine IT Processes/Controls Audit	300		High	Information Technology	IT	Evaluate whether appropriate IT General Controls are in place for the School of Medicine with a focus on responsibility for maintenance of systems.
Decentralized IT Audit	300		High	Information Technology	IT	Evaluate whether decentralized IT groups across UTRGV are adhering to State and UTRGV security controls and standards. Meets TAC 202 requirements.
Assurance Engagements Subtotal	**3550**	**34.7%**				

FY 2023 Internal Audit Estimated Budget $996,727

Appendix A – FY 2023 Audit Plan (Budgeted Hours)

FY 2023 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
Advisory and Consulting Engagements						
Electronic Medical Devices Inventory	200		Critical	Information Technology	IT	Assist UT Health RGV in conducting an inventory of electronic medical devices.
Data Analytics - Cost of Attendance, Enrollment Reporting	100		High	Enrollment Management	Data Analytics	Consulting: Provide Financial Aid and Registrar Offices with periodic exception cost of attendance and enrollment reports to monitor compliance with federal requirements.
Institutional Committee Meetings and Adhoc Workgroups	450		N/A	Governance	N/A	Advisory: Attend campus committee meetings and other meetings with management.
Education, Training and Advice to Institutional Departments	250		N/A	Governance	N/A	Education: Provide internal controls training or assistance to UTRGV supervisors, cost/project center reviewers, and/or depts.
Executive Leadership Meetings and Others	200		N/A	Governance	N/A	Advisory: Meetings with Executive Leadership and Others.
	.					
Advisory and Consulting Engagements Subtotal	**1200**	**11.7%**				
Required Engagements						
NCAA Agreed Upon Procedures	350		Low	Auxiliary Services	N/A	Assist UT System Audit in the performance of the required annual NCAA Agreed Upon Procedures for FY2022.
McAllen Family Practice Residency Program Audit	100		Low	Finance	N/A	Assess whether revenues, expenditures, and unexpended fund balance were reported accurately in the FY2022 AFR and whether grant funds were utilized in accordance with guidelines for operational and optional rotation programs.
DHR Family Practice Residency Program Audit	100		Low	Finance	N/A	Assess whether revenues, expenditures, and unexpended fund balance were reported accurately in the FY2022 AFR and whether grant funds were utilized in accordance with guidelines for operational and optional rotation programs.
Knapp Family Practice Residency Program Audit	100		Low	Finance	N/A	Assess whether revenues, expenditures and unexpended fund balance were reported accurately in the FY2022 AFR and grant funds were utilized in accordance with guidelines for operational and optional rotation programs.
THECB Facilities Audit	150		Low	Facilities Management	N/A	Conduct Facilities Development Projects Audit in accordance with THECB guidelines concurrently with Peer Review Team.
FY2022 Financial Audit - Final	20		N/A	Finance	N/A	Assist External Auditors in FY2022 UT System wide AFR audit final work.

FY 2023 Internal Audit Estimated Budget $996,727

Appendix A – FY 2023 Audit Plan (Budgeted Hours)

FY 2023 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
FY2023 Financial Audit - Interim	10		N/A	Finance	N/A	Assist External Auditors in FY2023 UT System wide AFR audit interim work.
Audits/Reviews by External Agencies	75		N/A	N/A	N/A	Assistance to external agencies auditing UTRGV, such as the Statewide Single Audit, Sponsored Program Reviews, etc.
TEC 51.9337 Compliance Assessment Audit	25		Low	Purchasing/Supply Chain	N/A	Annual assessment that UTRGV has adopted the rules and policies required by Senate Bill 20.
Required Engagements Subtotal	**930**	**9.1%**				
Investigations						
Reserve Hours for Investigations	300					Reserve for investigations.
Investigations Subtotal	**300**	**2.9%**				
Reserve						
Reserve Hours for Unanticipated Projects	300					Reserve for unanticipated projects and management requests.
Reserve Subtotal	**300**	**2.9%**				
Follow-Up						
1st Quarter	150					Follow up on all recommendations, including corrective action plan for Consortium Observations.
2nd Quarter	50					Follow up on all recommendations.
3rd Quarter	50					Follow up on all recommendations.
4th Quarter	50					Follow up on all recommendations.
Follow-Up Subtotal	**300**	**2.9%**				

FY 2023 Internal Audit Estimated Budget $996,727

Appendix A – FY 2023 Audit Plan (Budgeted Hours)

FY 2023 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
Development - Operations						
UT System Meetings and Reporting	100					CAE weekly meetings and reporting requests.
Annual Audit Plan and Risk Assessments	400					Conduct risk assessments capturing critical and high risks and prepare annual audit plan for FY2024.
Internal Quality Assurance Review	100					CAE to perform periodic internal quality assessments.
Quality Assurance & Improvement Program - External Validation & Self-Assessment	300					Conduct quality assurance self-assessment in preparation for independent validation.
Internal Audit Committee Meetings	300					Prepare and conduct Internal Audit Committee meetings, including meeting with external members.
Annual Internal Audit Report	65					Prepare FY2022 Annual Internal Auditor's Report. State requirement; Due November 1, 2022.
Development/Maintenance of Technologies	250					Configuration of the new audit management system and maintenance of audit program libraries and templates. Address technical issues throughout the year.
Management of Audit Activity	700					Staff meetings to discuss updates/status of multiple audit projects include travel time between campuses.
Development - Operations Subtotal	**2215**	**21.6%**				
Development - Initiatives and Education						
UT System Audit Office Initiatives	100					Staff's participation in System Audit Office Initiatives includes Time-related to Audit Management Software.
Professional Development	800					Training for professional staff includes CPE, non-CPE, and travel time.
New Audit Management System Training	200					Functional training for all staff on the new audit management software.
Internal Audit Office Organization and Strategic Initiatives	100					Updating internal audit manual and procedures, evaluating internal audit strategic plan.
Professional Organizations	100					Staff's participation in professional organizations.
Internal Auditing Education Partnership Program	150					Assist the School of Accountancy with the application process.
Development - Initiatives and Education Subtotal	**1450**	**14.2%**				
Total Budgeted Hours	**10245**	**100.0%**				

Available Audit Hours

Calculation of Available Hours	CAE Director	Management Team	Staff	Total	%
Audit Hours*	1,527	2,902	5,816	**10,245**	73%
Non-Audit Hours:					
General Administration	249	500	750	1,499	11%
Holidays	104	208	390	702	5%
Vacation & Sick Leave	200	550	844	1,594	11%
Total Available Hours	2,080	4,160	7,800	14,040	100%

Gross Budgeted Positions (# of FTEs)	7.00
Position Vacancies (# of FTEs)	0.25
Net Positions (# of FTEs)	6.75

Reminders:
AUDIT HOURS SHOULD BE EQUIVALENT TO TOTAL BUDGETED HOURS ON TAB A – AUDIT PLAN
*Audit Hours **SHOULD** include co-source staffing for engagements that are on the audit plan in Appendix A*
*Audit Hours **SHOULD NOT** include students/interns unless they will be tracking time in TEC (non-typical)*
*Audit Hours **SHOULD** include Training/CPE hours in Development – I&E Section (was included in Non-Audit Hours in past years)*

	Total	Holiday	V/S Leave	GA	Projects
CAO	2,080	104	200	249	1,527
Director	2,080	104	300	250	1,426
Assistant Director	2,080	104	250	250	1,476
Senior Auditor	2,080	104	225	200	1,551
Senior Auditor	2,080	104	225	200	1,551
Senior IT Auditor	2,080	104	225	200	1,551
Auditor	2,080	104	225	200	1,551
	14,560	728	1,650	1,549	10,633
Less 25% estimated vacancy	(520)	(26)	(56)	(50)	(388)
	14,040	702	1,594	1,499	10,245

Appendix C – Critical & High Risks Not on FY 2023 Audit Plan

The risk assessment process identified critical and high risks that were not included in the FY 2023 audit plan. The following is a list of these risks and the mitigation strategies for each.

Detailed Risk Description	Risk Mitigating Factors
Risk of not being ready for the new Athletic Sports Programs	Working groups established to address risk.
Athletic facilities not adequate to meet overall program expansion goals	Working groups established to address risk.
Better processes for care in the training room	Associate Athletic Director for Sports Medicine and four Assistant Athletic Trainers
Poor graduation rates, APR, and retention. Academic Performance Fund (failure to earn units)	Athletic Academic Service Unit, resources for SA studying during travel, Virtual Tutoring, Hired employees to work with At-Risk student-athletes, APR Education, Annual meeting with President.
Implementation of the new state legislation related to name image likeness	Legal and Compliance will be addressing, future education.
Risk of not being prepared for the new NCAA landscape - NCAA Transformational Committee	Athletic Compliance Office monitoring the transformational outcomes of the committee
Loss of significant revenue due to lack of CDA/CTA/MTA review & processing infrastructure. Ensure acceptable language and timeframes are in documents (i.e., IP language, subject injury language, data entry timelines, payment metrics, budget aligns with a negotiated budget, invoiceable items and payments details, records storage, screen failure details, etc.)	UT System Master Agreements with some pharma companies; Research Compliance currently reviews SOM clinical trial agreements/contracts.
Need an institutional research fee sheet, charge master details, standards for industry/pharma-related budget negotiations, standards for investigator-initiated projects	The Standard has not been set up. AVP for Clinical & Translational Research has developed a template fee sheet of standard industry fees but still needs to coordinate on rates.
Need staff (coverage analyst) for coverage analysis and billing matrix development activities (front-end billing compliance) who works with PIs to detail research vs routine cost items in protocol well as research financial analyst for back-end billing compliance who can disposition charges based on the billing matrix as well as add research coding to claims (research modifiers, NCT numbers, etc.) and correct billing compliance errors with third-party payors, patients, sponsors. Need functionality within the electronic medical record to support a billing compliance workflow including linking participants to a research protocol where all (clinical and research) charges route to a research queue and get dispositioned appropriately while that person is linked to the study. Need institutional HOP, need clinical research SOPs, need training of clinical staff regarding linking of patients, appointment scheduling when researching, need research personnel training on same issues.	Develop coverage analysis (billing compliance) HOP. Plan to develop clinical research SOPs detailing research billing compliance workflows. Once technology options are defined and built.
Account set-up, account invoicing, and account reconciling against met clinical milestones per participant, ensuring holdbacks are paid, ensuring data locks are timely to receive payment, ensuring data is clean to receive payment	Exploring new EMR systems because current EMR system does not have the capabilities needed for Clinical Research activities
We will need investigational pharmacy infrastructure for the receipt, storage, randomization, dispensing, tracking, and destruction of drugs; need a system that can keep records electronically (ideally). Space, storage, temperature monitoring, hood for mixing (chemo), freezers, refrigerator, pharmacy committee for review of protocols prior to IRB approval, develop, review, and approve investigational drug orders (ideally you want these in your medical record to decrease errors and increase patient safety)	Management is addressing with SOM Dean.
Need radiation safety committee to review and approve trials with radiation; template language for ICFs, policy regarding incidental findings in research scans	Drafting Policy related to incidental findings; will have a conversation with IRB about adding template language to ICFs.
Improperly consenting a patient - consent is a process that involves discussion with potential participants, documentation of the process is critical, signatures/dates (prior to screening activities); version control (ensuring one is using the most recently approved consent form); storage of original signed consents is a requirement; process for electronic consenting; (language translation)	SOP developed to address consent process and documentation of such; training modules to be developed.
Routine monitoring of approved research to ensure the protocol is being followed, documentation standards are met, subject eligibility is followed, consent processes are documented and complete, data is captured and entered in EDC timely and clean; SAE/UPs documented timely; regulatory binders are complete and well maintained; sponsor monitoring reports are addressed in a timely and complete manner, training is documented; amendments are approved and documented, etc.	The post-Approval monitoring program was identified in GAP analysis as a priority area. The office of Compliance working on awareness of Human Subjects; a Monitoring Plan has been developed and will be put in place in the Summer of 2022.

Appendix C – Critical & High Risks Not on FY 2023 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
IDEALLY - Clinical research - in all contexts - normal controls or as an option for the treatment of disease, should have workflows and documentation standards within the medical record. Ability to identify a patient is on a research protocol (i.e., Epic has a button on the chart header that turns green when a patient is active in research); research infrastructure within the system to build study profiles where staff can "link" a participant to a study in the system which then drives billing workflows; uploading consents, documenting research activity (nurse vs coordinator (who is allowed to document in medical record); orders for research; scheduling procedures/clinic visits - understanding in-window time frames; billing work queue where all charges regardless of payor are routed and dispositioned on the "backend"; medication administration documentation; adverse event documentation, concomitant medication documentation; research notes vs clinical notes	Exploring new EMR systems because current EMR system does not have the capabilities needed for Clinical Research activities
Must timely re-consent patients after an amendment receives approval; documentation of the process, storage of originally signed re-consent, the process for electronic consenting apply; Document version control	SOP developed to address consent process and documentation of such; training modules to be developed.
Limitations of space cause significant challenges in accommodating academic and administrative needs	Permanent remote work is providing some space alleviation. Space management committee in place.
Financial Accountability -SOM Accounting Roles and Institutional Finance roles overlapping	Management is addressing the overarching structure, including understanding the extensive job responsibilities within SOM and any duplication already conducted by Financial Services or others (HR, SE, etc.). Items under consideration include: (1) need to enhance the lines of communication; (2) understanding of job responsibilities: and (3) the seriousness in which work/reports need to be provided to Financial Services
Examples of decentralized tasks across campus that impact financial reporting include monthly cost center/project financial reconciliations & annual certification, capital asset & inventory/equipment certifications, pCard purchase reconciliations, workflow document approval (iShop, travel, HR, IT, etc.), personnel action forms (hires, terminations, transfers, promotions, etc.), employee time-cards, etc.	Some SOM processes create duplication of effort, confusion, and inefficiencies. Centralize SOM processes within university processes. Fit for Growth Review performed by the consultant.
Not appropriately invoicing and lack of oversight may increase the possibility of revenue not being recorded accurately	Currently, UTRGV does not have a centralized contracts office to capture all revenue contracts; Contract invoicing, reimbursement requests, and revenue collection affect GASB reporting. An ad-hoc workgroup is currently reviewing contract processes at UTRGV.
Inadequate staffing to address needs and communications with officials at local, state, and federal levels and across the disbursed region resulting in missed opportunities	Working long hours, participating in many organizations, meeting with state and federal representatives, work on building relationships, work as a team and divide duties.
Student tuition & fees are insufficient to cover operations.	UTS Board did not act on requests for Tuition and Fees and declined to act on Guaranteed Fixed Rate tuition plans. Planning & Analysis working with UTS to address this critical issue. Currently using vacant positions to support budget. Need to address excess funds in departmental budgets such as ongoing vacant positions.
The risk of not committing to construction projects due to significant delays and costs	Outside of Management Control; however, Management is monitoring closely.
Noncompliance of HIPAA regulations may result in significant financial penalties as well as reputational damage	HIPAA Privacy Manual completed-updated 49 policies-located in SOM Shared Drive & Blackboard. Designation of Hybrid Entity completed with identified departments which fall within Hybrid Designation. Compliance Office completed HIPAA GAP analysis in FY 2021. Compliance Office updated HIPAA training (to be taken every 2yrs) and assigned the training to all SOM Clinical Staff employees. Required employee Online training for all SOM employees; HIPAA training to be more detailed for SOM clinical staff; HIPAA training migrating from Blackboard to different Learning Mgmt. System software which is integrated with PeopleSoft employee directory. Focus will be on education for FY 2023
Risk of non-compliance with accreditation standards and statutory/regulatory requirements	LCME Accreditation: Currently PROVISIONAL Status; Site visit planned February 2023 for full accreditation. Consultant hired to help address any gaps. Expected decision June 2023
Increased risks of non-compliance to regulatory requirements due to complexity of operations	Clinical Research developing SOPs and training initiatives; Newly hired Director of Clinical Research will oversee implementation

Appendix C – Critical & High Risks Not on FY 2023 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
Lack of qualified interpreters to support students requiring signing/captioning. Outsourced services, especially for specialty areas such as SOM, are expensive requiring an increase in budget.	A request for additional funds was made in May 2022 to address the shortfall. Support from SoM and the general fund are potential sources.
Risk of inadequate staffing to provide services.	Management is addressing the risk and creating an interim team.
NCAA sanctions	Compliance Office monitoring, monthly education, annual training for Compliance staff, Audits, monthly compliance meetings for the different sports
Failure to report a Title IX or Clery Act incident	Education, Awareness
Not fostering an environment that promotes diversity and inclusion – Staff.	Athletics Council, Diversity and Inclusion Plan, Gender Equity Working Group, Campus Resources, Hiring Practices
Student-Athlete or Athletic staff health emergencies insufficiently addressed.	Health emergency response training, Exit Physicals, New Associate Athletic Director for Sports Medicine, Working with the SOM
Gap in staffing and resources in campus departments that work with Athletics	Athletics Administration, Audits, Sub Committee work, Athletics Council
Failure of the Campus Advising Office to oversee Student Athlete Eligibility Certification calculations.	Academic Advising Subcommittee, Policies and Procedures, Compliance Office Monitoring
Not being able to meet Conference membership expectations	Constant conversations, communications, and monitoring
Inadequate facilities for athletic programs.	Maintenance grounds plan, deferred maintenance plan, financial capital projects plan, inspections, working on the University Master Plan, Fundraising
Risk of injury/death of children.	The age of children makes them vulnerable to injury. Video surveillance cameras aid in the investigation of incidents. Employees receive training including CPR and maintain coverage to never leave children unsupervised.
Annual Security Report (ASR) not encompassing all required elements.	1) Clery Coordinator has been hired with UTRGV since Aug 2018. 2) A Clery Compliance Committee was put in place in 2019 to address required Clery elements in the ASR. 3) Subcommittees are being formed to address specific elements. 4) Approximately 95% of the members of the Clery Compliance Committee have received training from NACCOP's 10-part webinar series released in 2019. One new member of the committee will work on completing each webinar by Fall 2022. 5.) UTRGV's membership with the Clery Center Association provides an annual review of the ASR for required policy statements and a sub-committee reviews suggested edits with consultants to continue to improve the ASR. The subcommittee has worked with the Clery center on two reports so far. 6.) Clery Coordinator has received approval from Sr. VP to move forward with the process of purchasing a software called Clery Edge. The software will provide the ability to collect and maintain information on institution-specific modules that assists in completion of the ASR and overall lower campus risk and improve Clery Act compliance.
Pre-review of study documents prior to routing to IRB to ensure it is feasible to conduct the study properly - site has personnel, equipment, space, patient population, etc. to be successful	Developing feasibility review/signoff process within RedCap to ensure appropriate stakeholders have the opportunity to review study documents prior to IRB submission.
Federal guidelines (and Good Clinical Practice ICHE6(R2) detail regulatory compliance expectations; clinical trials are monitored with regularity and site data needs to be complete and clean.	Develop regulatory SOP, currently reviewing Regulatory solutions with AVP Research to set a standard across campus.
Occurs when PI does not understand the difference between following clinical care vs following the protocol.	SOP developed and training modules to be developed.
Ensuring patient safety; consent template language, contract template language to address payment of costs incurred; documentation and notification within expected sponsor (and GCP) timeframes.	SOP developed and training modules to be developed.
Injury or death to personnel. Increase in workers compensation-related expenses.	Effective Program in place. High risk groups are still on campus . UTRGV is in the process of retaining personnel in order to manage projects in-house. With this increase in responsibilities, also comes an increase in project surveillance by EHSRM personnel especially for ROCIP projects . This warrants the review of hiring of new personnel under the umbrella of the Occupational Safety Program. In addition, their has been a significant increase in the volume of activities related to Marine Safety. We currently do not have personnel in the Brownsville area that are needed to address occupational safety related issues relating to OHS in the workplace, construction sites, or the increase in marine related activities.

Appendix C – Critical & High Risks Not on FY 2023 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
Injury to laboratory personnel from exposure to hazardous chemicals.	Program in place to address lab safety. Ventilation issues are being addressed through upgrades. Increased use of chemicals requires additional personnel in the lab safety program. Increase in activity associated with SEEMS and Biology warrants the review of additional personnel and greater surveillance, primarily in the Brownsville area.
Faculty in high-risk areas are unaware of their responsibility and role when engaging in international travel or when hiring foreign nationals.	Attestation form for the hiring of foreign nationals; Export Controls office is notified of any foreign shipments; Export Controls is included in foreign travel notifications; Mandatory Export Training
Not receiving accurate or timely information to perform the role of project PI (oversight activities).	Constant communication, review of policies, involvement of key members, meetings to discuss the issuance of funds, UT System approval of plans
Risk of unallowable expenses being charged to institutional and MSI portions	Constant communication, review of policies, involvement of key members, meetings to discuss the issuance of funds, UT System approval of plans
Risk of Continuing Education unable to support itself as a revenue-driven department due to services not aligned with the workforce environment.	They will work on better aligning services.
Allowability of Costs-Non-Compensation Cost.	Procurement Implemented Concur Travel+. G&C working with Procurement to address the new workflow in Concur Travel+ because expenses are now routed to Grants & Contracts for review & approval before the PI; G&C reviewing allowability and fund availability (no system check).
Allowability of Costs-Compensation Cost.	Effort Certification timeliness process has improved. Required training, including Effort Certification, must be completed before new projects are activated. Projects may be placed on hold until training is completed. Effort training is required every 2 yrs. The effort Coordinator periodically performs follow-ups on certifications.
Subrecipient Monitoring to ensure proper stewardship of sponsor funds.	Grants & Contracts has developed a subrecipient monitoring process; New employee hired to review sub-recipient monitoring. She is reviewing invoices, documentation, and justification, or when costs do not match the budget. Implemented a Sub-recipient tracker that identifies all Sub Recipients which tracks, ending dates, links to archives. Template for cost breakdown implemented; meet with PIs of identified high-risk sub-recipients to discuss expectations of documentation; Process has been established - review of invoices & documents submitted, request additional information when needed. New employees will receive additional training.
Not having Remote employment policies that address employees working outside of Texas due to different employment statutory requirements; workers' compensation; leave policy.	Monitoring of remote employees left to individual departments. Issues and definitions like workers' compensation may arise. Need to address behavior at home. ADM 04-112 WORKING REMOTELY Policy addresses most of the issues.
Lack of compliance with federal regulations - Affordable Care Act (Equifax)	Regular monitoring of ACA eligibility. Regular monitoring and audit of Federal ACA Reporting to IRS.
Risk of stock market/economy changes effects on fundraising goals	Outside Management's Control
Risk of not retaining qualified staff.	Management will work on addressing the risk
Not having a system that can accurately and effectively assign, track, and engage the members of the institution. Not updating training content regularly.	Management is addressing risk with a new learning management system called KnowBe4.
business continuity measures, planning procedures, software system implementation and training of staff are not current or have not been implemented.	We are in process of developing and implementing a business continuity/COOP program across all departments of the institution. This includes the purchase and implementation of a critical software system, training, and regular review and management of newly developed plans across the institution.
Foreign influence of theft of IP and research data	Mitigation plans for foreign influence are being conducted. Constant meeting with State and Federal agencies;
Having 2 sets of processes and forms for pre-award submissions may lead to inefficiencies, confusion, and delays in timely perform required compliance checks with limited staff.	Research Administration has addressed the 2 sets of forms and is addressing the pro
Non-sponsored contracts are not appropriately reviewed.	Need good communication with Accounting. Maybe review the cost center setup process for those non-sponsored contracts to see what needs to be done to properly identify those that need to go through grants accounting and properly set up contracts upfront. Adhoc work group has been created to address the review of cost center setup and address these issues
Possible physical harm to the public during Special Events.	Increased FTE's and reduced vacancies. Conduct Special Event Plan's for large events. The completed initial phase of installation of Bollards at specific locations to eliminate access to the campus community.

Appendix C – Critical & High Risks Not on FY 2023 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
Possible physical harm to members of the campus community.	Continued Advance Law Enforcement Rapid Response Training (ALERRT) for commissioned police department staff. Continued Civilian Response to Active Shooter Event (CRASE) training to the campus community.
Project Managers assigning the administration of these contracts to staff not familiar with the contract specifications.	The Procurement Contracts Office will review who is assigned as contract administrator for any updates as needed prior to contract execution.
Lack of infrastructure to support human subject research before committing the institution to the study.	Will establish feasibility committee in consultation with the SOM
Lack of training of current P&P which may lead to non-compliance.	Currently Research Compliance efforts are mainly to review and screen protocols. Keys to Research implemented for faculty and graduate students.
Ongoing Compliance with Regulatory requirements.	Recently received laboratory accreditation through the College of American Pathologists (CAP);
Revenue could decline as a result of inefficient billing and collection process	1 FTE works on Billing and collection components of Avalon.
Lack of a single hospital partner causes inefficiencies in timely payment or non-compliance of contract terms due to operating in multiple environments (hospitals, providers, etc.).	Ongoing communications with multiple partners. Process of renewing some agreements.
Lack of revenue contract management- Invoicing, accounts receivable, collections., resulting in failure to properly collect and account for revenue.	More oversight and focus by management to improve revenue collections.
Lack of Compliance with UT System UTS 155 MSRDP.	UT System annual audit requirement: MSRDP Audit report issued in FY 22. Management Action Plans are currently being implemented.
Risk that processes may not be in place which are needed in the areas of faculty development, aligning their skillsets with institutional needs, and establishing goals for them by department in all aspects of their work (e.g., clinical productivity, research, and academics).	Sufficiency of faculty and administrative staff for accreditation requirements. Pay at 50th percentile for the region in line with AAMC Standard.
Students not returning for the subsequent semester.	Action Academic/Health Affairs co-own retention risk. Strategic Enrollment has a communication plan to encourage returning students to continue enrollment in subsequent semesters, via print mail, email, text messages, and phone calls. Strategic and targeted messages are sent to all students who are eligible to enroll but have not enrolled, which include registration reminders, clearing holds, and taking care of pending items to clear their financial aid and scholarship eligibility.
Risk of not safeguarding information, risk of exposure of personal information, risk of inappropriate access.	Requests for access are vetted and questioned as needed to (1) ensure access is given only where the appropriate need exists, and (2) to mitigate risks associated with access that is too general and broad and/or allows for altering of data not owned by particular users. A Banner Access Security audit was completed in 2021 and a working group was formed to enhance processes.
Not knowing about 50% or more teaching at a location without having received proper approvals.	We do have a process in place to report new locations and programs. When there is a new program or location is created the President's office informs stakeholders including financial aid and financial aid determines if PPA needs to be updated. High rating because failure to report new locations and new programs can result in refunding the Department of Education for students awarded in unreported locations and programs. Also, a risk for the Academic Division.
Safety of minors; noncompliance with state and federal rules and regulations.	There is a Youth Program Support Manager position to provide support and youth programs reside in College Access and K-12 Partnerships for oversight. All youth programs must be registered with College Access and K-12 Partnerships. This registration allows the Youth Program Support Manager to contact program directors for training and adherence to youth program guidelines. We have established guidelines in place and HOP policy under review. CircuiTree contract paused.
Difficulty in reconciling WS due to PS system limitations.	Monthly recon process is in place to ensure reconciliations are completed. However, system limitations exist that makes it difficult to reconcile timely. For example, 1) fringe benefits are charged to federal WS accounts inaccurately, 2) closed accounts are being expensed causing reconciliation differences, 3) incorrect accounts are selected in the ePAF system causing reconciliation differences, 4) students getting paid from incorrect accounts due to position number business process within PS. Recommended action is to consolidate the funding currently allocated to departmental accounts and only use one account to process WS through payroll.
Not being able to track and intervene with students of concern; risk to student safety; and managing student conduct processes.	Staff involved in student conduct and Dean of Students complete have annual training to mitigate risks. Weekly meeting on high complex cases.

Appendix C – Critical & High Risks Not on FY 2023 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
Risk to safety and academic progress for individuals with disabilities; not complying with ADA rules and regulations in purchasing practices of services/software, facilities/grounds, and online content.	EIR committee made up of campus representatives to review software purchases to ensure compliance with ADA rules and regulations. OIED released a web content training on web accessibility which is required training for all web content managers. Student Accessibility Services (SAS) completes professional development and SAS works with COLT to provide training and information to faculty on making materials accessible. A statement is included on all syllabi regarding ADA accommodations.
Risk that UTRGV does not comply with laws and regulations.	Management is addressing the risk.
Not effectively monitoring the international student's good standing through the Student Exchange Visitor information system from the U.S. Department of Homeland Security.	Management is addressing the risk and creating checks and balances.
Damage to buildings - flooding, broken windows, power outages (spoiled food in dining areas).	We sometimes do not have an adequate number of staff to prepare the facilities for a storm, especially in the summer. An updated weather incident response plan is needed (for example, a plan tiered by the Hurricane category).
Potential for spread of infectious disease.	Updated for Post-COVID - Protocols have been established to exceed the cleaning and disinfection process. Training is provided to all students and full-time staff to monitor the cleanliness of the facility. Space capacities from COVID have been removed; however, cleaning procedures have remained because MRSA is still a common Gym concern.
Risk of unallowable costs charged to HEERF Grants. HEERF Grant funds have their own set of guidelines. Guidelines are not consistent between HEERF I, II, and III grants received.	The remaining grant funds are to be spent by August 31, 2022. There is an institutional oversight team for these funds.
MSA not meeting enrollment goals.	Consulting services for MSA are currently being performed.
Inaccurately completing MSA student transcripts.	Consulting services for MSA are currently being performed.
MSA admits students who are not prepared for the program.	Consulting services for MSA are currently being performed.
Unable to reestablish operations due to natural disaster.	Conversations about the need to identify resiliency to natural disasters is occurring.

SECTION VI
External Audit Services Procured in Fiscal Year 2022

EXTERNAL AUDIT SERVICES PROCURED IN THE FISCAL YEAR 2022

Report Date	Type of Service	Objective
December 10, 2021	Deloitte and Touche performed an independent audit on the UT System consolidated financial statements.	Express an opinion on the UT System consolidated financial statements and related notes for the years ending August 31, 2021, and 2020.
January 18, 2022	NCAA Agreed-Upon Procedures conducted by UT System Audit Office.	Performed procedures to evaluate whether the Statement of Revenues and Expenses of UTRGV's Department of Intercollegiate Athletics is in compliance with NCAA Bylaw 3.2.4.16 for FY 2021.
March 11, 2022	Deloitte & Touche performed an audit of the Schedule of Expenditures of Federal Awards for the U.S. D.O.E. Financial Assistance Cluster.	Express an opinion on the Schedule and compliance for major federal programs for program award year 2020-2021.

SECTION VII
Reporting Suspected Fraud and Abuse

Reporting Suspected Fraud and Abuse

To comply with the requirements of Section 7.09, Page IX-37, General Appropriations Act (86th Legislature), and Section 7.09, Page IX-38, General Appropriations Act (87th Legislature), a link for Fraud Reporting was created at the bottom of The University of Texas Rio Grande Valley's website https://www.utrgv.edu/.

In addition, the UTRGV Office of Audits and Consulting Services has a link directly to the State Auditor's Office as follows:

> https://www.utrgv.edu/audits/report-fraud/index.htm
>
> "To report suspected fraud, waste, or abuse of state appropriated funds by UTRGV, please contact the Texas State Auditor's Office through the fraud hotline @ 1-800-TX-AUDIT (1-800-892-8348) or online through the State Auditor's website @ http://sao.fraud.state.tx.us.
>
> In addition to reporting it to the Texas State Auditor's Office, please report it to the "UTRGV Anonymous Compliance Hotline @ 1-877-882-3999."

The Institutional Compliance Office receives inquiries and allegations regarding a wide range of compliance issues including fraud and abuse, and the Office tracks investigations and any resulting actions through to completion.

To comply with the Coordination of Investigation requirements of Texas Government Code, Section 321.022, the UTRGV Office of Audits and Consulting Services notifies the Texas State Auditor's Office of Investigations and Audit Support when investigations of fraud are conducted. The University of Texas System Administration's Audit Office is also notified.