University of Minnesota Medical School

Financial Audit
For the Period July 1, 1993 through December 31, 1994

October 1995

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Financial Audit Division
Office of the Legislative Auditor
State of Minnesota

95-44

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STATE OF MINNESOTA
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Dr. Frank Cerra, Dean
University of Minnesota Medical School

Scope

We have audited selected areas of the University of Minnesota Medical School for the period July 1, 1993, through December 31, 1994, as further explained in Chapter 1. Our audit primarily focused on Medical School oversight of the departmental practice groups. Our audit scope included the expenditures of the departmental practice groups associated with the Medical School departments of Anesthesiology, Radiology, and Surgery. We emphasize that this has not been a complete audit of all University of Minnesota Medical School and departmental practice group activities. The Summary highlights our audit objectives and conclusions. We discuss these issues more fully in the individual chapters of this report.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we obtain an understanding of management controls relevant to the audit. The standards also require that we design the audit to provide reasonable assurance that the University of Minnesota Medical School complied with provisions of laws, regulations, contracts, and grants that are significant to the audit.

This report is intended for the information of the Legislative Audit Commission and the management of the University of Minnesota Medical School. This restriction is not intended to limit the distribution of this report, which was released as a public document on October 18, 1995.

We thank the University of Minnesota Medical School and the departmental practice group staff for their cooperation during this audit.

James R. Nobles
Legislative Auditor

John Asmussen, CPA
Deputy Legislative Auditor

End of Fieldwork: June 9, 1995

Report Signed On: October 11, 1995

SUMMARY

State of Minnesota
Office of the Legislative Auditor
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University of Minnesota Medical School

Financial Audit
For the Period July 1, 1993 through December 31, 1994

Public Release Date: October 18, 1995 No. 95-44

Agency Background

The University of Minnesota Medical School has 23 departments. The five basic science departments center their activities around teaching and research. The 18 clinical departments have the added responsibility of patient care. Doctors involved in patient care do so through various departmental practice groups (DPGs). DPG revenues and expenses were estimated at $100 million for fiscal year 1995. In a 1993 audit of the Medical School, we found that the private practice administrative system did not provide for adequate oversight of the DPGs. In July 1993, the Board of Regents adopted a new policy governing the University's relationship with the practice groups.

Audit Areas and Conclusions

Our audit focused on Medical School oversight of the departmental practice groups. In addition, we reviewed the DPG reorganization process required by the new Regents' Policy. Our audit scope included expenditures of the departmental practice groups associated with selected Medical School departments.

We found that the Medical School has made progress in implementing the Regents' Policy but has not established effective oversight of the DPGs. The Medical School does not adequately review annual budgets or monitor quarterly financial information submitted by the DPGs. In addition, the Medical School does not ensure that DPGs only incur ordinary and necessary business expenses. It has not provided DPGs with allowable business expense criteria and is not billing DPGs for internal departmental services. Also, the Medical School needs to clarify its audit requirements to ensure outside accountants verify DPG expenses. The Medical School is currently monitoring faculty compensation. However, some departments have established procedures that could result in faculty compensation exceeding established limits. In addition, the Medical School has not addressed administrative salary limits and does not control the use of DPG professional service contracts.

The Medical School developed sound procedures for establishing DPG governing structures. However, the reorganization process is taking much longer and is more complex than originally anticipated. Some departments cannot reach a consensus on an acceptable DPG structure and are not in compliance with the Regent's Policy.

Contact the Financial Audit Division for additional information.
296-1235

University of Minnesota Medical School

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Audit Participation

The following members of the Office of the Legislative Auditor prepared this report:

John Asmussen, CPA	Deputy Legislative Auditor
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Lori Pellicci, CPA	Auditor-In-Charge
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Exit Conference

The findings and recommendations in this report were discussed with the following staff of the University of Minnesota Medical School on September 26, 1995:

Dr. Frank Cerra	Medical School Dean
JoAnne Jackson	Academic Health Center Chief Financial Officer
Gail Klatt	Director of Audits
Howard Schur	Medical School Assistant Director of Practice Plan Administration

Chapter 1. Introduction

The University of Minnesota first established a Medical School in 1888. As described in its Mission Statement, the Medical School was created:

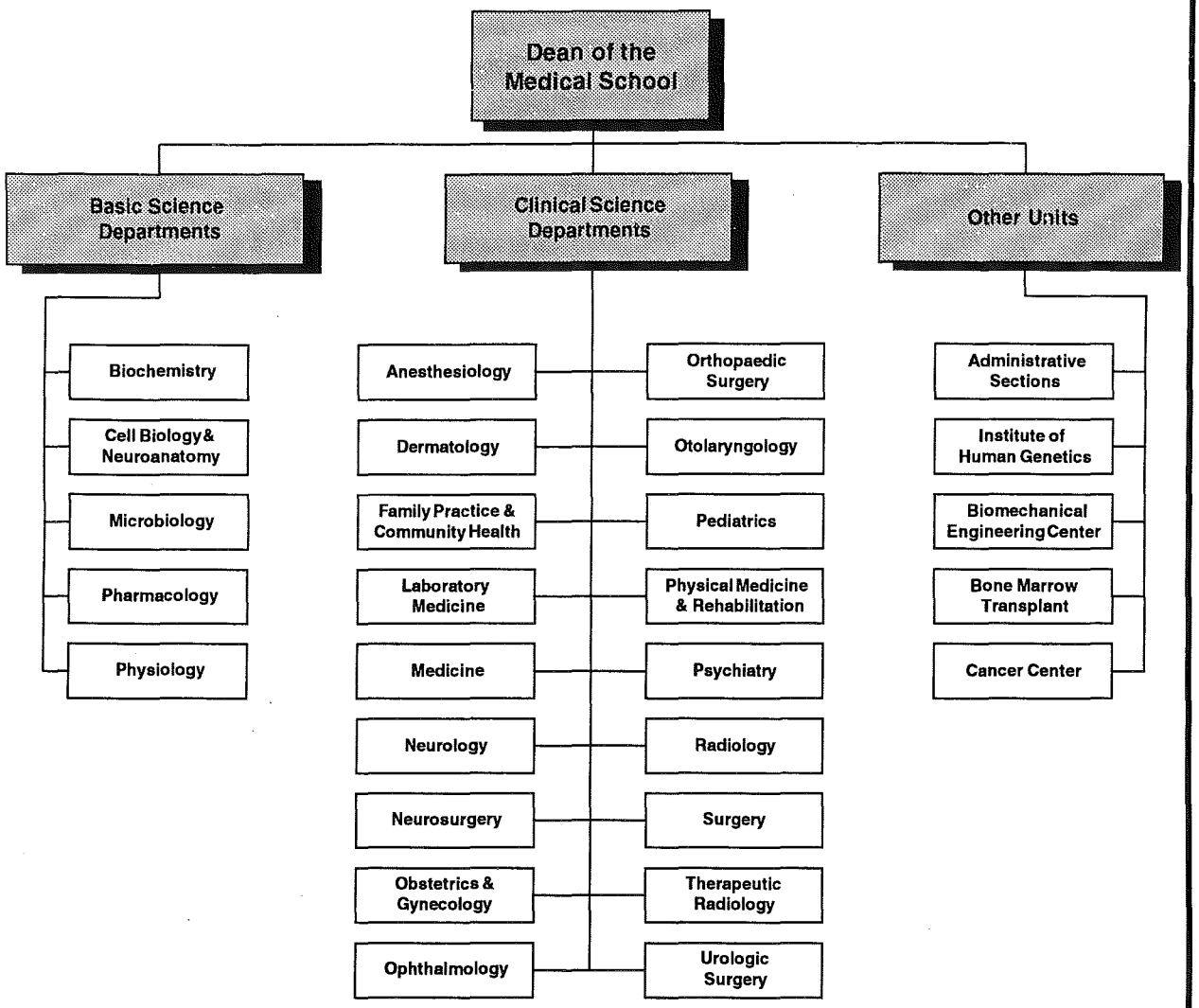
> to conduct high quality programs of research, education and service through which the college contributes significantly to the provision of excellent health care for the people of Minnesota.

The President of the University appoints the dean, who is the administrative head of the Medical School. The dean reports to the provost of the Academic Health Center, who in turn reports to the President of the University. The President appointed Dr. David Brown as the dean in 1986. Dean Brown resigned effective June 30, 1993. Dr. Shelley Chou was the acting dean until May 31, 1995. Dr. Frank Cerra currently serves as the dean.

The Medical School has 23 medical departments, each with its own department chair and administrative personnel. Figure 1-1 shows the Medical School components. The five basic science departments center their activities around teaching and research. The 18 clinical departments have the added responsibility of patient care. In addition to these departments, the Medical School has various administrative offices and research institutes.

Doctors involved in patient care do so through various departmental practice groups (DPGs) established for that purpose. DPGs may organize as non-profit corporations, for-profit partnerships, professional corporations or another form acceptable to the dean. DPG revenue includes all funds derived from clinical or patient care services. The practice group revenue is not deposited directly with the University. Therefore, the University's accounting system records only a portion of the revenue and expenses attributable to Medical School and DPG activities. Table 1-1 shows Medical School departmental expenditures for fiscal year 1994, as recorded on the University's accounting system. These amounts do not include departmental practice group direct expenditures for additional compensation to physicians and other plan expenses. Effective July 1, 1994, the departmental practice groups began providing quarterly financial information to the dean's office. The University, based on information provided by the DPGs, has estimated practice group revenues at about $100 million for fiscal year 1995. Of this amount, the Medical School estimates that approximately $60 million will be spent on direct practice group expenses, and $40 million will be remitted to the University for Medical School departmental support.

Figure 1-1
University of Minnesota Medical School
Organizational Structure



Source: The Medical School Dean's Office.

History of private practice at the Medical School

Prior to mid-century, most University hospital patients were indigent. The wider availability of health insurance in the 1950's and 1960's, however, reduced the number of indigent patients and created an untapped financial resource for the Medical School. The University of Minnesota Board of Regents' adopted a policy approving the start of private practice plans in 1961. These practice groups have operated with a fair amount of independence since their inception.

Table 1-1
University of Minnesota Medical School
Expenditures by Department
Fiscal Year 1994

Department	Total Expenditures
Administrative Sections/Other Units	**$20,923,825**
Basic Science	
Biochemistry	$6,048,515
Cell Biology and Neuroanatomy	6,168,658
Microbiology	4,944,226
Pharmacology	8,137,745
Physiology	4,418,850
Subtotal Basic Science:	**$29,717,994**
Clinical Science	
Anesthesiology	$3,143,856
Dermatology	2,349,960
Family Practice	18,918,295
Laboratory Medicine & Pathology	21,201,522
Medicine	38,162,815
Neurology	8,107,199
Neurosurgery	3,131,134
Obstetrics & Gynecology	3,972,094
Ophthalmology	5,229,863
Orthopedic Surgery	5,329,146
Otolaryngology	5,016,907
Pediatrics	26,954,997
Physical Medicine & Rehabilitation	2,750,621
Psychiatry	8,413,934
Radiology	11,209,347
Surgery	21,130,774
Therapeutic Radiology	3,640,795
Urology	1,631,916
Subtotal Clinical Science	**$190,295,175**
Totals:	**$240,936,994**

Note 1: The clinical science departments' expenditures do not include amounts spent directly by departmental practice groups (DPGs). The University estimates these direct DPG expenditures at about $60,000,000 annually. Departments have considerable discretion in determining whether to pay expenditures from university accounts or through their affiliated DPG. This makes comparisons between departments difficult.

Note 2: These expenditure amounts do not include transfers out, which totaled $48,902,095. Transfers out between Medical School departments totaled $43,654,892. Transfers out to other University departments totaled $5,247,203.

Source: University of Minnesota general ledger accounting system records.

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In 1963, the Board of Regents adopted a Statement of Policy and Implementing Resolution allowing faculty members to accept private patients. The statement provided that private patient funds "should be used in an appropriately flexible manner, in the spirit of a gentlemen's agreement based on mutual trust". It permitted the faculty to establish private businesses to collect and distribute patient fees and provided broad guidelines for setting faculty salaries. It did not, however, establish a way to determine compliance with those guidelines.

In 1975, the Legislative Auditor issued a report criticizing the Regents' policies and administration of the private practice system. Subsequently, the University entered into a private practice monitoring agreement with the faculty. This agreement authorized the President to appoint a monitor to serve as a reviewer and referee of compliance with the Regents' policy. The monitor's responsibilities included verifying that faculty compensation did not exceed existing guidelines and determining that practice groups only incurred legitimate business expenses. The agreement authorized the monitor to substantiate the data reported, but did not require such a verification. The purpose of the monitor's review was to assure that the Medical School received its appropriate amount of DPG revenue. Attorneys at a Minneapolis law firm have served as the monitor since 1976.

In the mid 1980's, the University added seven new provisions to the private practice monitoring agreement. These supplemental provisions authorized the dean to collect an annual assessment from each clinical department. Known as the dean's tax, it provides the dean with discretionary funds for the general benefit of the Medical School.

The Medical School's departmental practice groups have come under great scrutiny in recent years. The Office of the Legislative Auditor conducted an audit of the Medical School in 1993. We cited a number of issues in that audit report. We found that the private practice administrative system did not provide for adequate oversight or sufficient assurance that DPGs comply with operational guidelines. Because of limited access to financial information, the University did not know whether DPG expenditures were appropriate.

On July 9, 1993, the Board of Regents rescinded the 1963 private practice plan policy, replacing it with a new department practice group policy. The changes occurred at a time of ongoing investigations and media exposure of improprieties. The new Regents' Policy requires department administrators to disclose DPG financial information to University management. It also limits each department to one DPG, unless approved by the dean, and defines oversight measures to ensure compliance. The new policy limits DPG expenses to only those that are ordinary and necessary. It also requires verification of these expenses by outside accountants. The policy clarifies faculty compensation guidelines and gives the dean final approval of all faculty compensation limits. Shelly Chou, Interim Dean of the Medical School, issued a template of procedures which established the framework for DPGs to implement the Regents' Policy provisions. This template outlines the format that DPGs must use to report their financial activities. It also discusses procedures for dissolving prior DPG activities and forming new consolidated entities.

Since the adoption of the new departmental practice group policy, the University has created a number of new positions, in part to implement the policy and monitor private practice activity. Table 1-2 lists the new positions and start dates.

Table 1-2
U of M Health Sciences Division
New Positions

Title	Date Hired
Program Director of Medical School Financial Operations	February 1, 1994
Assistant Director of Information Technology	June 1, 1994
Assistant Director of Human Resources	April 4, 1994
Assistant Director of Medical School Practice Plan Administration	September 1, 1994

Source: Medical School Dean's Office.

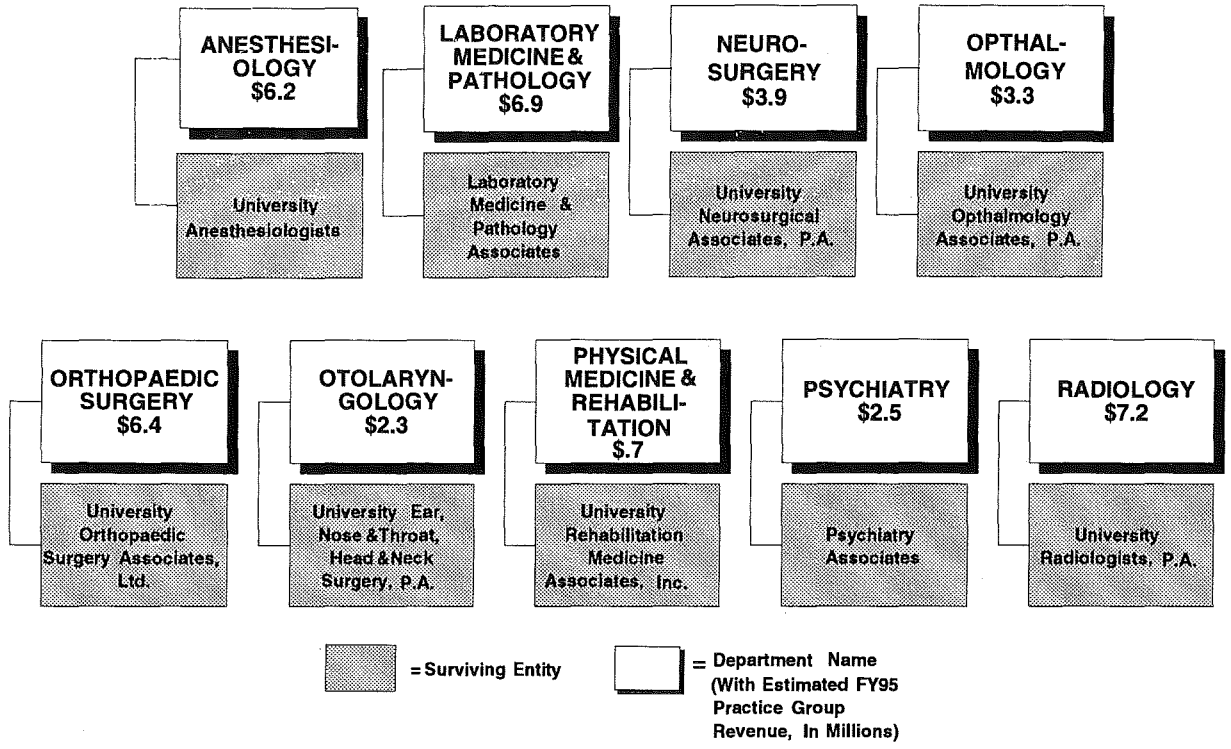
In the past, each of the clinical departments had one or more DPGs. At the conclusion of our last audit there were a total of 39 DPGs. However, changes to the Regents' Policy forced departments to consolidate their practice groups. The Medical School plans to have 20 DPGs after it completes the consolidation. A committee of DPG officials is currently investigating the possibility of creating only one DPG for the entire Medical School. The University supports the concept of one Medical School DPG.

Figure 1-2 depicts the nine Medical School clinical departments that had only one DPG at the conclusion of our 1993 audit. It also shows the fiscal year 1995 estimated revenue for these DPGs, in millions.

The other nine clinical departments had multiple DPGs or related entities at the conclusion of our last audit. Figure 1-3 illustrates these departments and their associated DPGs. It also shows the surviving DPGs and the total fiscal year 1995 estimated revenue, in millions.

We focused our detailed testing primarily on the departmental practice groups of three departments. We reviewed the Department of Surgery DPG transactions for the period January 1, 1994, through December 31, 1994. As a part of its ongoing investigations, the federal government has custody of all records prior to January 1, 1994. We reviewed the Department of Anesthesiology DPG financial transactions for the period July 1, 1993, through December 31, 1994. We reviewed the Department of Radiology DPG financial transactions for the period January 1, 1994, through December 31, 1994. We also reviewed the consolidation process of the DPGs in the Department of Neurology, but not its detailed transactions.

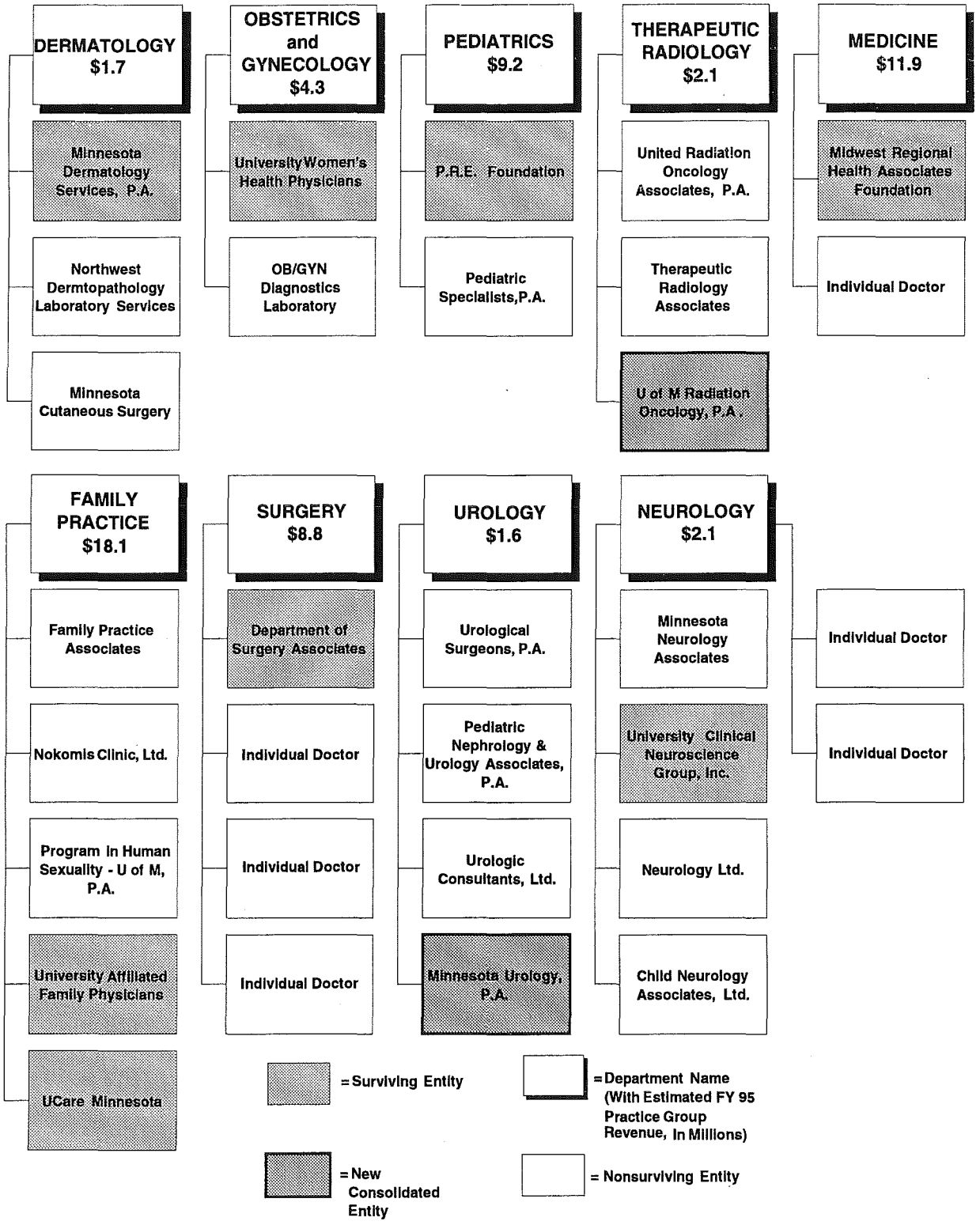
Figure 1-2
University of Minnesota Medical School
Departments with a Single Practice Group



Note: Organizational status as of June 1993.
Source: Medical School Dean's Office.

In Chapter 2, we discuss our conclusions on the Medical School's oversight of departmental practice group activities. In Chapter 3, we review the DPG reorganization process as a result of the 1993 Regents' Policy changes.

Figure 1-3
University of Minnesota Medical School
Departments with Multiple Practice Groups



Note: Organizational status as of June 1993.
Source: Medical School Dean's Office.

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Chapter 2. Oversight of Departmental Practice Groups

Chapter Conclusion

The Medical School has made progress in implementing the Regents' Policy, but has not established effective oversight of the DPGs. The Medical School is now receiving financial information from DPGs. However, the Medical School does not adequately review annual budgets or monitor quarterly reports. In addition, the information is not in the proper format to effectively monitor compliance with the Regents' Policy.

The Medical School still does not ensure that DPGs only incur ordinary and necessary business expenses. It has not provided DPGs with allowable business expense criteria. In addition, the Medical School needs to clarify its DPG audit requirements to ensure the outside accountants verify DPG expenses. It is also not billing DPGs for internal departmental services.

The Medical School is currently monitoring faculty compensation. The department heads determine outer income limits for faculty and the dean must approve all faculty salaries that exceed Regents' Policy guidelines. However, some departments have established procedures that could result in faculty compensation exceeding established limits. In addition, the Medical School has not addressed administrative salary limits and does not control the use of DPG professional service contracts.

Our 1993 audit raised serious questions about the Medical School's oversight of departmental practice groups (DPGs). We concluded that this lack of oversight was exposing revenues derived from patient care to unnecessarily high financial risks. A primary reason for undertaking this current audit was to determine if changes made to the old private practice system have improved DPG oversight.

Audit Objectives and Methodology

The Board of Regents' new departmental practice group policy provides broad guidelines governing DPG operations. Management of the Medical School is responsible for developing procedures to implement these guidelines. In this chapter, we will assess whether the new Regents' Policy and the Medical School's implementing procedures improve controls over DPG financial activities.

The specific questions we will address to fulfill this objective include:

University of Minnesota Medical School

- Does the Medical School receive sufficient information to oversee DPG financial operations?

- Does the Medical School ensure that DPGs transfer residual funds to the University?

- Does the Medical School ensure that DPGs only incur ordinary and necessary business expenses?

- Does the Medical School ensure that faculty compensation is within limits imposed by the Regents' Policy?

To answer these questions, we began by reviewing the new Regents' Policy and the Medical School's implementing procedures, commonly referred to as the template. We then discussed these policies and procedures with the dean, other Medical School administrators, and the attorney who currently serves as the monitor. Finally, we reviewed the financial operations of two DPGs to determine compliance with these policies and procedures. We reviewed the detailed accounting records of the practice groups affiliated with the Departments of Anesthesiology and Radiology. We also reviewed the accounting records of the DPGs affiliated with the Department of Surgery to test faculty compensation limits.

Budgeting and Financial Reporting

The Regents' Policy outlined certain financial requirements for DPGs. The Medical School developed a set of procedures, commonly referred to as the template, as a framework for implementing the Regents' Policy. For example, the template established the following requirements:

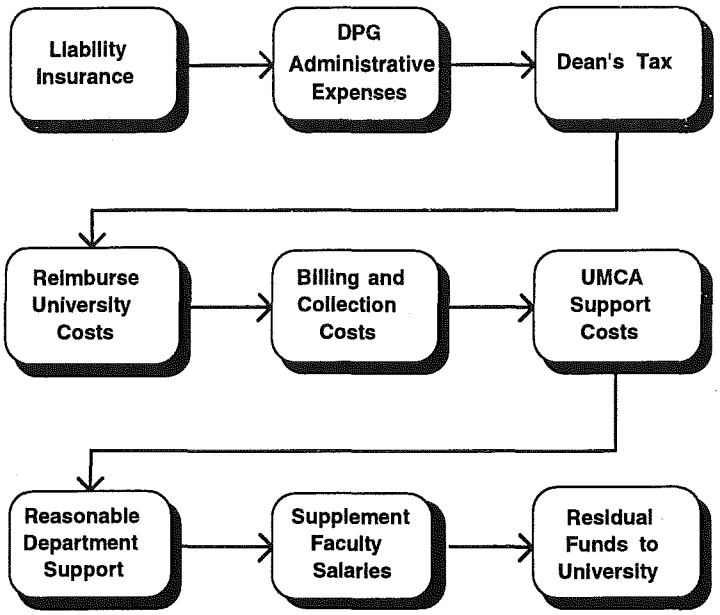
- DPGs must pay expenses in a predetermined order before distributing net income to practice group members. After paying these expenses, DPGs must deposit any residual funds into University accounts. Figure 2-1 illustrates this payment order.

- DPGs must submit an annual budget outlining the sources and uses of clinically derived funds. The dean is responsible for reviewing and approving these budgets.

- DPGs must submit an annual financial performance report to the dean and the provost of the Academic Health Center. The department head is to obtain these reports from the DPGs' regular external auditors.

The Medical School has taken some steps to improve its oversight of DPG financial operations. At the time of our review, the Medical School was developing a DPG policy manual. Practice groups now must submit budgetary and actual financial information to the Medical School. Also, the University's Department of Audits has access to and has started its review of DPG financial records. Previously, the Medical School did not have access to DPG records and knew very little about their financial operations.

Figure 2-1
University of Minnesota Medical School
Required Order of DPG Expenses



Source: Section 10 of the template and Section 3.07 of the Regents' Policy.

We do not think, however, that the Medical School has established effective oversight of DPGs. It receives financial information from DPGs. However, the Medical School does not effectively review this information. In addition, the reporting format makes it difficult to monitor compliance with the Regents' Policy and ensure that DPGs make departmental support payments to the University. The following findings offer suggestions to improve the oversight of DPG financial activities.

1. The DPG budgeting and reporting format does not provide the information needed to monitor compliance with key provisions in the template that outline financial requirements.

Medical School administrators do not have a system to monitor whether DPGs are using their funds in accordance with the template. Section 10 of the template requires DPGs to pay expenses in a particular order before distributing net income to practice group members. Figure 2-1 illustrates this payment order. After paying other expenses, DPGs must deposit any residual funds into University accounts.

The Medical School administration relies on DPGs to comply with this key template provision. However, it does not have a well-defined process or data in a usable format to monitor compliance. Specifically, the standard budgeting and financial reporting categories differ from the expense categories outlined in Section 10 of the template. This makes it difficult to determine if DPGs are complying with this key template provision. Since the quarterly report categories are different from the template expense categories, we could not determine if the DPGs complied with Section 10 of the template. Consistent reporting would help the Medical

School determine if it received the appropriate amount of departmental support and residual income.

Recommendation

- *The Medical School administration should revise its reporting and oversight process so it can monitor compliance with section 10 of the template.*

2. The Medical School does not adequately review DPG budgets or monitor quarterly financial reports.

The Medical School administration has not reviewed DPG budgets to verify that they provide reasonable departmental support. In addition, the Medical School administration has not adequately investigated unusual financial information in DPG quarterly reports and has not resolved departmental financial problems.

The Medical School administration does not have a formal process for reviewing and approving DPG budgets. In fiscal year 1995, all DPGs submitted budgets to the Medical School. However, the dean did not review or approve these budgets, as required by Section 10 of the template. We feel that the Medical School should implement a formal system of approvals for DPG budgets. We also think that these budgets should include a schedule showing the timing of anticipated departmental support payments to the University. Medical School departments receive a significant amount of funding from their affiliated DPGs. Estimated departmental support schedules could help the Medical School budget these resources and manage its cash flow.

The Medical School needs to manage its cash flow closely to minimize the risk of overspending accounts. At the time of our audit, several Medical School departments had negative cash balances in their unrestricted University accounts. Table 2-1 shows each department's unrestricted cash balance as of May 1995. In our 1993 audit we addressed the issue of deficit balances and recommended improved oversight in this area. However, the problem still exists. In the 1993 report, we noted that the Department of Obstetrics and Gynecology had a deficit balance of approximately $340,000 at the end of fiscal year 1992. As of May 1995, the department's unrestricted cash balance was a negative $1.14 million. We think that estimated departmental support schedules would provide one tool to help the Medical School improve cash management in the future.

One DPG we reviewed only contributes money to the department when departmental funds are low. Other departments we reviewed are not depositing departmental support checks timely. During one month at the end of its fiscal year, the Department of Surgery Associates (DSA) wrote departmental support checks totaling $3,011,707. However, the department did not deposit these checks into University accounts for an extended period of time, ranging from 74 to 88 days. University Anesthesiologists also did not deposit a $200,013 departmental support check for 20 days. Estimated departmental support schedules could help the Medical School detect these deposit delays in departments.

Table 2-1
University of Minnesota Medical School
Department Unrestricted Cash Balances
May 1995

Department	Cash Balance
Anesthesiology	$ 368,660
Dermatology	238,370
Family Practice	3,376,877
Laboratory Medicine & Pathology	2,363,234
Medicine	1,204,852
Neurology	(1,007,589)
Neurosurgery	539,856
Obstetrics & Gynecology	(1,140,360)
Ophthalmology	1,736,954
Orthopedic Surgery	582,243
Otolaryngology	1,080,690
Pediatrics	1,953,829
Physical Medicine & Rehabilitation	546,038
Psychiatry	1,413,579
Radiology	857,641
Surgery	2,542,654
Therapeutic Radiology	514,503
Urology	(177,790)
Total	**$16,994,241**

Note: The cash balances do not include restricted funds.

Source: University Accounting System.

The Medical School also has not adequately investigated unusual variances in DPG quarterly financial reports. The administration does not compare DPG reported departmental support to the amounts budgeted. For example, University Anesthesiologists budgeted $950,000 for departmental support in fiscal year 1995. However, the DPG only contributed $300,000 through March 1995. The Medical School did not pursue the reason for this departmental support shortage. We think the Medical School administration should analyze and investigate unusual variances reported by DPGs.

The Medical School is also having difficulty monitoring financial activities because DPG quarterly reports are not always consistent. Many DPGs are not interpreting the reporting instructions correctly. Also, some DPGs have fiscal year end dates while others report on a calendar year basis. We think the Medical School could improve its monitoring capabilities if it standardized the reporting process and DPG business years.

Recommendations

- *The Medical School should develop a process for reviewing and approving DPG budgets. These budgets should include a schedule of estimated departmental support.*

- *The Medical School should compare DPG reported financial information to amounts budgeted and investigate significant differences.*

- *The Medical School should improve the consistency of DPG financial information by standardizing the reporting process and DPG business years.*

Business Expenses

The section of the Regents' Policy governing business expenses is very general. According to Regents' Policy 3.02:

> DPGs will record as practice plan expenses only those that are ordinary and necessary business expenses and that do not otherwise violate reasonable University policies on allowance of expenses.

The template further states that DPGs cannot spend funds for car leases or club memberships.

The DPGs pay various expenses from their practice income. Departmental support and physician's salaries and benefits are the largest expense categories. Other large expense categories include malpractice and disability insurance, purchased services, and billing expenses. Table 2-2 shows total expenses reported by the DPGs for the period July 1, 1994, through March 31, 1995.

The Medical School does not ensure that DPGs only incur ordinary and necessary business expenses. Medical School administrators did not provide DPGs with allowable business expense criteria. Without this criteria, we feel that there can be little assurance that DPGs will only incur appropriate business expenses. We reviewed the detailed records of three DPGs and found that, in general, they were complying with the spirit and intent of the Regents' Policy. However, confusion still exists as to what is an ordinary and necessary business expense. Many DPGs simply follow Internal Revenue Service (IRS) guidelines. These guidelines are more liberal than the Regents' Policy, which states that DPG expenses must not violate reasonable University policies. The following findings discuss our concerns about business expenses.

Table 2-2
Total Departmental Practice Group Operating Expenses
Nine Months Ended March 31, 1995

Expense Type	Amount	Percent
Liability Insurance	$ 2,330,766	2.88%
DPG Administrative Expenses:		
Physician Benefits	6,230,678	7.69%
Non-physician Salaries and Benefits	5,858,709	7.23%
Non-member Salaries and Benefits	1,273,550	1.57%
Purchased Services	4,394,324	5.42%
Equipment, Rents, Leases & Supplies	1,381,792	1.71%
Physician Purchased Services	1,059,250	1.31%
Other Expenses	5,698,283	7.03%
Dean's Tax	1,428,142	1.76%
Reimburse University Costs	0	0.00%
UMCA/Hospital Billing & Collection Costs	2,156,234	2.66%
UMCA Non-Billing Support Costs	2,419,926	0.33%
Medical School Departmental Support	27,983,863	34.54%
Supplemental Faculty Salaries	20,966,851	25.88%
Total	**$81,026,134**	**100.00%**

Note: Non-UMCA billing and collection costs are included in purchased services.

Source: March 31, 1995 quarterly reports-dean's office.

3. The Medical School has not defined what constitutes an ordinary and necessary business expense.

The Medical School administration has not clarified the meaning of "ordinary and necessary" business expenses. As a result, many DPGs are incurring expenses that are acceptable in accordance with IRS guidelines, but may not be allowed under University guidelines. For example, many DPGs we reviewed used patient revenues to pay for holiday parties and other social events. However, under the University's Hospitality and Special Expense Policy for Private Funds, these types of expenses are not allowable.

We also observed that one practice group paid substantial legal fees from DPG funds. We think this is an important area to establish allowability criteria. It is necessary to differentiate between personal and business expenses. Policies should define the circumstances when payment of legal fees is appropriate and the process for determining maximum amounts that can be paid. Because DPG residual funds revert to the Medical School, the University should ensure that there are adequate controls over potentially volatile expenses, such as legal fees.

The Regent's Policy establishes broad guidelines for DPG expenses, as follows:

> DPGs will record as practice plan expenses only those that are ordinary and necessary business expenses and that do not otherwise violate reasonable University policies on allowance of expenses.

Recommendation

- *The Medical School should develop specific criteria for allowable DPG business expenses.*

4. The Medical School needs to clarify its DPG audit requirements.

The Medical School does not require DPGs to obtain financial audits. Instead, it permits DPGs to have their expenses reviewed by a certified public accountant (CPA). In the accounting profession, a review is a type of engagement that is not as comprehensive as an audit. CPAs conducting reviews have no obligation to examine source documentation for transactions.

The Regents' policy requires outside accountants to "verify" DPG expenses. However, the template only requires CPAs to review DPG expenses. In our opinion, the work done during a review does not meet the requirements imposed by the Regents. We think the Medical School should modify its implementing procedures in the template. Specifically, it should require DPGs to obtain periodic financial audits.

Recommendation

- *The Medical School administration should require DPGs to obtain periodic financial audits.*

5. The Medical School is not billing DPGs for internal departmental services.

Some DPGs may be using University services without directly paying for them. The Regents' Policy requires the Medical School to bill practice plans for the use of University personnel, equipment, space, utilities and other services. However, the Medical school administration has not measured the value of these services. Medical School administrators told us that they have not accumulated sufficient information to allocate costs between departments, practice groups, and the University Hospital. Therefore, the Medical School is hiring a consultant to prepare a space usage analysis and develop a billing process.

Space usage is only one component of the information needed to allocate University costs. The Medical School needs to develop a comprehensive plan to appropriately allocate all departmental services, including personnel and equipment costs.

Recommendation

- *The Medical School administration should bill DPGs for departmental services, as required by the Regents' Policy.*

University of Minnesota Medical School

Faculty Compensation Limits

The Regents' Policy requires each department head to determine outer income limits for faculty members. These outer limits must include compensation from both the Medical School and DPGs. The Regents' Policy also requires that the limits be no more than 80 percent of an approved salary maximum, given the applicable faculty member's specialty and academic rank. The Regents' Policy permits that with the dean's approval, department heads can set a faculty member's outer income limit above the 80 percentile limit. Most departments use the Association of American Medical Colleges (AAMC) salary survey as their guideline for salary maximums. For the 1994-1995 survey the AAMC obtained data from 123 of the 126 fully accredited medical schools in the United States. The survey used gross income to calculate the salary information.

The DPGs and the dean's office are responsible for ensuring compliance with compensation limits. The DPGs also send annual compensation information to the monitor, who requests repayment for any salary amounts over the applicable limit.

The Medical School has made progress in monitoring faculty compensation. The acting dean reviewed all faculty compensation limits for 1994 and 1995. The Medical School still relied on the monitor to review all faculty compensation for calendar year 1994. Calendar year 1995 will be the first year that the Medical School actually completes the review process. However, the Medical School allowed one department we reviewed to exceed the compensation limits. In addition, it has not addressed administrative salary limits or contractual arrangements with outside physicians.

6. Some Medical School departments have established procedures that could result in faculty compensation exceeding established limits.

In the Department of Anesthesiology, most faculty members' compensation limits exceed national salary maximum guidelines. In addition, the Departments of Anesthesiology and Radiology use net wages rather than gross wages in the calculation of income limits. This allows faculty to exceed established salary limitations, as occurred in the Department of Anesthesiology in 1994. The monitor would not have detected this type of overcompensation as a part of his review.

The Department of Anesthesiology used a metro area survey as their 80 percentile limit. One reason it used the metro survey was that all of the salaries, except the Chairman's, exceeded the 80 percentile limit of the Society of Academic Anesthesiology Chairs (SAAC) survey. The interim dean approved the metro area survey and the higher compensation limits. The metro area survey is an informal, non-academic survey of private practice Anesthesiology groups throughout the Twin Cities metropolitan area. Therefore, it did not break down the salaries by academic rank or years of experience. It only showed the salary range for Anesthesiologists at eight different unidentified groups. The Medical School should require the department heads to set faculty compensation limits in line with other medical schools rather than with non-academic medical groups. In addition, any non-AAMC survey should contain level of experience ranges and should be representative of the surveyed population.

The Department of Anesthesiology used net wages to define income. This allowed faculty to earn more than their compensation limits without having to face repayment. The department did not include any elective University of Minnesota salary deferrals such as deferred compensation and medical or dependent care expense account contributions in net wages even though they are part of the doctor's Medical School base salary. After including elective deferred compensation in the salary calculation for the Department of Anesthesiology, seven of twenty faculty members exceeded their limits in 1994. The Medical School's review process did not detect these exceptions. The Department of Radiology also used net wages to define income. However, no Radiology faculty members exceeded their limits after including elective deferred compensation in their 1994 income calculation.

Recommendations

- *The Medical School should ensure that faculty compensation limits are in line with other medical schools.*

- *The Medical School should use gross wages to calculate compliance with income limitations.*

7. The Medical School is not controlling DPG salary supplements to administrative and clerical employees.

The practice groups are supplementing salaries of University of Minnesota non-faculty employees for work completed for the DPG. According to DPG staff, they complete most of this DPG work outside of their normal University of Minnesota work hours. However, sometimes they must complete DPG work during the normal business hours. The Medical School administration is aware of these salary supplements, but does not have effective procedures to control and monitor their propriety. All three DPGs we reviewed paid salary supplements to some University administrative and clerical employees. The supplements ranged from $1,050 to $25,600 during calendar year 1994. For example, an administrative director's salary was increased from $42,534 to $68,134. An executive secretary's salary was increased from $41,824 to $63,645. In addition, a senior secretary's salary was increased from $24,396 to $39,448. The Regents' Policy addresses faculty compensation limits. However, it does not place limits on non-faculty salaries. We think the Medical School should establish guidelines addressing the allowability of non-faculty salary supplements to ensure that the compensation is appropriate and reasonable.

Recommendation

- *The Medical School should establish appropriate controls over salary supplements paid to administrative and clerical staff.*

8. The Medical School has not addressed the appropriate controls over DPG professional service contracts.

Many DPGs enter into contracts with doctors to treat patients and teach medical students. These contractual employees are not members of the DPG. The Medical School is not controlling the use of these contracts. In most cases, the contract doctors practice at the University and use its equipment. However, these doctors are not held to the same requirements as DPG members. Some are not required to pay dean's tax or departmental support. The contract doctors are not held to compensation limits. In addition, some of the doctors are treating patients before entering into formal written agreements with the DPGs.

Professional service contracts can be beneficial to both the DPGs and the Medical School. However, when not controlled properly, they provide a mechanism to bypass the spirit and intent of the Regents' Policy. They can also expose DPGs and the University to significant financial risks.

Recommendation

- *The Medical School should establish appropriate controls over DPG professional service contracts.*

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Chapter 3. Reorganizing Departmental Practice Groups

Chapter Conclusions

The Medical School developed sound procedures to help each department establish the governing structure for its practice group. However, the reorganization process is taking much longer and is more complex than originally anticipated. Some departments cannot reach a consensus on an acceptable DPG structure and are not in compliance with the Regent's Policy. Management of the Medical School needs to bring these departments into compliance. It also needs to take a stronger role in overseeing financial aspects of the reorganization process.

On July 9, 1993, the Board of Regents adopted a new policy governing Medical School private practice plans. This new policy intended significant changes for the private practice system. Most significantly, it only permitted Medical School departments to have one departmental practice group (DPG), unless approved by the dean. Also, it required widespread faculty participation in the governing structure of each group. Previous guidelines let departments have multiple practice groups. Key financial decisions and control of these groups often rested in the hands of one or a select few individuals.

Audit Objectives and Methodology

In this chapter, we will review how well the Medical School is controlling the DPG reorganization process. Reorganizing departmental practice groups has proven to be a very complicated process. This is particularly true for those departments that had more than one group under the old private practice system. Management of the Medical School must closely monitor this process to ensure that new DPG governing structures comply with the Regents' Policy. The Medical School must also oversee the financial activities of the new and existing groups to protect its residual interest in patient revenues.

The specific questions we will address in this chapter include:

- Did the Medical School ensure that new DPG governing structures comply with the Regents' Policy?

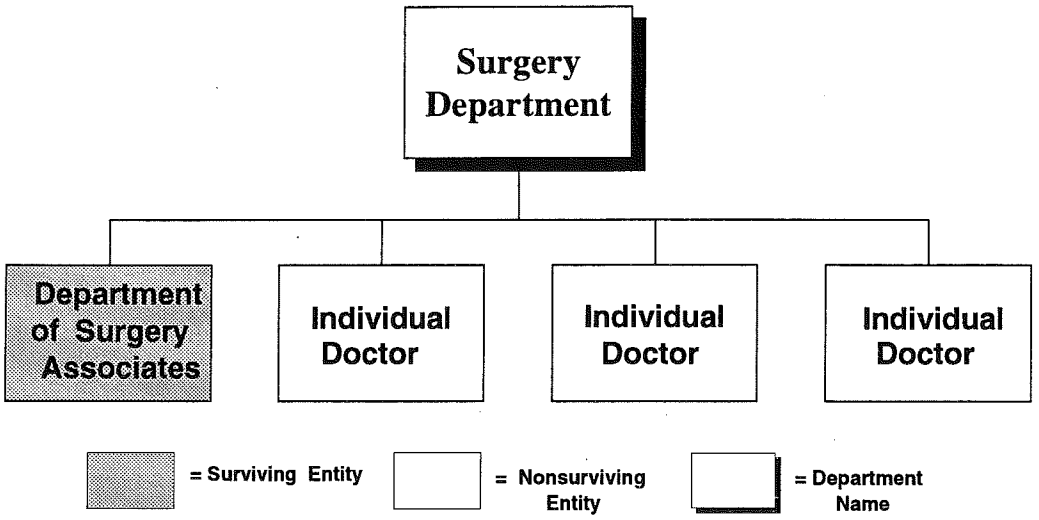
- During the DPG reorganization process, are the Medical School's financial oversight procedures sufficient to protect its residual interest in patient revenues?

To answer these questions, we interviewed Dr. Shelley Chou, Interim Dean of the Medical School, his administrative staff, the monitor, several department heads, and practice plan employees. We also studied the Regents' Policy, the Medical School's implementing procedures,

and DPG financial reports. Finally, we reviewed the detailed accounting records of the practice groups associated with the Department of Surgery.

Figure 3-1 illustrates the reorganization process for the Department of Surgery. The Department of Surgery Associates (DSA) is a partnership that will be the surviving DPG under the new Regents' Policy. One doctor's previous practice was organized as a sole proprietorship and one was organized as a corporation. Both of these doctors joined the DSA partnership in July 1994. The third doctor resigned his university appointment in July 1993 and now works as a contractor for DSA.

Figure 3-1
The Department of Surgery's DPGs



Note: Organizational status as of June 1993.
Source: Data compiled by the monitor.

Forming A Single DPG For Each Department

The interim dean of the Medical School took a multifaceted approach to implement the new Regents' Policy. He began by organizing a Private Practice Implementation Task Force (task force). He also created a new administrative position in the dean's office that is responsible for overseeing the financial activities of departmental practice groups. This practice plan administrator will eventually assume the duties of the monitor.

The dean formed the task force in September 1993, with Dr. Peter Lynch as chair. The task force members were primarily high level Medical School physicians and department heads.

The task force played a leading role in developing a set of procedures to implement the new Regents' Policy. Commonly referred to as the "template," these procedures established the framework for DPGs to reorganize their legal and governing structures. They also document time frames for dissolving existing practice groups and forming new DPGs. The interim dean distributed the template to all departments in December 1993.

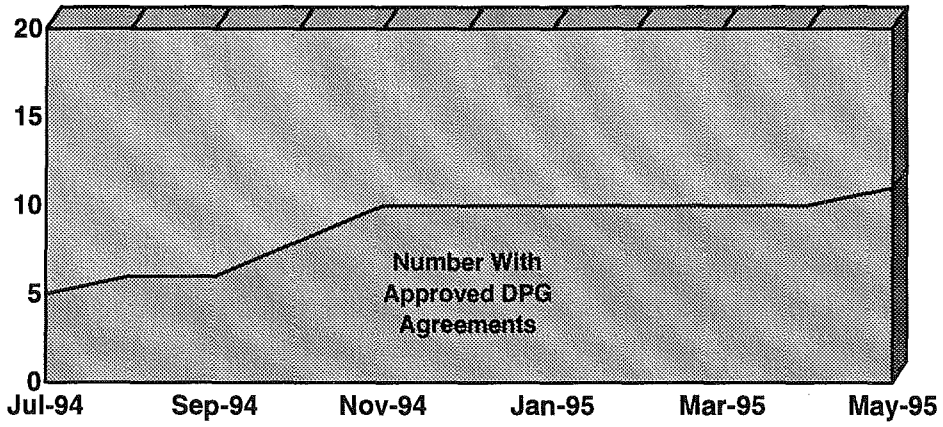
Under the new Regents' Policy, DPGs are still free to assume various legal forms. However, they all must submit their organizational documents to the dean and the general counsel's office for review and approval. They also must enter into a DPG Agreement with the Medical School. DPG Agreements are important because they document the DPGs' governing structure and membership criteria. They also certify that all DPG members will comply with the Regents' Policy. The dean's office, in consultation with outside legal counsel and the general counsel's office, developed a standard format to help each practice group prepare its DPG Agreement.

The interim dean and the task force developed comprehensive procedures to control the DPG reorganization process. The template and standard DPG Agreement are intended to help DPGs reorganize their legal and governing structures. The dean and the general counsel's office then review these reorganized entities to verify that they comply with the Regents' Policy. Unfortunately, as the following finding indicates, the implementation process is taking much longer than the Regents or the interim dean anticipated.

9. Some departments are not complying with the single practice group limit outlined in the Regents' Policy.

The template and the Regents' Policy required departments to reorganize and form a single DPG by July 1, 1994. However, only 5 of the 20 authorized DPGs were reorganized by that date. In fact, as Figure 3-2 illustrates, approximately half of the departments still had not complied with the Regents' Policy and the template as of May 1995.

Figure 3-2
Status of the 20 Practice Groups Authorized By The Dean As of May 1995



Source: Medical School Dean's Office.

Medical School administrators provided many reasons why the reorganization process is taking longer than anticipated. Some departments simply cannot reach a consensus on an acceptable DPG structure. Others needed to make one or more revisions before the dean would approve their organizational documents and agreement with the Medical School. Under the Regents' Policy, a majority of the department faculty must approve each new practice group. Scheduling these administrative meetings caused delays in some Medical School departments. Staffing shortages in the dean's office compounded the delays. The new practice plan administrator is now coordinating the Medical School's effort to reorganize DPGs. However, this position did not exist until September 1994. Prior to this date, departments had very little guidance or pressure to comply.

The new practice plan administrator is still negotiating with nine departments that do not have a single practice group. However, serious legal and financial issues need to be resolved. For example, the Department of Neurology had six DPGs under the old private practice system. Despite repeated negotiations, doctors in two of these groups refused to join the surviving DPG. One doctor claimed to be exempt from the Regents' Policy. Another doctor thought that the group would suffer severe financial hardship by joining the surviving DPG. The doctor also had concerns about the financial viability of both the department and its surviving DPG. This concern arose in part because the Department of Neurology had a $1,007,590 deficit cash balance in its unrestricted University account as of May 1995. Its surviving DPG also disclosed that it had no cash and was operating at a loss through the first half of fiscal year 1995.

The university appointed Dr. Frank Cerra as the new dean of the Medical School in May 1995. The interim dean made numerous attempts to negotiate agreements with departments and DPGs who were not in compliance with the Regents' Policy. However, some DPGs simply refused to comply or could not reach an internal consensus on an acceptable structure. It is important that Dr. Cerra continue the efforts to achieve compliance.

Recommendation

- *The Medical School dean needs to bring the remaining nine departments into compliance with the Regents' Policy. The dean should establish deadlines and address possible courses of action if DPGs refuse to comply.*

Overseeing DPG Financial Activities During the Reorganization

Reorganizing and combining practice groups poses unique risks to the Medical School. Without strong oversight procedures, cash, accounts receivable, and other assets could be lost during the transition from one entity to another. We think the Medical School needs to understand and monitor this process to protect its residual interest in patient revenues and ensure compliance with the Regents' Policy.

The Medical School is not taking sufficient steps to oversee the financial activities of DPGs during the reorganization process. Administrators did not even request any financial information from surviving and nonsurviving DPGs until the reorganization process was well underway.

They also did not actively pursue information from departments that did not appropriately respond to the original request.

10. Management of the Medical School needs to improve its financial oversight of surviving and nonsurviving DPGs.

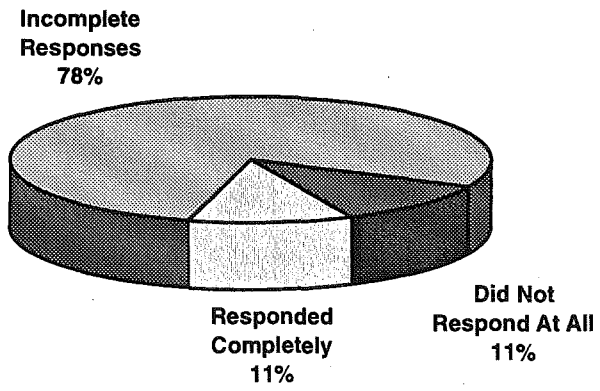
Medical School management did not have sufficient financial controls over DPGs during the reorganization process. Instead, it is relied on the monitor to oversee the financial activities of the surviving and nonsurviving practice groups. We think that the monitoring system did little to prevent or detect inappropriate financial activity. We also feel that the scope of the monitor's work could not mitigate the unique risks associated with combining and reorganizing practice groups. Our prior audit report, dated August 1993, discusses our concerns with the monitoring system in more detail.

The interim dean did not ask department heads to disclose detailed DPG reorganization information until January 13, 1995. For each nonsurviving entity, the interim dean requested:

- A narrative describing the wind up process, the DPG's legal status, the date it was dissolved or is expected to be dissolved, and the procedures for handling expenses, accounts receivable, pensions, and other significant financial matters;
- A statement of accounts receivable and outstanding expenses as of the date when patient billings were shifted to the surviving DPG;
- A statement identifying how collections on outstanding accounts receivable will be distributed; and
- Legal documents relating to the dissolution or wind up of the practice entity.

As Figure 3-3 depicts, only one of the nine departments with nonsurviving DPGs disclosed all of the financial information requested by the interim dean. Seven departments submitted incomplete responses and a one did not respond at all.

Figure 3-3
Departmental Response Rates To The Dean's Information Request



Source: Data supplied by Medical School Administration as of May, 1995.

University of Minnesota Medical School

Medical School administrators know very little about the financial status of many nonsurviving DPGs because they did not aggressively pursue the information. For example, the Department of Surgery sent its response to the interim dean on February 2, 1995. In a one-page letter, the Associate to the Department Head said that Drs. Goodale and Delaney joined the surviving DPG in July 1994. The letter also stated that the remaining financial information would be compiled and provided shortly. Medical School administrators had not received the information by June 1995.

Most nonsurviving DPGs did not consolidate their assets with surviving practice groups. Therefore, we are concerned that Medical School administrators do not know the value or disposition of these assets. Unlike surviving practice groups, nonsurviving DPGs do not have to submit quarterly financial reports to the Medical School. Therefore, the monitor was the only person who reviewed nonsurviving DPG financial information, and his review period ended on December 31, 1994. After this date, the new practice plan administrator does not plan to review financial activities for nonsurviving DPGs.

The University may be entitled to certain of the accumulated assets of nonsurviving DPGs. In our review of practice plan financial records, we noted that a nonsurviving DPG had a remaining cash balance of approximately $25,000 on December 31, 1994. The DPG ceased its affiliation with the University on June 30, 1994. The only financial activity after that date would have been collection of outstanding receivables and payment of accrued liabilities. Under the Regents' Policy, DPGs must remit all excess funds to the University to help support departmental operations. If there were no remaining prior year liabilities, the DPG should have paid its residual cash to the University, since the doctor associated with the plan earned the upper income limit in 1994. The Medical School's practice plan administrator was unaware of the plan's remaining funds and had no procedures to ensure that the University received all funds that it was due.

Establishing control over the prior financial activities of nonsurviving DPGs at this point will be difficult. However, we still think it is important to obtain and review the financial information requested by the interim dean. We also feel that the Medical School needs to substantiate the accuracy and completeness of this information. The work done by the University internal auditor on nonsurviving DPGs could help attest to the reliability of the reported information. It also could help the Medical School account for all DPG assets during the reorganization and provide assurance that expenses complied with the Regents' Policy. In the future, we feel that the Medical School should require nonsurviving DPGs to document the disposition of all remaining assets.

Recommendations

- *The Medical School should obtain and review the financial information requested by the interim dean.*
- *The Medical School should require nonsurviving DPGs to document the disposition of all remaining assets.*

UNIVERSITY OF MINNESOTA

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October 9, 1995

Mr. James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155

Re: Response of the Medical School of the University of Minnesota to an audit of the period July 1, 1993 to December 31, 1994 (fiscal years 1994 and partial 1995)

Dear Mr. Nobles:

We found the audit report to be reflective of the implementation status of the University of Minnesota Regental Policy on Private Practice for the period audited. We understand that by the temporal constraints built into the audit process, i.e., the need to examine a "snapshot" in time, that the audit does not acknowledge the changes and progress of the last several months. The report is informative and your recommendations will be incorporated into the Dean's workplan in this area for the 1995-1996 fiscal year. We are appreciative of the time and effort the auditors made, and the open and cooperative manner in which the audit was conducted. We do have a common goal, that of achieving appropriate oversight of the Departmental Practice Groups (DPGs) as expressed in the University of Minnesota Regental Policy on Private Practice.

This communication comprises the response of the Medical School to the report of the Office of the Legislative Auditor in its audit of the Medical School oversight of the DPGs. This response has three sections: 1) general comments, 2) specific responses to the recommendations of the report, and 3) the workplan of the Dean's office of the Medical School for the 1995-1996 fiscal year.

GENERAL COMMENTS:

There are three areas of general comments: the affirmation of the position of the DPGs relative to the University, the Dean's workplan for implementation of the Regental Policy on Private Practice adopted by the Board of Regents in July 1993, and the importance of the DPGs to the financial viability of the Medical School.

1. The position of the DPG's relative to the University:

The Regental Policy permits each department in the Medical School to have a DPG structured as an independent legal entity for the purpose of providing patient care services by the faculty of that department. As such, each DPG exists as an entity outside the University. While establishing this status for the DPGs, the Regental policy also provides for the establishment of internal controls to assure the public accountability of the DPGs, and their conformity to the public mission of the Medical School. However, this external, independent status of the DPGs does influence the oversight mechanisms used by the Medical School to assure compliance with the Regental Policy. Direct oversight of DPG structure is provided for in that the structure of each DPG must be approved by the Medical School. Oversight of DPG operations and financial activity needs to utilize both direct and indirect internal controls. Expenses that each DPG chooses to make through the University have direct oversight in real time. Expenses that each DPG chooses not to make through the University require indirect methods of oversight. The expectation is that each DPG will make these expenses in accord with reasonable University policies. Confirmation of this activity is made through the appropriate financial audit performed by each DPG, a copy of which is supplied to the Medical School; and through the newly established process of periodic auditing of each DPG by the University Department of Audits. The Private Practice Monitor has also played an important role in this process, particularly with regard to the compliance with salary limits allowed by the University. This process has now moved into the Dean's office.

2. Dean's Office Workplan for the Regents' Policy adopted July 1993:

The Regental Policy on Private Practice was adopted by the Board of Regents in July 1993. The Dean's office approached this policy by first focusing on DPG structure and then on the oversight functions necessary to assure DPG compliance with the Policy. A timeline was established to reformulate the structure of the departmental DPGs by July 1994. This process required the formulation of a template for use by each new DPG, establishing one DPG per department unless an exception was approved by the Dean, reorganization of the legal structure of many of the DPGs, dissolution of 19 DPG legal entities, review and approval of each new DPG structure and bylaws by the Dean, and implementation of the new structure by each department of the Medical School. The enormity and complexity of this process was underestimated, resulting in some extension of the completion endpoint. Nonetheless, the focus on DPG function began in the fall of 1994 with the hiring of a practice plan administrator in the Dean's office to establish and implement a workplan to achieve the necessary internal controls. This latter process also necessitates establishing the appropriate infrastructure, such as information systems, budgeting and accounting systems, and human resources systems. Three additional personnel were hired to initiate these processes. In addition, given the number of compliance areas necessary, the functional oversight requires prioritization of the internal controls and a timeline for their implementation and monitoring. These areas will be addressed in subsequent sections of this report.

3. Clinical Practice and the Financial Viability of the Medical School:

The provision of patient care services by the faculty of the Medical School is essential for the education and research mission of the Medical School. This clinical service is achieved through the DPGs. The revenue generated through the DPGs, by the faculty providing these clinical services, is a reflection of their clear commitment to the education and research mission of the Medical School. Of the revenue generated, approximately one third is used for faculty salaries, one third for expenses incurred in the performance of the clinical service at the University, and one third is used for direct support of the education and research mission of the Medical School. As depicted in Figure 1, this revenue constitutes the largest portion of the budget of the Medical School, and represented approximately 40% of that budget in fiscal 1995.

MEDICAL SCHOOL REVENUE
FISCAL 1995

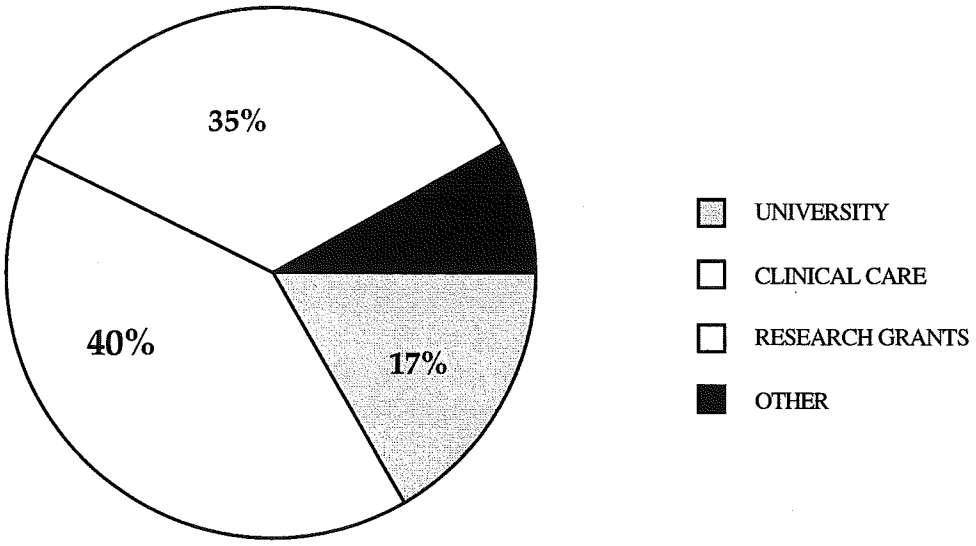

Figure 1

SPECIFIC RESPONSES TO RECOMMENDATIONS IN THE AUDIT REPORT

This section will respond to the information and recommendations contained in Chapter 2 and Chapter 3 of the Audit Report.

Overview

The Medical School began to implement its functional oversight of DPG financial operations in accord with the new Regental Policy in fiscal 1995, a process that continues in the workplan for fiscal 1996. The operational elements include:

1. The Regental Policy on Private Practice and other applicable policies of the University have been formulated into a single procedural document, the DPG Policy Manual. This manual was drafted in fiscal 1995 and is now in the final stages of completion.
2. An information system to support the DPG Policy Manual was designed in fiscal 1995 and will be operational in the current fiscal year.
3. Each DPG reports to the Medical School the current status of its revenue and expenses on a quarterly basis.
4. Each DPG submitted a budget for fiscal 1996 to the Dean's office for approval; these budgets are currently under review. This process will be moved ahead in fiscal 1996, such that each DPG budget will be submitted for approval prior to implementation in the next fiscal year. The new information systems will permit these functions to be performed electronically, and will permit budget variance analysis to be performed on an ongoing basis by the Dean's office.
4. The University Department of Audits is currently reviewing two DPG's and has four additional DPGs in its audit plan for 1996.
5. Other aspects of the implementation of DPG financial oversight will be discussed in the workplan for fiscal 1996.

Following are responses to the specific recommendations in the audit report. Each recommendation is presented in bold type as numbered in the audit report. The response immediately follows the recommendation.

1. **The Medical School administration should revise its reporting and oversight process so it can monitor compliance with section 10 of the template. (chapter 2, page 12)**

There is complete agreement with this recommendation. In fiscal 1995, the DPG budget approval and quarterly reporting processes were established. Improvements will continue in fiscal 1996. A common financial information system with the departments, DPG's and the Dean's office will use the same chart of income and expense accounts. DPG budgets for fiscal 1997 will be reviewed and approved prior to the start of that fiscal year.

Each DPG is required to "zero out" at the end of its fiscal year by transferring all of its residual funds into the University via the Medical School. Carry over of funds within the DPG requires prior approval of the Dean. The oversight of this process has, in large part, been voluntary and, to a certain extent, through the private practice monitor system. DPG's will now be required to have an appropriate financial audit and will supply the Dean with a copy

of that audit. There are also periodic, ongoing compliance audits by the University Department of Audits, the results of which are reported to the Dean.

2. **The Medical School should develop a process for reviewing and approving DPG budgets. These budgets should include a schedule of estimated departmental support. The Medical School should compare DPG reported financial information to amounts budgeted and investigate significant differences. The Medical School should improve the consistence of DPG financial information by standardizing the reporting process and DPG business years. (chapter 2, page 14)**

There is complete agreement with these recommendations. As has been presented, the systems and processes to accomplish these goals are planned to become operational in fiscal 1996. There is one exception, that of having the Medical School and all the DPGs on the same fiscal year. This clearly needs to happen. However, the current plan to achieve this essential goal is to coordinate with the implementation of the single group practice. This process of establishing a single group practice is a current major effort of the DPGs and is strongly supported by the Dean and Provost.

3. **The Medical School should develop specific criteria for allowable DPG expenses. (chapter 2, page 16)**

There is complete agreement with this recommendation. The expectation already exists that DPG's will expense in accord with reasonable University policies. The development of specific criteria would greatly facilitate this expectation. Because of the complexities of determining these specific criteria, a consultant is being hired who will assist in defining categories of expenses, types of expenses in each category, and in defining reasonable allowances for each. There will then be an educational process for the DPG's and the criteria will become part of the DPG Policy Manual and Medical School oversight process.

4. **The Medical School administration should require DPG's to obtain periodic financial audits. (chapter 2, page 16)**

There is general agreement with this recommendation. A process will be established in fiscal 1996.

5. **The Medical School administration should bill DPG's for departmental services as required by the Regents' Policy. (chapter 2, page 16)**

There is general agreement with this recommendation. The overlapping missions of education, research, and clinical care create a number of areas where it is difficult to quantitate the relative contribution of each mission. The following is an example: a physician's secretary types a research grant, schedules several patients for admission to the hospital, and types a lecture for the medical students in a setting where the patients are the subject of the

lecture and potential enrollees for the research protocol. In conjunction with the consultant referred to in recommendation 3, we will analyze this problem and develop a reasonable basis and formula for application.

6. **The Medical School should ensure that faculty compensation limits are in line with other medical schools. The Medical School should use gross wages to calculate compliance with income limitations. (chapter 2, page 18)**

There is general concurrence with these recommendations. The Regental Policy requires the Dean of the Medical School to approve the reference for comparison in the establishment of faculty compensation limits and to approve all faculty salaries on a yearly basis. The reference used for this purpose has been the salary tables published yearly by the American Association of Medical Colleges. However, the Dean has, in some instances, approved other standards that more accurately reflect comparative salaries for particular specialties of medical practice. The Medical School must maintain expert faculty. In the competitive market that we practice in, this could necessitate a community competitive standard in order to retain expert faculty in specific service areas. Anesthesiology has been one such area, and the Dean, after diligent consideration, did approve such a reference for that department.

The approval of each faculty salary in the clinical departments occurs on a yearly basis. Beginning in fiscal 1995, the oversight for compliance with these income limitations moved into the Dean's office. There is agreement that gross wages, which will include deferred compensation in the year earned, but not benefits, will be used to calculate compliance with income limitations.

7. **The Medical School should establish appropriate controls over salary supplements paid to administrative and clerical staff. (chapter 2, page 18)**

There is complete agreement with this recommendation.

8. **The Medical School should establish appropriate controls over DPG professional service contracts. (chapter 2, page 19)**

There is complete agreement with this recommendation. A process will be implemented in Fiscal 1996.

9. **The Medical School Dean needs to bring the remaining nine departments into compliance with the Regent's Policy. The Dean should establish deadlines and address possible courses of action if DPGs refuse to comply. (chapter 3, page 24)**

There is complete agreement with this recommendation. At the conclusion of the implementation process, there will be twenty DPG's. At this time, sixteen are in compliance, two are in the final signing stage, and one is resolving a bylaws issue. For the final DPG, the

Dean is waiting for the completion of an audit by the University Department of Audits before completing the process. Figure 2 summarizes this current status.

STATUS OF THE 20 PRACTICE GROUP S AUTHORIZED BY THE DEAN AS OF SEPTEMBER 1995

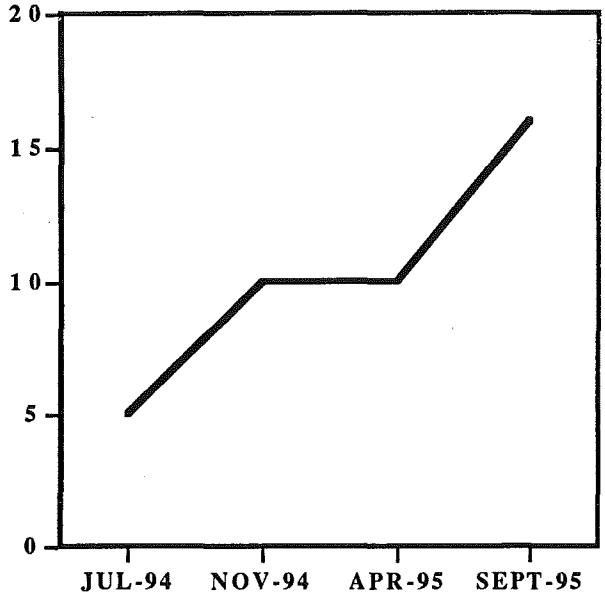

Figure 2

The Dean and the Provost are committed to undertake whatever course of action is necessary to complete the process of structural compliance of the DPGs with the Regental Policy.

10. The Medical School should obtain and review the financial information requested by the interim dean. The Medical School should require non surviving DPGs to document the disposition of all remaining assets. (chapter 3, page 26)

There is complete agreement with this recommendation. The Dean is working with the University Department of Audits to determine a workplan to bring this to closure.

WORKPLAN FOR 1995-1996 FISCAL YEAR

The Medical School's Dean's office established a workplan in June 1995 that focused on several areas of the Regental Policy on Private Practice. This plan was presented to the Provost on 22 August 1995 in a report entitled, 1995/96 Status Report of DPG Compliance with Regental Rules. This workplan contains new efforts in a number of areas. It has now been revised to accommodate the recommendations of the legislative auditors. The current workplan is summarized in Table 1.

Table 1

DPG WORKPLAN FOR FISCAL 1995-1996

ITEM	COMPONENTS	STATUS	TIMELINE
1. DPG policy manual	1.1 finalize 1.2 develop process for updating 1.3 revise as necessary	1.1 in final draft 1.2 starting 1.3 ongoing	1.1 done Nov 1995 1.2 done Dec 1995 1.3 uses Committee on Private Practice
2. Financial information system	2.1 electronically connected to departments 2.2 common financial software 2.3 common chart of accounts	2.1 plan completed 2.2 in process 2.3 in process	2.1 completed 2.2 implement before 7/96 2.3 implement before 7/96

3. DPG budgets	3.1 1996 fiscal year 3.2 1997 fiscal year 3.21 pre-approval 3.22 define expected revenue/expenses 3.23 define allowable expense categories, types, applicable policies 3.3 quarterly review, variance analysis, and reconciliation	3.1 review in process 3.21 in planning 3.22 in planning 3.23 in planning 3.3 quarterly review done now; rest in process	3.1 complete 11/95 3.21 Apr 1996 3.22 Apr 1996 3.23 June 1996 3.3 prior to FY 97
4. Complete structural compliance	4.1 current department DPGs 4.2 residual analysis of nonsurviving DPGs	4.1 16 completed 3 in process 1 in audit 4.2 University Dept of Audits	4.1 completed Nov 1995 prior to FY97 4.2 begun fiscal 1995; will continue
5. Oversight of DPG residual	5.1 quarterly review, variance analysis, and reconciliation 5.2 DPG yearly financial audit 5.3 periodic audits by University Dept. of Audits	5.1 has begun 5.2 began 1995 with audit/cpa review 5.3 began fiscal 95	5.1 will continue 5.2 audits begin 1996 5.3 to continue
6. Oversight of DPG revenue	6.1 yearly financial audit 6.2 quarterly budget variance analysis and reconciliation	6.1 begin 1996 6.2 in development	6.1 1996 6.2 1996

7. Oversight of compensation	7.1 faculty 7.11 move Monitor process to Dean's office 7.12 use gross wages 7.13 compare PCPA to PCP 7.2 administrative and clerical working for DPG	7.11 started 1995 7.12 planned 7.13 in development 7.2 implemented	7.11 continue 7.12 CY 1996 7.13 CY 1995 7.2 continue
8. Oversight of DPG contracts	8.1 develop process and procedure	8.1 to be developed	8.1 implement fiscal 1996
9. Use of excess DPG funds	9.1 define 9.2 develop process	9.1 to go to Committee on Private Practice 9.2 to go to Committee on Private Practice	9.1 for fiscal 1997 9.2 for fiscal 1997
10. Report use of funds from Dean's Tax	10.1 itemized report to DPGs and departments	10.1 done for 1995	10.1 to continue yearly

If there are any questions after your review of these responses, I would be happy to discuss the with you.

Respectfully,

Frank B Cerra

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FBC:kpa