ANNUAL INTERNAL AUDIT REPORT FISCAL YEAR 2023

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UTRGV

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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 2024 Internal Audit Plan and fiscal year 2023 Internal Audit Annual Report is due November 1, 2023. 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 2023 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 2024 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 2023

Explanation of Deviations from the Audit Plan

The FY 2023 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, several engagements were at draft report stage awaiting management responses. Due to timing, six of those were not issued by fiscal year end and the FY 2024 audit plan will be adjusted to include those engagements. Two-engagements had just started around fiscal year end and were carried forward to the FY 2024 audit plan. In addition, other engagements that were not started during the fiscal year were reassessed during the risk assessment and annual audit plan development process and either added to the FY 2024 Audit Plan or dropped.

Refer to the FY 2023 Annual Audit Plan Status Report for further details.

Audit Plan Status Report as of August 31, 2023

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, 2023	Report/Memo Issued Date
Assurance Engagements								
NCAA Compliance - Financial Aid Audit	300.00	(300.00)	0.00	0.00	0.00		Not Started - Included on FY2024 Audit Plan	-
UT Health RGV Multispecialty Clinic (Edinburg)	300.00	(100.00)	200.00	380.50	(180.50)		In Progress - Draft Report	-
UT Health RGV Surgical Specialty Clinic (Harlingen)	300.00	(100.00)	200.00	68.00	132.00		In Progress - Carryforward to FY2024 Audit Plan	-
Graduate Medical Education Audit	300.00	0.00	300.00	0.00	300.00		Not Started - Reassessed and dropped.	-
Cost Transfers Audit	200.00	0.00	200.00	330.50	(130.50)		In Progress - Draft Report	-
Institutional Review Board (IRB) Audit	300.00	(300.00)	0.00	0.00	0.00		Replaced - Included on FY2024 Audit Plan	-
Conflicts of Interest Audit	250.00	0.00	250.00	0.00	250.00		Not Started - Included on FY2024 Audit Plan	-
Student Housing & Residence Life Audit	300.00	0.00	300.00	358.00	(58.00)		Draft Report - Mgmt. Responses	-
Small Business Development Center (SBDC) Audit	250.00	0.00	250.00	0.00	250.00		Not Started - Reassessed and dropped.	-
Patch Management Audit	150.00	0.00	150.00	344.00	(194.00)		Report Issued #23-AEN-10	5/31/2023
Payment Card Industry Data Security Standards (PCI) Audit	300.00	(75.00)	225.00	0.00	225.00		Not Started - Consultant hired to evaluate	-
School of Medicine IT Processes/Controls Audit	300.00	0.00	300.00	0.00	300.00		Not Started - Included on FY2024 Audit Plan	-
Decentralized IT Audit	300.00	0.00	300.00	164.50	135.50		In Progress - Carryforward to FY2024 Audit Plan	-
Clery Audit	0.00	300.00	300.00	3.00	297.00		In Progress - Carryforward to FY2024 Audit Plan	-
FY22 Carryforward - Change in Personnel Action Form (cPAF) Audit	0.00	200.00	200.00	86.00	114.00		Draft Report - Mgmt. Responses	-
FY22 Carryforward - UT Health RGV - Orthopedics & Sports Medicine Clinic Audit	0.00	100.00	100.00	86.50	13.50		Report Issued #22-AEN-14	12/6/2022
FY22 Carryforward - UT Health RGV - Behavioral Health Clinic Audit	0.00	100.00	100.00	86.00	14.00		Report Issued #22-AEN-15	11/18/2022
Assurance Engagements Subtotal	**3,550.00**	**(175.00)**	**3,375.00**	**1,907.00**	**1,468.00**	**32.94 %**		
Advisory and Consulting Engagements								
Electronic Medical Devices Inventory	200.00	0.00	200.00	526.00	(326.00)		Completed	5/26/2023
Data Analytics - Cost of Attendance, Enrollment Reporting	100.00	0.00	100.00	460.00	(360.00)		Completed	-
Institutional Committee Meetings and Adhoc Workgroups	450.00	0.00	450.00	192.00	258.00		Ongoing	-
Education, Training and Advice to Institutional Departments	250.00	0.00	250.00	469.00	(219.00)		Ongoing	-
Executive Leadership Meetings and Others	200.00	0.00	200.00	130.00	70.00		Ongoing	-
iTravel + Consulting	0.00	220.00	220.00	382.50	(162.50)		Draft Memo	-
AIM Consulting Services	0.00	500.00	500.00	106.50	393.50		In Progress	-
Advisory and Consulting Engagements Subtotal	**1,200.00**	**720.00**	**1,920.00**	**2,266.00**	**(346.00)**	**18.74 %**		
Required Engagements								
NCAA Agreed Upon Procedures	350.00	0.00	350.00	174.00	176.00		Completed and Report Issued	1/17/2023
McAllen Family Practice Residency Program Audit	100.00	0.00	100.00	114.50	(14.50)		Report Issued #23-REQ-20	1/26/2023
DHR Family Practice Residency Program Audit	100.00	0.00	100.00	126.50	(26.50)		Report Issued #23-REQ-21	1/26/2023
Knapp Family Practice Residency Program Audit	100.00	0.00	100.00	120.00	(20.00)		Report Issued #23-REQ-22	1/26/2023
THECB Facilities Audit	150.00	0.00	150.00	232.00	(82.00)		Report Issued #23-REQ-23	3/15/2023
FY2022 Financial Audit - Final	20.00	(20.00)	0.00	0.00	0.00		No Assistance Provided	-
FY2023 Financial Audit - Interim	10.00	0.00	10.00	0.00	10.00		No Assistance Provided	-
Audits/Reviews by External Agencies	75.00	0.00	75.00	140.50	(65.50)		Particpated in Entrance & Exit Conferences	-
TEC 51.9337 Compliance Assessment Audit	25.00	0.00	25.00	13.00	12.00		Completed - Annual Internal Auditors Report	11/1/2022
Required Engagements Subtotal	**930.00**	**(20.00)**	**910.00**	**920.50**	**(10.50)**	**8.88 %**		

Audit Plan Status Report as of August 31, 2023

Investigations								
Reserve Hours for Investigations	300.00	(100.00)	200.00	7.00	193.00			
Investigations Subtotal	**300.00**	**(100.00)**	**200.00**	**7.00**	**193.00**	**1.95 %**		
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	150.00	(75.00)	75.00	87.50	(12.50)		Completed	
2nd Quarter	50.00	0.00	50.00	73.00	(23.00)		Completed	
3rd Quarter	50.00	0.00	50.00	16.00	34.00		Completed	
4th Quarter	50.00	0.00	50.00	32.00	18.00		Completed	
Follow-Up Subtotal	**300.00**	**(75.00)**	**225.00**	**208.50**	**16.50**	**2.20 %**		
Development - Operations				**44,866.00**				
UT System Meetings and Reporting	100.00	0.00	100.00	115.50	(15.50)			
Annual Audit Plan and Risk Assessments	400.00	0.00	400.00	409.50	(9.50)		FY2024 Plan Approved 7/6/2023	-
Internal Quality Assurance Review	100.00	0.00	100.00	70.00	30.00			
Quality Assurance & Improvement Program - External Validation & Self Assessment	300.00	0.00	300.00	35.50	264.50			
Internal Audit Committee Meetings	300.00	0.00	300.00	246.50	53.50			
Annual Internal Audit Report	65.00	0.00	65.00	22.00	43.00		Report Issued	11/1/2022
Development/Maintenance of Technologies	250.00	0.00	250.00	188.50	61.50			
Management of Audit Activity	700.00	0.00	700.00	1,176.00	(476.00)			
Development - Operations Subtotal	**2,215.00**	**0.00**	**2,215.00**	**2,263.50**	**(48.50)**	**21.62 %**		
Development - Initiatives and Education								
UT System Audit Office Initiatives	100.00	0.00	100.00	77.50	22.50			
Professional Development	800.00	0.00	800.00	725.00	75.00			
New Audit Management System Training	200.00	0.00	200.00	0.00	200.00			
Internal Audit Office Organization and Strategic Initiatives	100.00	0.00	100.00	53.00	47.00			
Professional Organizations	100.00	0.00	100.00	84.50	15.50			
Internal Auditing Education Partnership Program	150.00	(50.00)	100.00	27.50	72.50			
Development - Initiatives and Education Subtotal	**1,450.00**	**(50.00)**	**1,400.00**	**967.50**	**432.50**	**13.67 %**		
Total Audit Hours	**10,245.00**	**0.00**	**10,245.00**	**8,540.00**	**1,705.00**	**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 2023, 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 is 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 not included in the FY 2023 audit plan. During our risk assessment for the FY 2024 audit plan development, we assessed Benefits Proportionality Funding as low risk to UTRGV; therefore, an engagement was not included in our audit plan. We will continue to reassess Benefits Proportionality Funding through our annual risk assessment process.

FY 2023 Observations and Action Plans

REPORT NO.	REPORT DATE	REPORT NAME	OBSERVATIONS	MANAGEMENT RESPONSES/ACTION PLANS	IMPLEMENTATION STATUS
UTRGV 22-AEN-14	12/6/2022	UT Health RGV Orthopedics & Sports Medicine Audit (Weslaco)	PSRs are not consistently obtaining a second signature from a verifier on the Daily Cashier Check Out Form. Eight (38%) out of twenty-one reconciliations during the month of April 2022 did not have a second signature for verification. Additionally, PSRs have not attended recent cash handling.	Effective November 21, 2022, the PSRs will be reporting to a new PSR Supervisor. The responsibility of staying current with cash handling training will be the responsibility of the PSR Supervisor.	Implemented
UTRGV 21-AEN-08	12/12/2022	Electronic Protected Health Information (ePHI)	Confidential	Confidential	In Progress
UTRGV-23-AEN-10	5/31/2023	Patch Management Audit	We tested 20 software changes, changes were applied to different systems. All changes reviewed were documented in TeamDynamix. 16 out of the 20 software changes indicated "No" for the only question that refers to testing, "Is your completed test plan attached and successful?". No explanation for the "No" responses was provided.	Change Request form will be modified to have a mandatory text field as to why not tested if "no test plan" is checked and what validation will be done in lieu of testing. Will also modify the work instructions to explain the No Test Plan explanation field.	Implemented
UTRGV-23-AEN-10	5/31/2023	Patch Management Audit	Two systems were tested to ensure that they were up to date on their patches. One did not have proper testing documentation. Documentation provided had screenshots with the wrong version and dates.	Standard Change: Supervisor is responsible for reviewing and approving the change and supporting documentation. That includes is it up to date. Will reinstruct supervisors of their responsibilities. Will implement a monthly audit by the Change Management Coordinator of change documentation. Normal Change: Are reviewed by Change Management Coordinator before going to in the Change Advisory Board that the documentation is correct and up to date. Note: This finding was on a Standard change.	Implemented
UTRGV-23-AEN-10	5/31/2023	Patch Management Audit	Documentation reviewed did not have proof that changes were accurately deployed into production.	Will review the change management documentation and clarify the responsibilities of the person validating the change in production and what documentation is needed to document the results. Will resend Change Management training to all IT employees.	Implemented

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
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
5/26/2023	Electronic Medical Devices Inventory Consulting	Assist UT Health RGV create a complete inventory of medical devices that store electronically protected health information (ePHI).	Inventory of medical devices storing ePHI was developed.	Operations and Information Security

SECTION IV
External Quality Assurance Review
(Peer Review)

bakertilly
now, for tomorrow.

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

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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 2024

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 2024**).

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 2024 AUDIT PLAN

UTRGV

Office of Audits and Consulting Services

Approved by: Internal Audit Committee
July 6, 2023

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) 2024. 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 that 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 2024 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 2024 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, an engagement 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, EPIC – Electronic Medical Records System, Institutional Review Board, UT Health RGV Cosmetic Surgery Clinic, Medical School Practice Plan, Grant Draw Downs, Clery, and IT Governance/Procurement, which covers TAC 202 requirements.

Required Audits (Externally and Internally)

The UT System Board of Regents approved an independent accounting firm to conduct the FY 2024 UT System-wide Consolidated Financial Audit. Interim procedures will be conducted during the month of July 2024, and year-end procedures will be conducted in November 2024. 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, DHR 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 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 2023 and the certification will be included in the Annual Internal Audit Report.

Advisory Engagements

Advisory and consulting engagements will include Athletics Consulting and assisting the Research Division evaluate proper coding of research expenditure in support of UTRGV becoming an Emerging Research University. 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 appropriate categories.

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 26 years of audit experience. The director has 29

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 2024 Audit Hours

The number of audit hours available for FY 2024 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 **9,909 hours** for audits and consulting engagements as well as audit staff and management development hours. The FY 2024 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 26, 2023.
- The UTRGV Audit Committee – Audit plan was approved on July 6, 2023.
- The UT System Board of Regents – Audit plan provided on August 23, 2023

FY 2024 Internal Audit Estimated Budget $1,044,898

Appendix A – FY 2024 Audit Plan (Budgeted Hours)

FY 2024 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
Assurance Engagements						
NCAA Financial Aid Compliance 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 Clinic	250		High	Revenue Cycle related to medical services	N/A	Assess efficiency and effectiveness of front-end revenue processes as well as internal controls over clinical operations.
Conflicts of Interest	300		High	Governance	N/A	Assess the effectiveness of controls for ensuring the identification, communication, and management of conflicts of interest.
Medical School Practice Plan (MSRDP) Audit	250		High	Practice Plan	N/A	Per UT System Guidance, a risk-based audit related to the Practice Plan should be conducted to review compliance with MSRDP process or bylaws.
EPIC Audit	400		Critical	Revenue Cycle related to medical services	N/A	Ensure migration of medical records to EPIC is accurately completed and review access controls.
Student Drop Processes Audit	400		High	Finance	N/A	Evaluate the efficiency of the PeopleSoft to Banner relationship with respect to student drop processes.
Institutional Review Board (IRB) Audit	300		High	Research	N/A	Evaluate key activities of the IRB in the protection of human subjects in research.
University Staffing Audit	200		High	Human Resources	Data Analytics	Evaluate whether areas of the institution are aware of familial relationships and are monitoring and managing them.
IT Governance/Procurement	250		High	Information Technology	IT	Evaluate Procurement Office's role in the IT Governance process in relation to the procurement of software. Meets requirements for TAC 202.76

FY 2024 Internal Audit Estimated Budget $1,044,898

FY 2024 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
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 the maintenance of systems.
Grant Draw Downs Audit	250		High	Research	Data Analytics	Evaluate segregation of duties related to grant draw downs.
CARRYFORWARDS:						
Clery Audit	150		High	Auxiliary Services	N/A	Evaluate mandatory reporting responsibilities for Clery compliance.
UT Health RGV Surgical Clinic Audit	100		High	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.
Assurance Engagements Subtotal	**3450**	**34.8%**				
Advisory Engagements						
Athletics Consulting	250		High	Auxiliary Services	N/A	Review Athletics Business Processes for Efficiency in anticipation of new sports programs.
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	300		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.
Accountability, Innovation, Maximization Consulting	300		Critical	Research	Data Analytics	Assist the Research Division with ensuring research-related endowments are captured with the appropriate function code in support of the ERU initiative.
Advisory Engagements Subtotal	**1500**	**15.1%**				

FY 2024 Internal Audit Estimated Budget $1,044,898

Appendix A – FY 2024 Audit Plan (Budgeted Hours)

FY 2024 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
Required Engagements						
NCAA Agreed Upon Procedures	40		Low	Auxiliary Services	N/A	Assist UT System Audit in the performance of the required annual NCAA Agreed Upon Procedures for FY2023.
McAllen Family Practice Residency Program Audit	125		Low	Finance	N/A	Assess whether revenues, expenditures, and unexpended fund balance were reported accurately in the FY2023 AFR and grant funds were utilized in accordance with guidelines for operational and optional rotation programs.
KNAPP Family Practice Residency Program Audit	125		Low	Finance	N/A	Assess whether revenues, expenditures, and unexpended fund balance were reported accurately in the FY2023 AFR and grant funds were utilized in accordance with guidelines for operational and optional rotation programs.
FY2023 Financial Audit - Final	10		N/A	Finance	N/A	Assist External Auditors in FY2023 UT System wide AFR audit final work.
FY2024 Financial Audit - Interim	20		N/A	Finance	N/A	Assist External Auditors in FY2024 UT System wide AFR audit interim work.
Audits/Reviews by External Agencies	50		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	**395**	**4.0%**				
Investigations						
Reserve Hours for Investigations	350					Reserve for investigations.
Investigations Subtotal	**350**	**3.5%**				
Reserve						
Reserve Hours for Unanticipated Projects	450					Reserve for unanticipated projects and management requests.
Reserve Subtotal	**450**	**4.5%**				

FY 2024 Internal Audit Estimated Budget $1,044,898

Appendix A – FY 2024 Audit Plan (Budgeted Hours)

FY 2024 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
Follow-Up						
1st Quarter	50					Follow up on all recommendations.
2nd Quarter	50					Follow up on all recommendations.
3rd Quarter	50					Follow up on all recommendations.
4th Quarter	50					Follow up on all recommendations.
PCI Follow-up	75					Follow up on all recommendations included in the final report from PCI consultant.
Follow-Up Subtotal	**275**	**2.8%**				
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 FY2025.
Internal Quality Assurance Review	100					CAE to perform periodic internal quality assessments.
Quality Assurance & Improvement Program - External Validation	75					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	54					Prepare FY2023 Annual Internal Auditor's Report. State requirement; Due November 1, 2023.
Development/Maintenance of Technologies	250					Maintenance of audit program libraries and templates. Address technical issues throughout the year.
Management of Audit Activity	800					Staff meetings to discuss updates/status of multiple audit projects, includes travel time between campuses.
Development - Operations Subtotal	**2079**	**21.0%**				

FY 2024 Internal Audit Estimated Budget $1,044,898

Appendix A – FY 2024 Audit Plan (Budgeted Hours)

FY 2024 Audit Plan	Budget	Percent of Total	Risk	Primary Taxonomy	Specialty Audit Used	General Objective/Description
Development - Initiatives and Education						
UT System Audit Office Initiatives	160					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, evaluate internal audit strategic plan.
Professional Organizations	100					Staff's participation in professional organizations.
Internal Auditing Education Partnership Program	50					Continue providing assistance to School of Accountancy with program.
Development - Initiatives and Education Subtotal	**1410**	**14.2%**				
Total Budgeted Hours	**9909**	**100.0%**				

Available Audit Hours

Calculation of Available Hours	CAE Director	Management Team	Staff	Total	%
Audit Hours*	1,534	2,918	5,457	**9,909**	71%
Non-Audit Hours:					
General Administration	250	500	900	1650	12%
Holidays	96	192	432	720	5%
Vacation & Sick Leave	200	550	1,013	1,763	13%
Total Available Hours	2,080	4,160	7,801	14,041	100%

Gross Budgeted Positions (# of FTEs)	7.00
Position Vacancies (# of FTEs)	0.50
Net Positions (# of FTEs)	6.50

	Total	Holiday	V/S Leave	GA	Projects
CAO	2,080	96	200	250	1,534
Director	2,080	96	300	250	1,434
Assistant Director	2,080	96	250	250	1,484
Senior Auditor	2,080	96	225	200	1,559
Senior Auditor	2,080	96	225	200	1,559
Senior IT Auditor	2,080	96	225	200	1,559
Auditor	2,080	96	225	200	1,559
	14,560	672	1,650	1,550	10,688
Less 50% estimated vacancy	(1,040)	(48)	(113)	(100)	(780)
	13,520	624	1,538	1,450	9,909

Appendix C – Critical & High Risks Not on FY 2024 Audit Plan

The risk assessment process identified critical and high risks that were not included in the FY 2024 audit plan. The following is a list of these risks and the mitigation strategies for each.

Detailed Risk Description	Risk Mitigating Factors
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 not being ready for the new Athletic Sports Programs.	Working Groups.
Lack of compliance with federal regulations - Affordable Care Act (Equifax).	Monthly monitoring of ACA eligibility with corrections and changes. Annual reporting to IRS by due date. Correction of any findings after submission for error correction.
Leave balances for employees are not accurate due to not being 'Approved' and remain outstanding. This delays the Vacation Payout for terminated employees and affects the overall balance for active employees.	Supervisor series Time Management training in place. Absences not approved and older than 90 days will need to be approved by HR Leave. Propose: system update necessary to prevent timecard approval without absence approvals.
Risk of not retaining qualified staff.	Management will work on addressing the risk.
Risk of stock market/economy changes effects on fundraising goals.	Outside Management's Control.
Lack of qualified interpreters to support students requiring signing/captioning. Outsourced services, especially for specialty areas such as SOM, are expensive requiring increase in budget.	A request for additional funds was made in May, 2022 to address shortfall. Support from SOM and the general fund are potential sources.
Students not returning for 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 includes 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 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.
Noncompliance with federal or state financial aid requirements: • Return to Title IV inaccurate calculations and timeliness. • Inaccurate and/or untimely reporting impacting student repayment status. • Inaccurate verification of FAFSA items and no monitoring process. • Financial Aid applied to courses not in students' degree plans. • Awards to ineligible students. • Total aid awarded in excess of student's financial need. • Satisfactory Academic Progress for financial aid not calculated accurately. • Failure to provide accurate and timely info. to students. • Cost of attendance not calculated correctly.	At the beginning of every year, the financial aid management team reviews all award amounts, eligibility, and banner programming for accuracy and compliance with federal and state financial aid requirements. A continuous review takes place throughout the year by the program coordinators. In addition, a monitoring process is in place to review 100% of financial aid transactions.

Appendix C – Critical & High Risks Not on FY 2024 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
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. Critical 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.	Management oversight.
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 annual training as a way to mitigate risks. Weekly meeting on high complex cases.
Risk to accessibility 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.	Electronic Information Resources (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 a 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.
Not effectively monitoring the international student's good standing through the Student Exchange Visitor information system from the U.S. Department of Homeland Security.	The team has implemented reports to track the academic standing of numerous visa-type holders. Management will review the processes associated with J-1 visa holders (both faculty and student) to ensure SEVIS reporting is accurate. The team continues to improve communications to ensure students and faculty holding a visa receive timely and appropriate communications.
Risk of inadequate deferred maintenance.	Partnering with Facilities to identify and prioritize a project list for the next several years. Some funds have been requested from system that, if funded, would address funding for many of the deferred maintenance projects.
Ineffective implementation of TargetX CRM. Loss of functionality in new CRM versus current CRM applications. Risks associated with two-way integration between TargetX and Banner. Inaccurate and/or delayed communications to students.	The implementation of TargetX is in progress. Due to functionality concerns, the scope of this project was reduced to Graduate Recruitment, Graduate Admissions, and Undergraduate Recruitment. We will continue to assess what processes in Undergraduate Admissions we may use with TargetX. The go-live for Graduate Recruitment and Admissions is August 1, 2023 with additional go-live dates in other areas (i.e. Undergraduate Recruitment, departmental email management and TargetX retention module).

Appendix C – Critical & High Risks Not on FY 2024 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
Risk of having to reschedule/cancel graduation ceremony along with the corresponding financial implications.	There is a reputational risk and large financial impact of cancelling or rescheduling a ceremony. There is a lack of indoor venue options on the Brownsville campus which requires us to hold an outdoor ceremony costing roughly 300k per year. Rescheduling the outdoor ceremony could potentially cost an additional 100k per semester and impacts our services to students.
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 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 research, 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, 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).	SOP is being developed to address this.

Appendix C – Critical & High Risks Not on FY 2024 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
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 participant, documentation of the process is critical, signatures/dates (prior to screening activities); version control (ensuring one is using 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.
Must timely re-consent patients after an amendment receives approval; documentation of process, storage of original signed re-consent, process for electronic consenting apply; Document version control.	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.	Post-Approval monitoring program was identified in GAP analysis as a priority area. Office of Compliance working on awareness in Human Subjects; Monitoring Plan has been developed and will be put in place Summer 2022.
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 the 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.

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Detailed Risk Description	Risk Mitigating Factors
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 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 Eregulatory 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.
IDEALLY - a CTMS would interface with the electronic health record, IRB, and eRegulatory solution; aids in study management, subject management, and financial management of each trial.	SOP developed and training modules to be developed.
Monitoring activities may be deficient which may result in failure to become an emerging research institution.	Hired Assistant Director of Post Approval Monitoring. Monitoring Program has been developed, needs final approval and will launch. Post-approval monitoring will be on a needed basis.
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 NOT included in foreign travel notifications; Mandatory Export Training. The Export Controls position is still vacant. The Executive Director has access to a report and runs it on a needed basis. Disclosures for outside activities for 9-month appt faculty during the summer.
Foreign influence of theft of IP and research data.	Mitigation plans for foreign influence are being conducted. Constant meeting w State and Federal agencies; Granting agencies asking for Data Management & Security Plans at proposal stage. Federal government has increased support in this area.
Cost transfers are not processed timely resulting in loss of funding to the institution.	Audit to be completed by August 2023. Timeliness and completeness of the explanation of the transfer are important factors in supporting allowability and allocability in accordance with federal requirements.
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). Nelly periodically performs follow-up on certifications. CPAF audit addressed system limitations.
Non Research sponsored contracts not appropriately reviewed.	Fixed Contracts Audit issued 2021. Management is currently reviewed Contracts across the University. AIM Consulting Engagement to review Cost Center approval which include Non-Research funding.

Appendix C – Critical & High Risks Not on FY 2024 Audit Plan

Detailed Risk Description	Risk Mitigating Factors
Non-sponsored contracts not appropriately reviewed.	Need good communication with Accounting. Maybe review cost center set up 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. Work group has been created to address the review of cost center set and address these issues.
Unknowingly collaborating with restricted entities/parties; Deemed Export may occur when restricted information is made available to foreign nationals via any communication, visual inspection.	The Export Controls position is still vacant. Increased Training/Awareness; Contracts are reviewed by OSP; International agreements reviewed by Assoc VP or VP; Visual Compliance being used; Export Controls Manual on website; Mandatory module implemented for Undue foreign influence and export controls.
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) . Required employee Online training for all SOM employees; HIPAA training to be more detailed for SOM clinical staff; Focused on new training module during FY 2023.
Risk of non-compliance with accreditation standards and statutory/regulatory requirements.	LCME Accreditation: Currently PROVISIONAL Status; Critical gaps addressed in 2023. Expected decision June 2023.
Increased risks of non-compliance to regulatory requirements due to complexity of operations.	Performing an assessment and review of space allocation and equipment usage to make sure there is a process to allocate space. Clinical Research developing SOPs and training initiatives.
Ongoing Compliance with Regulatory requirements.	Recently received laboratory accreditation through the College of American Pathologists (CAP); Management is still working to improve processes
Revenue could decline as a result of inefficient billing and collection process.	1 FTE works on Billing and collection components of Avalon.
The lack of a standard ERM system exposes the university to risks and financial loss due to inefficiencies and lack of information.	Billing interfaces with partner hospitals as well as opportunities for improvement still need to be addressed. Revenue Cycle now has access to partners and login for authorizations and updates.
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 revenue.	More oversight and focus by management to improve revenue collections in GME and Call Pay. Currently SOM Finance Office billing monthly, monitoring collections, and reviewing collections reports.
Risk that processes may not be in place which are needed in the areas of faculty development, and retention.	Sufficiency of faculty and administrative staff for accreditation requirements. Pay at 50%ile for the region in line with AAMC Standard.

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Detailed Risk Description	Risk Mitigating Factors
Career outcome initiatives are not implemented.	Consultant hired to create shared goals for students.
MSA not meeting enrollment goals.	Leadership team meeting to discuss MSA.
Inaccurately completing MSA student transcripts.	This is being addressed by MSA.
Risk of unallowable expenses being charged to institutional and MSI portions.	Funds were monitored.
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, working on building relationships, working as a team, and dividing duties.
Not receiving Engaged University Carnegie reclassification.	Gathering all the data to support application and setting up a team for the writing.
Risk of Continuing Education unable to support itself as a revenue driven department due to services not aligned with the workforce environment.	The move to online workforce training resources available continues to push UTRGV's continuing education to remain diligent in generating sustainable revenue services. The center is currently in the process of hiring a new director which should have a positive impact on workforce alignment.
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.
Compliance and Adverse exposure to an Infectious agent. Compliance issues including violations, fines and shut down of clinical operations.	The program is deficient due to the significant increase in the number of clinical sites without a corresponding increase in the number of laboratory safety personnel. We have been approved to hire another laboratory safety person to alleviate the deficiency.
Compliance violations and adverse exposure to radioactive materials and radiation-producing devices. This can result in violations, fines, and shutdown of research.	The program is deficient due to the increase in the number and complexity of radiation-producing devices coupled with a corresponding increase in safety personnel. We do not have the adequate number of personnel necessary to provide adequate surveillance. Will are in the process of coordinating with the SOM on the need for additional personnel. We will also review with the RSO to address the PET Scan equipment to be installed at the Institute of Neuroscience.
Possible physical harm to the public during Special Events.	Increased FTE's and reduced vacancies. Conduct Special Event Plan's for large events. Recommending the placement of Bollards to specific locations to eliminate access to the campus community.
Inadequate protection of people and resources... Cameras and access control.	Currently updating security cameras and recommending transition to a single open architecture access control system (Genetec).

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Detailed Risk Description	Risk Mitigating Factors
Inability to lock down buildings remotely in case of an "active shooter" situation or some other emergency, and to help prevent theft and vandalism	Currently recommending the transition to a single architecture access control system (Genetec).
Annual Security Report (ASR) not encompassing all required elements.	1) Clery Coordinator has been hired. 2) A Clery Committee has been put in place to address all required Clery elements in the ASR. 3) Sub committees are being formed to address specific elements. 4) The Clery Committee is in the process of receiving Clery training.
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.
Risk of injury/death of children.	Age of children makes them vulnerable to injury. Video surveillance cameras aids in investigation of incidents. Employees receive training including CPR and maintain coverage to never leave children unsupervised.
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. Fit for Growth Report (identifies duplicate functions).
Examples of decentralized tasks across campus that impact financial reporting include capital asset & and inventory/equipment certifications, pCard purchase reconciliations, workflow document approval (iShop, travel, HR, IT, etc.), personnel action forms (hires, terminations, transfers, promotions, etc.), employee timecards, etc.	Continuous work in progress.
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. A committee is currently reviewing contract processes at UTRGV. Management is working on addressing this.
Student tuition & fees are insufficient to cover initiatives and growth.	UTS Board did not act on a request 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.	UTS construction delays may cost UTRGV over $1M if process delays are not addressed. Currently experiencing supply chain issues, and significant increases in construction costs (30%-40%).
Limitations of space cause significant challenges in accommodating academic and administrative needs.	Permanent remote work provides some space alleviation.

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Detailed Risk Description	Risk Mitigating Factors
Security compromise due to insider threats.	Multi-factor authentication (MFA) for major systems, ATHENA MFA, Global Protection has been implemented, Endpoint Detection and Response (EDR) monitoring East - West lateral movement traffic monitoring and increase number of Information Security staff.
Breach or loss of sensitive/confidential institutional data stored or processed on unapproved third-party and/or cloud services.	Improved user education. Audits conducted a Cloud/3rd Party Security Management Audit.
Loss, theft, or damage of insufficiently secured controlled or confidential data (e.g., research data and intellectual property).	Information Security is doing a better job of informing users. Server registrations. Some equipment in research labs managed by Abbott labs.
Sensitive personal or institutional information is lost or stolen due to a security breach	CISO does vulnerability scans on a list of IP address. CISO scans external facing IPs. IT performs internal facing scans and periodic desktop scans. Internal scans include Windows devices. Access to Athena is documented. Level of access granted depends on job duties. Athena Access Management Audit completed in FY20. Medical and non-traditional devices only connected to Local Area Networks (LANs). SSN's are masked.
Inability to resume business operations timely in the event of a disaster that affects system availability or data integrity	Management is aware of the risk.
Not able to comply with accessibility requirements for EIR (Electronic Information Resources).	A work group is involved in accessibility evaluations as part of the software assessment/procurement process.
Loss of data, damaged reputation, reduced funding, and incurring associated fines for non-compliance with security-related HIPAA regulations.	HIPAA gap analysis performed by Compliance and InfoSEC and gaps being addressed. CISO will present risks of not implementing MFA on Athena and SOM Deputy CIO will present the risks of implementing MFA to IT Governance Steering Committee and decision will be made.
Destruction or compromise of resources due to connection of unidentified and/or insecure devices.	Network Access Control (NAC) system in the process of being implemented. Brownsville campus does not allow non-University devices to be plugged into ethernet ports. New medical facilities are setup with new equipment. Old equipment is decommissioned. Medical and non-traditional devices only connected to Local Area Networks (LANs). Abbot Labs manages their servers.
Unable to keep up with Artificial Intelligence (AI) threats.	Management is aware of the risk and is working to address it.
Incomplete inventory of electronic medical devices.	Audit Office completed a consulting engagement on inventory of electronic medical devices.
Exposure to devices and network resources due to outdated applications and/or unpatched systems.	Follow up on Patch Management recommendations.
Unauthorized use of portable/removable storage devices or unsanctioned cloud storage solutions results in inadequate security of potential confidential data.	Email Data Loss Prevention (DLP). Procurement process provides some protection from purchasing unauthorized removable/portable storage devices. Information security awareness training.
Exposure to network and information resources from connected medical and other non-traditional devices.	NAC system in the process of being implemented. Some IT departments will implement it first and then it will gradually be rolled out to additional departments.

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Detailed Risk Description	Risk Mitigating Factors
Loss or destruction of information resources or breach of network due to velocity of change/expansion, lack of information security planning, or introduction of security flaws during routine application updates from third parties.	The governance process has significantly improved.
Decentralized IT groups not adhering to centralized processes and protocols creates broad data and network security concerns.	FY2023 Decentralized IT audit in progress.
The lack of a standard EMR system exposes the university to risks and financial loss due to inefficiencies and lack of information.	Transition to new EMR – EPIC.
Reduced ability to secure and monitor critical resources, respond to IT and IS requests, and timely address service failures due to insufficient or unskilled staff.	Management is aware of the issue.

SECTION VI
External Audit Services Procured in Fiscal Year 2023

EXTERNAL AUDIT SERVICES PROCURED IN THE FISCAL YEAR 2023

Report Date	Type of Service	Objective
January 13, 2023	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 2022.
January 18, 2023	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 2022.
February 24, 2023	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 2021-2022.

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.