ARIZONA AUDITOR GENERAL

Lindsey A. Perry, Auditor General

August 31, 2026

Members of the Arizona State Legislature

The Honorable Katie Hobbs, Governor

Executive Director Rivera
Arizona Medical Board

Transmitted herewith is the report *A Performance Audit and Sunset Review of the Arizona Medical Board*. This audit was conducted by the independent CPA firm Walker & Armstrong, LLP under contract with the Arizona Auditor General and was in response to an October 7, 2025, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Arizona Medical Board (Board) agrees with all the findings and plans to implement or implement in a different manner all recommendations. My Office has contracted with Walker and Armstrong, LLP to follow up with the Board in 6 months to assess its progress in implementing the recommendations. I express my appreciation to the Board's members, Executive Director Rivera, and Board staff for their cooperation and assistance throughout the audit.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

cc: Arizona Medical Board members

Arizona Medical Board

Board timely issued licenses, but did not timely resolve complaints, establish sufficient oversight and accountability mechanisms, or consistently act within or fully exercise its statutory authority, increasing risks to public safety and contributing to inefficient and ineffective operations, statutory noncompliance, unauthorized disciplinary actions, and waste of public resources

Performance Audit and Sunset Review

August 2026
Report 26-109

Walker & Armstrong
CERTIFIED PUBLIC ACCOUNTANTS AND ADVISORS

Walker & Armstrong

CERTIFIED PUBLIC ACCOUNTANTS AND ADVISORS

August 26, 2026

Lindsey A. Perry, CPA, CFE
Arizona Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Perry:

We are pleased to submit our report in connection with our performance audit and sunset review of the Arizona Medical Board. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq.

As outlined in its response, the Board agrees with all the findings and plans to implement, or implement in a different manner, all the recommendations. We will follow up with the Arizona Medical Board in 6 months to assess its progress in implementing the recommendations.

We appreciate the opportunity to provide these services and work with your Office. Please let us know if you have any questions.

Sincerely,

Walker & Armstrong, LLP

Walker & Armstrong, LLP
Phoenix, Arizona

Report Highlights

Walker & Armstrong
CERTIFIED PUBLIC ACCOUNTANTS AND ADVISORS

Arizona Medical Board (Board)

Performance Audit and Sunset Review

Board timely issued licenses, but did not timely resolve complaints, establish sufficient oversight and accountability mechanisms, or consistently act within or fully exercise its statutory authority, increasing risks to public safety and contributing to inefficient and ineffective operations, statutory noncompliance, unauthorized disciplinary actions, and waste of public resources

Audit purpose

To assess whether the Board issued and renewed licenses, registrations, and permits as required by statute and rule and investigated and resolved complaints within its jurisdiction in a timely manner and within its statutory authority, and to provide responses to the 10 statutory sunset factors.[1]

Key findings

- Board generally approved initial and renewal licenses/registrations/permits within required time frames, verified applicants met licensure requirements, and conducted continuing medical education audits.
- Board did not resolve within 180 days 78% of complaints it closed in fiscal year 2024, taking up to 4.5 years to resolve some complaints, despite 5 prior audit reports spanning 43 years recommending it timely investigate and resolve complaints.
- Board and its executive directors delegated key responsibilities to staff without establishing sufficient oversight and accountability mechanisms such as productivity and performance standards, increasing risk of inefficient and ineffective operations, noncompliance with Board statutes and policies, and waste of public resources.
- Board did not consistently act within or fully exercise its statutory authority and enforcement options when resolving complaints, potentially resulting in unauthorized disciplinary action, premature dismissal of a complaint, and increased risk to public safety.

Key recommendations to the Board

- Implement complaint-handling policies and procedures to help ensure timely investigations, including tracking, monitoring, identifying, and resolving delays, and regularly reporting to the Board.
- Continue to establish and subsequently enforce staff productivity and performance standards, and implement accountability measures to ensure performance expectations are met.
- Establish and follow processes for taking disciplinary actions as outlined in statute, address previously issued committee disciplinary actions as needed, and train Board members on the full scope of the Board's statutory authority and enforcement options.

[1] Walker & Armstrong conducted this performance audit and sunset review of the Board pursuant to an October 7, 2025, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq.

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Arizona Medical Board

The Arizona Medical Board (Board) regulates doctors of medicine by issuing and renewing licenses and registrations; investigating and resolving complaints; and providing information to the public about license, registration, and permit holders. The Board is statutorily required to consist of 12 Governor-appointed members who serve for 5-year terms beginning and ending on July 1. As of February 2026, 8 of 12 Board member positions were filled. In fiscal years 2025 and 2026, the Board was authorized 63.5 full-time equivalent (FTE) staff positions.

The Board does not receive any State General Fund monies. Rather, the Board's revenues consist primarily of licensing, registration, and permit fees, a portion of which are appropriated.

Active licenses and registrations as of February 2026: 35,332

Complaints opened in fiscal year 2024: 1,069

Complaints opened in fiscal year 2025: 1,095

Audit results summary

Key regulatory areas reviewed	Results			
Individual licenses—Process initial applications between 20 and 240 days. Key qualifications include education, experience, and a criminal history records check.	Issued timely?	✓	Ensured qualifications were met?	✓
License renewals—Process renewal applications within 90 days. Licensees must complete 40 hours of continuing education every 2 years.	Issued timely?	✓	Continuing education met?	✓
Complaint handling—Investigate complaints it receives and take action to address violations within 180 days.	Resolved complaints in a timely manner?	X	Followed statutory adjudication requirements?	X
Public information—Provide specific complaint and licensee information to the public on request and on its website.	Provided via website?	✓	Provided via phone?	X

Audit results summary (continued)

Other responsibilities reviewed	Results			
Fee setting—Establish fees based on the actual costs of providing services.	Assessed costs?	X	Based fees on actual costs?	X
Conflicts of interest—Sign a disclosure form, maintain substantial interest disclosures in a special file, and recuse oneself from decisions involving substantial interests.	Board members and staff signed disclosures?	✓	Board maintained a special file and Board members with conflicts recused selves during Board meetings?	✓
Rulemaking and open meeting law—Requirements include involving the public in rulemaking and posting recorded minutes on the Board's website in 5 days.	Involved public in rulemaking?	✓	Posted recorded minutes on the Board's website in 5 days?	✓

INTRODUCTION

On behalf of the Arizona Auditor General, Walker & Armstrong has completed a performance audit and sunset review of the Arizona Medical Board (Board). This performance audit and sunset review determined whether the Board (1) issued and renewed licenses, registrations, and permits in accordance with statute and rule requirements, (2) investigated and resolved complaints within its jurisdiction in a timely manner and imposed disciplinary action consistent with the nature and severity of violations, (3) provided information to the public as required by statute, and (4) complied with State conflict-of-interest requirements and aligned its conflict-of-interest processes with recommended practices. This report also provides responses to the statutory sunset factors.

Board mission and responsibilities include ensuring that regulated persons are competent to safely practice

The Board was established in 1913 to regulate doctors of medicine in Arizona (see textbox for definition of doctor of medicine).

Doctor of medicine (MD)

An individual with a post graduate medical degree who holds a license to practice medicine, also known as an allopathic doctor or MD.

Source: Walker & Armstrong staff analysis of information from Board statutes Arizona Revised Statutes (A.R.S.) §§32-1401 & 32-1422.

The Board's key statutory responsibilities include:

- Issuing and renewing licenses, registrations, and permits to qualified applicants. As shown in Table 1 (see page 4), the Board had 32,835 active licenses, 604 active registrations, and 1,893 active permits as of February 2026.
- Investigating and adjudicating complaints against license, permit, and registration holders. The Board is statutorily authorized to take various disciplinary and non-disciplinary actions if it determines that a statutory violation has occurred, including license revocation and civil penalties (see textbox for more information on disciplinary and non-disciplinary actions the Board may take).

  In fiscal year 2024, the Board opened 1,069 complaint investigations in relation to complaints received from the public (see Finding 1, pages 9 through 18, and Sunset Factor 6, page 38), for more information on our findings related to the Board's processes for handling complaints).

- Providing information to the public, including licensees' disciplinary and non-disciplinary histories (see Sunset

Examples of disciplinary and non-disciplinary actions the Board may take

Disciplinary actions	
* Revoke license	* Impose a probationary term
* Suspend license	* Impose civil penalty up to $10,000 per violation of statute
* Issue a letter of reprimand	
* Issue a decree of censure	
Non-disciplinary actions	
* Issue an advisory letter	* Require continuing education

Source: Walker & Armstrong staff review of A.R.S. §32-1451.

Factor 5, pages 35 through 38, for more information on issues we identified with the Board's provision of public information).

Table 1: Board license, registration, and permit types; number of active licenses, registrations, and permits; and education and experience requirements

As of February 2026
(Unaudited)

License, registration, or permit type	Active licenses. registrations, and permits	Education requirements for license, registration, or permit[1]
License		
Doctor of medicine (MD) license	32,835	Graduate from an approved school of medicine, successful completion of 12-month internship, residency, or clinical fellowship program or maintain a full, unrestricted license in a state other than Arizona and is authorized by the IMLC to work in other states.[2]
Teaching license[3]	-	Graduation from an approved school of medicine.
Registration		
Dispensing registration	502	Currently a registered MD in Arizona.
Telehealth registration	69	Maintain a full, unrestricted MD license in state, territory, or possession of the United States.
Dental anesthesia registration	14	Currently a registered MD in Arizona and successful completion of residency training in anesthesiology.
Locum tenens registration[4]	-	Maintain a full, unrestricted MD license in state, territory, or possession of the United States.
Pro bono registration[4]	19	Maintain a full, unrestricted MD license in state, territory, or possession of the United States.
Permit		
Post graduate training permit[5]	1,808	Graduate at a school approved by the Board.
Transitional training permit[5]	85	Graduate at a school approved by the Board.
Total active licenses, registrations, and permits	**35,332**	

[1] In addition to education requirements, applicants must also pass a professional exam to obtain a license.

[2] An MD can practice in Arizona as part of an agreement between the State and other states participating in the Interstate Medical Licensure Compact (IMLC). This compact addresses the licensing of physicians across state lines. The Board's licensees include 400 active licensees under the IMLC.

[3] An MD who is not licensed in Arizona may be employed as a full-time faculty member by a school of allopathic medicine if the doctor holds a teaching license. Additionally, the Board issued teaching permits, which grants MDs who are not licensed in Arizona to demonstrate and perform medical procedures for the purpose of promoting education for students, interns, residents, fellows, and doctors of medicine for not more than 5 days.

[4] Locum tenens and pro bono registrations allow MDs licensed in another state or inactive in Arizona to temporarily practice medicine in the State, either to assist other physicians or to provide volunteer medical services.

[5] Training permits authorize permit holders to train in facilities approved for post graduate training.

Source: Walker & Armstrong staff analysis of A.R.S. §§32-1403, 32-3241, and 32-1422 through 32-1432.04 and licensing information provided by Board staff.

Board comprises 12 members, supported by 63 staff positions shared with the Arizona Regulatory Board of Physician Assistants

Board and committees

A.R.S. §32-1402 requires the Board to consist of 12 Governor-appointed members who serve 5-year terms beginning and ending on July 1. Board membership must include 8 doctors who are actively practicing medicine and 4 public members.[1] All members, other than public members, must have practiced medicine in Arizona for the previous 5 years. As of February 2026, 8 Board member positions were filled and 4 licensed medical physician Board positions were vacant.

Statute authorizes the Board chairperson to establish subcommittees consisting of Board members assigned by the Board chairperson, as deemed necessary, to carry out the functions of the Board.[2] Meetings of the Board's subcommittees are open to the public. As of February 2026, the Board had 4 active subcommittees, including 2 subcommittee comprised of Board members and Arizona Regulatory Board of Physician Assistants (PA Board) Board members, with which the Board shares its executive director and staff, as follows:

- Joint Legislative and Rules Committee, which is responsible for reviewing statutes, rules, and regulations and recommending changes or action to the Board (consists of 6 members of the Board, all positions filled as of February 2026).
- Biannual Joint Officers Committee, which is responsible for meeting with appointed board members of the PA Board to discuss matters of common interest (consists of 5 members, including 2 members of the PA Board and 3 members of the Board; all positions filled as of February 2026).
- Executive Director Selection and Retention Committee, which is responsible for meeting with appointed members of the PA Board to select an executive director (consists of 14 members, including 2 members of the PA Board and all members of the Board; there were 4 vacant Board positions, as of February 2026).
- Physician Health Program Committee, which is responsible for overseeing the Physician Health Program (consists of 3 members of the Board; there was 1 vacant position as of February 2026).

In fiscal year 2024, the Board also had 2 review committees, which were responsible for conducting formal interviews; each was comprised of at least 4 Board members, 1 of which was a public member. In September 2025, the Board reported that the use of these committees had been discontinued (see Finding 3, pages 28 through 30, for more information).

Joint operations with the PA Board

Laws 1984, Chapter 102 created the Joint Board on the Regulation of Physician Assistants, now known as the PA Board, which required the Arizona Medical Board to share both its executive director and staff to carry out the administrative responsibilities of the Board. These administrative responsibilities included tasks such as issuing certificates, reviewing continuing medical education completion, renewing certificates, and investigating complaints.

[1] A.R.S. §32-1402(A) requires that 1 of the 4 public members be a licensed nurse with at least 5 years' experience.

[2] A.R.S. §32-1404(C).

Board staffing

The Board and PA Board were authorized 63.5 full-time equivalent (FTE) staff positions for fiscal year 2026. As of February 2026, the Board reported that a total of 53 FTE positions were filled as follows:

- 44 full-time employees, consisting of an executive director, chief medical consultant, department managers—chief operating officer, chief technology officer, investigations manager, and licensing manager—as well as licensing, complaint investigation, information technology (IT), and administrative staff, and internal medical consultants.
- 7 full-time contracted employees for licensing, complaint investigations, and IT.
- 7 part-time employees, totaling 2 FTE positions for medical consultants.

As of February 2026, 15 employees worked fully remote, 38 worked hybrid schedules, and 5 were required to work fully in-office.[3] The Board reported that it maintained 54 workstations at its office. See Finding 2, pages 21 and 22, and Sunset Factor 2, pages 32 and 33, for more information on our findings on the Board's compliance with State remote work policies.

Board's revenues primarily consist of fees from its regulated community and its expenditures were mostly for personnel costs

The Board's operations are administered in conjunction with the PA Board, with which it shares an operating fund. The Board does not receive any State General Fund monies. Instead, the Board's revenues consist of licensing and other fees, a portion of which are appropriated to the Board to pay for both boards' operations as part of the State budget process. The Board is statutorily required to remit 10% of all monies received to the State General Fund and to deposit the remaining 90% into the Board's Fund.[4] However, effective September 15, 2024, Laws 2024, Ch. 222, requires the Board to remit to the State General Fund 15% of all monies it receives through June 30, 2028.

Board staff record the Board's and the PA Board's revenues in separate accounts within its accounting system and deposits both boards' revenues in the Board's Fund. However, Board staff do not separately account for the costs associated with administering each board with the exception of costs related to compensation, travel, and training for members of each board. As shown in Table 2, pages 7 and 8, in fiscal years 2023 through 2025, the 2 boards' combined expenditures were primarily associated with personnel costs, professional services such as legal fees paid to the Arizona Attorney General's Office, temporary staffing, investigation services, and other operating expenses, such as such as rent, IT services, software support and maintenance, financial services, supplies, and insurance. Between fiscal years 2023 and 2025, the Arizona Medical Board Fund's fiscal year ending fund balance decreased from approximately $11 million to $3.8 million due to a transfer of $9.3 million of the Board's fund balance to the State General Fund required by the State-approved budget for fiscal year 2025.

[3] The Board reported that employees working hybrid schedules varied by position and supervisor discretion and ranged from 1 to 4 days per week working remotely. Additionally, the Board reported having no staff working from outside of Arizona.

[4] A.R.S. §§35-146, 35-147, and 32-1451.

Based on the 2 boards' fiscal year 2025 revenues and expenditures, the Arizona Medical Board Fund's fiscal year 2025 ending fund balance was $3,798,423, or approximately 46% of the 2 boards' annual operating expenditures for the fiscal year.

Table 2: Schedule of revenues, expenditures, and changes in fund balance
Fiscal years 2023 through 2025
(Unaudited)

	2023 (Actual)	2024 (Actual)	2025 (Actual)
Fund balance, beginning of year	$10,366,718	$11,002,830	$ 2,892,604
Revenues			
Licensing and fees	8,507,549	9,455,586	9,425,377
Charges for goods and services[1]	74,472	84,814	65,612
Fines, forfeits, and penalties[2]	163,625	195,146	320,821
Credit card transaction fees	(154,603)	(156,730)	(199,038)
Remittances to the State General Fund[3]	(872,481)	(976,931)	(1,410,481)
Total Board net revenues	7,718,562	8,601,885	8,202,291
PA Board net revenues[4]	826,463	879,024	966,081
Total Board and PA Board net revenues	8,545,025	9,480,909	9,168,372
Expenditures and transfers			
Payroll and related benefits	4,768,537	4,808,198	4,897,164
Professional and outside services[5]			
Legal services	554,011	630,161	542,223
Outside medical consultants	150,750	277,125	426,900
Contracted employee services	671,851	798,878	718,930
Other	23,857	22,244	23,259
Staff travel	17,185	3,662	7,696
Board member expenditures[6]	51,037	54,427	44,623
Other operating[7]	1,330,639	1,453,004	1,512,217
Furniture, equipment, and software[8]	256,306	230,061	76,734
Transfers to other agencies[9]	84,740	13,375	12,807
Transfers to State General Fund[10]	-	9,300,000	-
Total expenditures	7,908,913	17,591,135	8,262,553
Excess of revenues over (under) expenditures	636,112	(8,110,226)	905,819
Fund balance, end of year	$11,002,830	$ 2,892,604	$ 3,798,423

[1] Charges for goods and services consist of fees for various services, such as fingerprinting and providing a license verification for licensure in another state.

[2] The Board reported that fee revenue increased significantly in fiscal year 2025 primarily due to higher collections from fines and penalties resulting from an increased number of late license renewals. However, the Board was unable to determine the underlying cause of the rise in late renewals.

[3] The Board is required to remit to the State General Fund 10% of all monies received by the Board in accordance with A.R.S. §§35-146 and 35-147 and all civil penalties in accordance with A.R.S. §32-1451. For fiscal years 2025-2028, the Board is required to remit to the State General Fund 15% of all monies received by the Board.

[4] Amount is the net revenues available from the PA Board to pay for the Board and the PA Board's combined expenditures. The Board and PA Board are not required to and do not separately account for each board's financial activities. However, separate accounts are used to track revenues and board member expenditures for each board. Therefore, the PA Board presented net revenues include the PA Board's revenues less its board member expenditures and remittances to the State General Fund.

[5] Professional and outside services expenditures primarily consist of legal fees paid to the Arizona Attorney General's Office and fees for contracted outside medical consultants and employment services. The Board reported that fees for outside medical consultants increased in fiscal years 2024 and 2025 because payments for case reviews increased from $200 to $450 per review.

[6] Board member expenditures consist of compensation to Arizona Medical Board members in accordance with A.R.S. §32-1402 and board member travel.

[7] Other operating expenditures consist of various expenditures, such as rent, IT and software support services, financial services, supplies, and insurance.

[8] The Board reported purchases of computers, equipment, and software in fiscal years 2023 and 2024 and purchases of primarily software in fiscal year 2025.

[9] Transfers to other agencies primarily consist of transfers pursuant to an interagency service agreement with the Arizona Department of Administration to make improvements to facility boardrooms shared between the Board and other State agencies and another with the Office of Administrative Hearings to conduct formal hearings.

[10] Laws 2024, Ch. 209, Sec. 133, required a transfer of $9.3 million of the Arizona Medical Board Fund's fund balance to the State General Fund for the purpose of providing adequate support and maintenance for agencies of the State.

Source: Walker & Armstrong staff analysis of the State of Arizona, *Arizona Financial Transparency* data files for fiscal years 2023 through 2025, the State of Arizona *Annual Financial Report* for fiscal years 2023 through 2025, and Board-provided information.

Board did not resolve most complaints in a timely manner, which may affect patient safety

Board is responsible for investigating and resolving complaints against licensees

The Board is responsible for investigating and resolving complaints against licensees. Specifically, statute authorizes the Board to investigate and resolve complaints alleging that a licensee may be medically incompetent, is or may be guilty of unprofessional conduct, or is mentally or physically unable to safely engage in the practice of medicine.[5] Investigators working for health regulatory boards are tasked with evaluating the allegations of each complaint, determining what information is needed to investigate, and gathering evidence, as needed. Additionally, in some cases, the investigators are responsible for interviewing parties involved with the complaint and reporting their findings. The Board's complaint-handling process is similar to other health regulatory boards and includes assigning complaints to investigators based on their experience or area of expertise and designating each complaint a priority level that reflects the potential risk of harm to the public based on the nature of the allegation (see textbox, page 10). Although the Board expects investigators to use these priority levels to manage and prioritize their individual workloads, the Board did not operate using time frames for completing complaint investigations or resolving complaints.[6] The Arizona Auditor General has determined that Arizona health regulatory boards should investigate and resolve complaints within 180 days of receiving them to ensure timely enforcement and protection of the public.

The Board has internal medical consultants as part of its staff and contracts with medical consultants with a similar specialty as a licensee under investigation, to review complaints alleging quality-of-care deficiencies. For example, physicians may specialize in dermatology, cardiology, or emergency medicine.[7] The Board's investigators are responsible for reviewing each complaint case file and notifying the outside medical consultant coordinator when a case involves a medical specialty. The coordinator then determines whether the specialty is beyond the scope of the Board's internal medical consultants or whether the Board's internal consultants have the capacity to conduct a timely review. Based on this assessment, the coordinator is responsible for determining whether it is necessary to engage an outside medical consultant to ensure the complaint is appropriately and efficiently reviewed. If needed, the coordinator will then use the Board's internal list of previously contracted practitioners in the licensee's specialty to select someone who can assist with consulting on the case.[8]

[5] A.R.S. §§32-1403(A)(2) and 32-1451.

[6] See pages 16 through 18, for additional information on the Board's lack of time frames for key steps in its complaint-handling process.

[7] Physicians may obtain specialty certification by a board that specializes in one specific area of medicine and that may require examinations in addition to those required by Arizona to be licensed to practice medicine.

[8] The Board requires medical consultants to sign a confidentiality agreement and attest to having no conflicts-of-interest in cases they review.

Board's process for handling complaints

1) Board receives a complaint from the public or opens one internally.[1]
2) Intake officer determines if the Board has jurisdiction. If within the Board's jurisdiction, it sends a notice to the licensee and complainant that an investigation is being opened or sends to the executive director for dismissal if without merit.
3) Intake officer assigns a priority level (1-3) and an investigator to the case:
    - 1—sexual misconduct, drug or alcohol abuse, severe quality of care violation, such as inappropriate prescribing of medications resulting in death.
    - 2—violations of quality of care or professional conduct related to patient care that do not present imminent danger to the public (those not prioritized as level 1 or 3), such as failure to diagnose a medical condition.
    - 3—professional conduct complaints unrelated to patient care, such as failure to provide medical records or billing-related complaints.
4) Investigator sends a request for licensee response and subpoenas to licensee and involved parties, as applicable.
5) Investigator investigates the complaint—including receiving and reviewing documents, interviewing witnesses, and sending follow-up document requests—and writes the report.
6) Investigations manager reviews non-quality of care investigations or medical consultant reviews quality of care investigations report to ensure that adequate support for the investigation has been obtained and report is appropriate, then approves the complaint to proceed to step 7, for quality of care investigations, or step 8, for non-quality of care investigations, below.
7) Staff Investigational Review Committee (SIRC) reviews cases with substantiated violations and provides its recommendation to the Board.[2]
8) Executive director or Board may dismiss a complaint or refer the case to the Office of Administrative Hearings for a formal hearing or the Board may issue a disciplinary or non-disciplinary order.

[1] The Board opens complaints when applicants self-report unprofessional conduct during the initial or renewal application process or when background checks reveal undisclosed conduct considered unprofessional.

[2] The SIRC committee is comprised of the Board's staff, including its executive director, deputy executive director, investigations manager, chief medical consultant, and Board operations manager who review and determine the accuracy and completeness of the case file, obtain legal advice from the Board's assistant attorney general, and develop a recommendation to be presented to the Board for disciplinary or non-disciplinary action.

Source: Walker & Armstrong staff review of the Board's procedures and information provided by Board staff.

Despite 5 prior audit reports, spanning 43 years, recommending that the Board investigate and resolve complaints timely, it still has not done so due to various causes

Historically, the Board has not timely investigated and resolved complaints

Board performance audits conducted by the Arizona Auditor General as far back as 1981 all found that the Board had not investigated and resolved complaints in a timely manner. Additionally, although the Board made some improvements to address the recommendations made in the previous audits, some improvements were not sustained.

Specifically:

- **1981 performance audit found that Board member involvement and the use of informal interviews led to unnecessary delays in complaint resolution**

  The Arizona Auditor General's review of all complaints received between January 1, 1979 through June 30, 1980, found approximately 23% of complaints were not resolved within 180 days, and as of March 1981, approximately 10% remained open.[9] The Arizona Auditor General found that because Board members had limited time to dedicate to Board responsibilities and were involved in the investigation of complaints, the Board had delays in the investigation process. To address these delays, the Arizona Auditor General recommended that the Board decrease board members' participation in the complaint investigation process and require Board staff to conduct most of the investigation and to conduct formal hearings in all cases in which doctors are uncooperative with the Board. Although a follow-up report issued in 1982 indicated that these recommendations had been implemented, the follow-up report did not indicate if implementing this recommendation resulted in investigations being completed and complaints being closed more timely.

- **1994 performance audit found that the Board lacked a complaint prioritization process and needed to streamline its adjudication process**

  The Arizona Auditor General's review of complaints resolved in fiscal years 1992 through 1994 found that the Board's process to resolve complaints unrelated to malpractice took an average of 355 days and those arising from malpractice took an average of 1,159 days, or over three years.[10] The key recommendations to the Board were to develop and implement a formal process for prioritizing complaints, eliminate administrative delays, conduct an analysis to determine if additional resources are necessary to address delays, and to reduce its backlog. A follow-up report issued by the Auditor General in 1996 indicated that the Board had taken some steps to reduce its backlog and had developed a formal process for prioritizing complaints but did not eliminate administrative delays, such as Board staff identifying and assigning cases to outside medical consultants or requesting responses from licensees.

- **1998 performance audit found that the Board needed to use management information reports to identify where backlogs may be occurring**

  The Arizona Auditor General's review of 52 non-malpractice complaints closed in fiscal year 1997 found that the Board was taking an average of 200 days to resolve complaints, but that 15 of 52 complaints took from 255 days to approximately 6 years to resolve.[11] The key recommendations to the Board were to develop and use management information reports to better determine where backlogs may be occurring; request medical records from licensees or their employers in a timely manner; and to assign file reviews to a medical consultant and Board member within established time frames. The follow-up report issued in 2001 indicated that the Board had developed management reports to track the overall status and age of complaints but

[9] See Arizona Auditor General report 81-11 *Board of Medical Examiners—Performance Audit*.

[10] See Arizona Auditor General report 94-10 *Board of Medical Examiners—Performance Audit*.

[11] See Arizona Auditor General report 98-16 *Board of Medical Examiners—Performance Audit*.

that it did not prevent individual complaint investigations from languishing. During the follow up audit, auditors raised this concern with Board management, and the Board reported that it had developed a report that would identify cases that had been inactive for 30 days and that it planned to follow up with the assigned investigators when such delays were identified.

- **2011 performance audit found that the Board needed additional information to determine overall complaint timeliness and timeliness of key steps in the complaint-handling process**

  The Arizona Auditor General's review of complaints investigated and resolved in fiscal year 2010 found that 76% of complaints requiring board action were not resolved within 180 days.[12] The key recommendations were for the Board to develop a report to capture additional complaint-handling timeliness information to help identify and address factors in the process that may impact timeliness and that the report should include a priority level so the Board can assess whether complaints are processed within required time frames according to assigned priority. The Arizona Auditor General's 24-month follow-up report found that the Board implemented the recommendations.

- **2017 performance audit found delays in the complaint resolution process resulted from difficulties in finding outside medical consultants timely to review cases, SIRC review, and the frequency of Board meetings**

  Similar to prior audits, the Arizona Auditor General found in its 2017 performance audit that more than 24% of complaints received in calendar year 2016 took longer than 180 days to resolve, ranging from 181 to 428 days.[13] The Board continued to have delays in its complaint handling processes for record requests, outside medical consultant (OMC) reviews, SIRC reviews, and Board action. At the time of the review, the Board reported taking steps to resolve these delays, including hiring additional staff and holding additional SIRC and Board meetings. However, because these steps had recently been implemented, the Arizona Auditor General was unable to determine their long-term impact on the complaint resolution process. The Arizona Auditor General's recommendations were to continue to implement the measures it adopted to address the delays, assess the impact of these measures, and take any additional actions needed to resolve delays.[14] The Arizona Auditor General, in its 6-month follow-up report, determined that the Board had implemented the recommendations.

[12] See Arizona Auditor General report 11-04 *Board of Medical Examiners—Performance Audit*.

[13] The Arizona Auditor General reported that 24% of complaints were not resolved in 180 days, ranging from 181 to 428 days. Additionally, 24% of complaints received in calendar year 2016 remained open at the time of the review. Of the complaints that remained open, just over half had been open for more than 180 days.

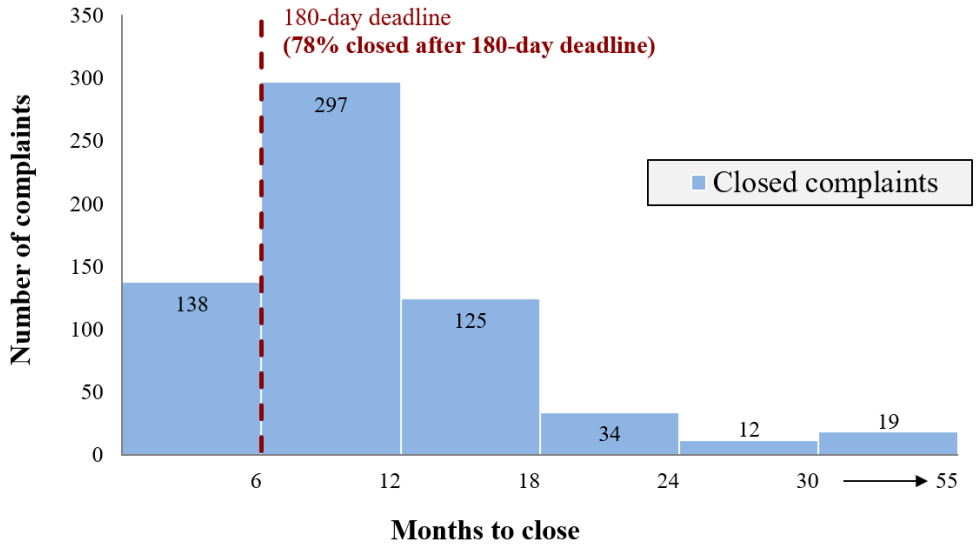
[14] See Arizona Auditor General report 17-107 *Board of Medical Examiners—Performance Audit*.

Despite continued findings and recommendations, the Board did not resolve most complaints closed in fiscal year 2024 within 180 days, and the majority of open complaints had been open longer than 180 days

Similar to issues found in the Board's previous 5 performance audits and sunset reviews, the Board still has not resolved complaints within 180 days. Specifically, our review of the Board's complaints database found:

- The Board took more than 180 days to resolve 487 of 625 complaints, or 78%, that it closed in fiscal year 2024 (see Figure 1), consisting of 5 priority 1 complaints, 468 priority 2 complaints, and 14 priority 3 complaints. The Board took between 181 and 1,653 days—or nearly 4.5 years, to investigate and resolve or refer these 487 complaints to the Office of Administrative Hearings for a formal hearing. These complaints included allegations such as a licensee sexually harassing staff, inappropriately performing surgical procedures, inappropriately prescribing controlled substances, including prescribing high-dose opioids without justification, and failure to query the Controlled Substances Prescription Monitoring Program (CSPMP) as required.

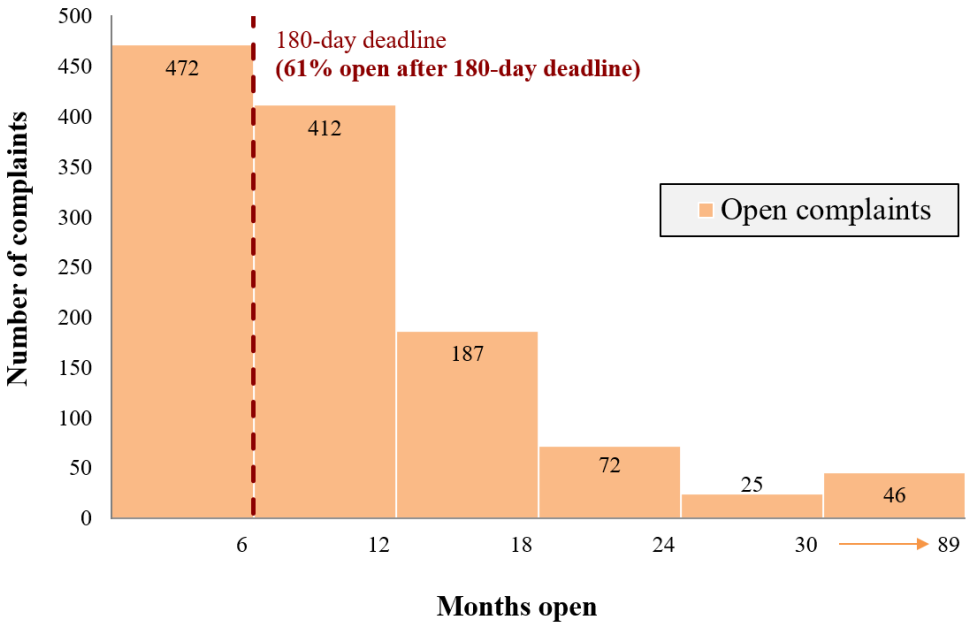
Figure 1: Board took more than 180 days to resolve 487 of 625 complaints, or 78%, that it closed in fiscal year 2024



Source: Walker & Armstrong staff analysis of complaints closed in fiscal year 2024 as indicated in the Board's database.

- As of June 30, 2024, 742 of the Board's 1,214 open complaints, or 61%, had been open for more than 180 days (see Figure 2, page 14), consisting of 23 priority 1 complaints, 700 priority 2 complaints, and 19 priority 3 complaints. These 742 complaints had been open between 184 days and 2,669 days—or more than 7 years, as of June 30, 2024. These complaints included allegations such as sexual harassment, improper procedures being performed resulting in paralysis, and inappropriate prescribing of controlled substances, including increasing dosage without cause, and failure to query the CSPMP.

Figure 2: 742 of 1,214, or 61%, of Board's open and unresolved complaints had been open longer than 180 days, as of June 30, 2024



Source: Walker & Armstrong staff analysis of complaints indicated as open in the Board's database as of June 30, 2024.

Board's failure to timely resolve complaints may negatively affect patient safety and may cause undue burden for licensees under investigation for lengthy periods of time

Untimely complaint resolution may negatively impact patient safety when delays allow licensees to continue to practice while under investigation for allegedly violating standards of care or committing other violations indicating that they may be unfit to do so. For example:

- In one instance, the Board took 1,141 days, or more than 3 years, to resolve a complaint alleging a licensee failed to comply with the standard of care by not obtaining consent from a patient prior to conducting a procedure that was not medically necessary. Almost 9 months after receiving the first complaint, the Board received a second complaint alleging that the licensee performed surgery on a patient who had a recent infection at the surgical site, did not inform the patient of the associated risks, failed to obtain consent before the procedure, and provided inadequate post-operative care, treatment, and communication. During the Board's investigation, it received 2 additional complaints for the licensee. The Board substantiated the allegations and ordered a letter of reprimand with probation, which included practice restrictions, against the physician's license. However, the licensee was allowed to continue practicing for more than 3 years while under investigation, and therefore, may have continued to provide patient services that fell below the standard of care during that time, leaving the public at risk.

- In another instance, the Board took 1,653 days to resolve a complaint alleging deviations from the standard of care and unprofessional conduct by allowing a radiology practitioner assistant to independently perform procedures on at least 4 patients while the licensee was out of the state

and charging patients for services not provided. The Board ultimately issued an advisory letter for failing to retain medical records, inadequate documentation, charging a fee for services not rendered, obtaining a fee by misrepresentation, and for allowing a practitioner assistant who was inadequately supervised to perform procedures. These practices created a substantial risk to patient safety, compromised the quality and continuity of medical care, and resulted in potential financial harm through deceptive billing practices. However, despite these risks, during the investigation, the licensee maintained an active license and was allowed to continue practicing without restriction for more than 4.5 years. As a result, the licensee may have continued providing inadequate care, potentially placing additional patients at risk, and undermined regulatory oversight and public trust of the medical profession.

In addition, even when the Board does not substantiate and dismisses complaints, untimely complaint handling subjects licensees to unproven allegations of professional or harmful conduct for longer than necessary. Untimely complaint handling may also create an undue burden for licensees who are under investigation, as they may be required to be responsive to Board requests for information or documentation for a lengthy period of time. For example, although the Board found that a doctor had not deviated from the standard of care, the Board took 1,101 days to dismiss a complaint alleging that the licensee failed to properly oversee a patient who showed clear warning signs of dangerous electrolyte imbalances that could lead to heart rhythm problems, fainting, or a life-threatening medical emergency. Finally, pursuant to A.R.S. §32-3214, the Board is required to make certain disciplinary history available on its website, but this information cannot be made available until the investigation is complete. As a result, delayed investigations can impede the public's access to licensee disciplinary information, which can be useful when making healthcare decisions.

Board failed to use its statutory authority and lacked time frames and performance expectations to help ensure timely complaint investigation and resolution

We completed an in-depth review of the complaints to determine the causes of the delays. Of the 20 complaints we reviewed, 17 were not resolved within 180 days.[15] Our assessment found that there were multiple contributing factors in most cases. Specifically, the Board:

- **Failed to timely issue subpoenas and request the court to enforce subpoenas when licensees or third parties failed to respond to information requests/subpoenas—**In order to obtain the information necessary to adjudicate complaints, statute authorizes the Board to issue subpoenas to licensees and third-parties who hold information, such as medical records, critical to the investigation process, and these subpoenas can be enforced by the Superior Court of Arizona.[16] However, the Board did not timely issue subpoenas or request the Superior Court enforce its subpoenas to help ensure licensees or third parties timely responded to its information request and subpoena deadlines. For example, in 6 complaints we reviewed in which the Board issued a subpoena, it took an average of 118 days for the Board to receive the subpoenaed information, and the Board did not request the Superior Court to enforce any of the subpoenas when

[15] We reviewed 20 complaints, including a stratified random sample of 15 of 649 complaints recorded in the Board's database as opened and closed in fiscal year 2024 and a random sample of 5 of 160 complaints that were opened in fiscal year 2024 that were open for more than 180 days at fiscal year-end.

[16] A.R.S. §32-1451.01(B).

individuals failed to meet the subpoena deadlines. The Arizona Auditor General reported in its 2017 performance audit that the Board's investigative staff worked with the Board's assistant attorney general to obtain information needed for the investigation from third parties and recommended that the Board continue to implement the measures it adopted to address delays. However, although the Board reports that it continues to work with its assistant attorney general to facilitate the release of records, third parties and licensees continue to not provide records timely, and the Board has not exercised its authority to file injunctions with the Superior Court to enforce its subpoenas, which could have reduced the time it took to resolve complaints.

- **Lacked time frames, associated performance measures, and tracking and monitoring for complaint-handling—**Despite recommendations from the Arizona Auditor General in its 1994, 1998, and 2011 reports to eliminate administrative delays and to develop and use management reports to identify delays and address factors and delays within the Board's control, the Board had not established time frames for some key steps in the complaint-handling process or adopted performance goals or benchmarks for timely complaint resolution, likely contributing to its continued untimely resolution of complaints. For example, our review of the 15 complaints that were opened and closed in fiscal year 2024 found:

    - For 6 complaints, the Board took an average of 76 days after receipt of the complaint for initial information requests to be sent to licensees. Although the Board had established a policy to inform licensees that a complaint has been filed against them, the Board lacked required time frames for its staff to send initial information requests to the licensee.

    - For 7 complaints, it took an average of 83 days for the Board's staff to issue a dismissal or closure letter following the executive director's dismissal or administrative closure of the complaint. The Board had not established a required time frame for dismissal and closure letters to be sent to licensees.[17]

  Board management reported that it managed complaints on a case-by-case basis and found it challenging to assign time frames for key steps in the investigation process due to the variability of circumstances related to each complaint. In response to previous performance audit and sunset review reports, the Board developed a report within its investigations database that could be used to monitor the progress of some key steps in each investigation. The Board's investigations manager reported reviewing this report and staff workloads and regularly inquiring about individual case progress. However, the Board lacked policies and procedures outlining a process and requirements for regularly and consistently tracking and monitoring complaint-handling timeliness. Although the Board had an informal process to review and identify delays, it did not require Board staff to address delays within the investigative process that were not subject to variating circumstances. For example, the Board did not establish time frames for staff to issue dismissal or closure letters to licensees after the Board made a final decision, despite this process being consistent for all complaints. Additionally, as discussed in Finding 2, the Board did not develop productivity or quality standards for investigative staff, and investigators were expected to manage their own caseloads without oversight (see pages 20 through 23, for additional information on the Board's lack of performance measures for Board staff).

[17] A.R.S. §32-1405(C)(21) authorizes the Board to delegate authority to its executive director to dismiss unsubstantiated complaints after the Board's investigation.

Lastly, the Board's previous and current executive directors reported that the reason for delays in the complaint-handling process was due to a shortage in staffing. Although additional staffing may be necessary to more timely resolve complaints, as discussed in Finding 2, pages 23 and 24, the Board's previous and current executive directors did not evaluate Board staffing needs, reallocate resources, or fill vacant positions. If the Board's previous and current executive directors had conducted a workload analysis to support additional staffing requests or determined whether it could reallocate resources from other current staff positions, the Board may have been able resolve complaints more timely and could have reduced its growing backlog.[18] For example, if the Board were to reallocate staffing, it could have closed approximately 705 additional complaints in fiscal year 2024 (see Table 3 and Finding 2, pages 23 and 24, for additional information on how the Board could reallocate staff).

Table 3: Potential fiscal year 2024 impact of reallocating Board staff

Number of reallocated staff	15
Average complaints closed per investigator [1]	47
Additional closed complaints	**705**

[1] Total complaints closed in fiscal year 2024 divided by the number of investigative staff, excluding administrative assistants.

Source: Walker & Armstrong staff review of fiscal year 2024 complaints and staffing information provided by the Board.

- **Lacked a time frame for outside medical consultants to accept or reject a case for review—** The Board provided complaint case files to outside medical consultants for review, but did not have a policy for nor did it require them to respond within a specified time frame as to whether they were independent and had availability to review the cases (see pages 9 and 10 for information on the Board's complaint-handling process). Specifically, 6 of the complaints we reviewed that were opened and closed in fiscal year 2024 took approximately 82 days before an outside medical consultant accepted the case. Similarly, a 2017 performance audit issued by the Arizona Auditor General identified delays related to the assignment of cases to outside medical consultants. The report noted that Board staff experienced difficulties finding physicians who had sufficient time to review complaints and who did not have potential conflicts of interest with the subject of the complaint.

  However, based on our inquiries with Board staff, our observation of the Board's process for obtaining outside medical consultants, and our review of complaints, we found that although some delays are attributable to specialty-specific issues, most cases could be reviewed by outside medical consultants already available to the Board. We further found that the Board's process for identifying and assigning an outside medical consultant involved contacting only one consultant at a time. Board staff indicated that this practice was intended to preserve working relationships with consultants by awaiting a response before offering the case to another physician. However, this approach further delays complaints involving physicians who may pose a risk to public safety. These delays could be reduced by establishing response deadlines for consultants, which would allow the Board to more promptly secure an outside medical consultant.

Because of similar delays identified in our 2025 performance audit for the PA Board, Board staff have begun developing procedures that establish time frames for more key steps in the complaint

[18] Our review of the complaints received and closed in fiscal year 2024 found that the Board's backlog grew by 428 complaints.

investigation process, including those we identified to have common delays. Our September 2025 walk-through of the new process found that although the Board's investigations manager had developed these time frames and started to evaluate investigation staff performance as it related to meeting these time frames, the new procedures were still in the development stage; therefore, we were unable to evaluate the effectiveness and efficiency of the new process.

Recommendations to the Board

1. Investigate and resolve complaints within 180 days.
2. Follow its established time frame for requesting subpoena enforcement from the Superior Court of Arizona after deadlines are missed.
3. Request the Superior Court of Arizona enforce subpoenas when licensees and/or third parties miss deadlines for providing subpoenaed information.
4. Finalize the development and implementation of policies and procedures that include required time frames for completing key steps in a complaint investigation, including how long it should take to send initial requests to licensees for a response to a complaint, issue subpoenas, time the Board may grant licensees to respond to complaint allegations or outside medical consultants to accept cases for review, and issue dismissal and closure letters.
5. Finalize the development and implementation of policies and procedures for tracking and monitoring complaint handling, including establishing a mechanism to document and track completion of key steps in the complaint-handling process and assigning responsibilities to Board staff to use management reports to actively monitor the progress of complaint investigations.
6. Continue its development and implementation of a formal process to review its tracking and monitoring of complaint handling to identify and address reasons for delays.
7. Require Board staff to regularly report to the Board on complaint timeliness, the reason for delays, and plans to resolve and prevent such delays in future complaints.

Board response: As outlined in its response, the Board agrees with the finding and will implement the recommendations.

Inconsistent with recommended practices, Board and executive directors delegated key responsibilities without establishing oversight and accountability mechanisms, potentially resulting in inefficient and ineffective operations, noncompliance with Board statutes and policies, and waste of public resources

Although the Board appointed an executive director to carry out functions of operating the Board, the executive director failed to oversee Board staff and did not develop and implement effective internal controls, resulting in an increased risk of fraud and wasted public resources. As discussed in the introduction (see pages 3 through 8), the Medical Board provides all administrative functions for the PA Board—including application processing, complaint investigations, website management, and general administrative support—because the PA Board has no staff of its own. Our performance audit and sunset review report of the PA Board in September 2025 found that its former executive director, who performed the same role for the Medical Board, delegated key responsibilities to staff without establishing oversight and accountability mechanisms.[19,20] Given that both boards depend on the same staff for fulfilling their statutory responsibilities, and the underlying deficiencies originated within the Medical Board's administrative operations, this report includes similar findings as those reported in the PA Board report.

In addition, despite having reviewed our performance audit and sunset review of the PA Board, our observation of Board member behavior from September 2025 through February 2026 found that the Board did not establish clear expectations or accountability for staff to implement necessary changes, potentially limiting progress toward effectively and efficiently conducting operations to fulfill its obligation to protect the public. For example, during our inquiries with a Board member, they reported that the Medical Board is one of the most challenging boards to work for and that most delays are not due to Board staff, but legal counsel. Additionally, members of the Executive Director Selection and Retention Committee expressed dissatisfaction with the executive director's suggestion for the Committee to stop the executive director's performance incentive payments in its February 2026 meeting. Specifically, Committee members stated that stopping the payments was inappropriate and that the executive director should continue to receive payments, consistent with other Board staff. The Board's executive director clarified the reasons for the recommendation to stop payments was due to not being approved in their employment contract, but Committee members were confused about why

[19] See Arizona Auditor General report 25-108 *Arizona Regulatory Board of Physician Assistants—Performance Audit*.

[20] The Board's former executive director retired in April 2025.

stopping these payments was necessary. Ultimately, based on the executive director's request, the Committee approved stopping the performance incentive payments to its executive director.

Although many of the deficiencies we initially identified were under the direction of the former executive director's leadership, our review found that the Board's current executive director assumed their role in April 2025 and had not demonstrated significant progress in improving Board operations as of March 2026.

Board's executive director is responsible for overseeing its day-to-day operations and should establish accountability mechanisms to ensure delegated responsibilities are performed as intended

Board statute assigns the executive director the authority to perform the Board's administrative duties and to employ staff necessary to carry out its functions.[21] According to the Government Accountability Office (GAO), although an entity's management should assign responsibility and delegate authority to achieve the entity's objectives, management retains responsibility for implementing internal controls, including establishing accountability mechanisms to ensure delegated responsibilities are performed as intended.[22] This includes monitoring that assigned duties are carried out in accordance with established requirements and within expected time frames.

In addition, the National State Auditors Association recommends that regulatory boards implement a systematic process to monitor staff performance, ensure compliance with policies and procedures, assess data reliability and operational effectiveness, adopt necessary improvements, and report on key outcomes.[23] This includes maintaining internal controls over financial activities, aligning resources with workload needs, and ensuring accurate and timely communication with the public and stakeholders.

Board's executive directors failed to establish oversight and accountability mechanisms for delegated responsibilities, resulting in potentially inefficient and ineffective Board operations and waste of public resources, poor performance, and noncompliance with statute and Board policies

The Board's former executive director failed to provide, and the current executive director failed to establish, oversight and accountability mechanisms, such as performance monitoring systems, management reports, and sufficient internal controls and policies, to ensure staff were appropriately performing key responsibilities delegated to them, resulting in potentially inefficient and ineffective Board operations; noncompliance with statutes and Board policies; increased risk of errors, abuse, and

[21] A.R.S. §32-1405(C)(1).

[22] U.S. Government Accountability Office. (2014). *Standards for internal control in the federal government* (GAO-14-704G). Retrieved May 31, 2025, from https://www.gao.gov/assets/gao-14-704g.pdf

[23] National State Auditors Association. (2004). *Carrying out a state regulatory program: A best practices document.* Retrieved April 19, 2025, from https://www.nasact.org/files/News_and_Publications/White_Papers_Reports/NSAA%20Best%20Practices%20Documents/2004_Carrying_Out_a_State_Regulatory_Program.pdf

fraud; potential waste of public resources; and reduced operational control that could diminish public confidence in the Board. Specifically:

- **Lack of centralized management for staff performance and inconsistent oversight and accountability resulted in poor performance and noncompliance with Board policy—**Board policy requires supervisors to establish productivity and quality standards and implement accountability measures for their employees, and the Board's former executive director delegated this responsibility to the Board's department managers. However, the Board's former executive director failed to establish oversight and accountability measures to ensure department managers fulfilled these responsibilities, resulting in inconsistent oversight and accountability for Board staff, poor staff performance, and noncompliance with Board policy. Specifically, based on interviews with Board supervisors and staff and review of documentation provided to demonstrate staff productivity, we identified that department managers set inconsistent expectations, inconsistently tracked and monitored staff productivity, and had limited assurance that critical functions were being performed efficiently or effectively. For example:

    - The Board's investigations department manager did not establish or document clear productivity and quality standards to ensure accountability, as required by Board policy. Instead, Board investigators were assigned complaints and expected to independently manage their caseloads. Additionally, although the investigations department manager reported reviewing staff workloads and regularly inquiring about individual case progress, as discussed in Finding 1, pages 9 through 18, the Board did not resolve within 180 days 78% of complaints it resolved in fiscal year 2024.

      As of March 2026, the Board had established a formal investigative timeline that establishes expectations for investigative staff to complete an investigation within 252 days, or 37 weeks. The Board's investigations manager reported that monitoring compliance with the timeline was time-intensive and that they were working with the Board's IT department to develop a system-based approach to track compliance rather than relying on manual processes. However, neither the IT department nor the investigations manager could provide an estimated timeline for when this system will be implemented. In the interim, the investigations manager indicated that they would select a sample of investigators and investigations to review to determine staff compliance with Board policy. Our review of the IT department's priority list found that projects are categorized into five levels: Priority 1 through Priority 4, and "Wish," with Priority 1 representing the highest priority and "Wish" being the lowest. Our review found that the IT department prioritized the investigations timeline project as "Wish" and did not assign an estimated completion date for the project.

    - The Board's chief operating officer (COO) required support services staff to work primarily in the office due to manual, paper-based processing of applications and payments, allowing supervisors to provide direct supervision and oversight of their staff. However, other departments—including licensing, complaints, and IT—permitted staff to work remotely but did not establish formal accountability measures for staff productivity and quality as required by Board policy. Instead, managers in these departments monitored staff performance and productivity using informal practices or subjective judgment, such as reviewing staff workloads and inquiring about individual case progress or holding informal team meetings to discuss the status of projects.

As of March 2026, the Board's executive director reported that none of the Board's departments, except for the changes noted above for the investigations department, had established formal accountability measures for their staff.

The Board's executive director reported that they anticipate that all departments will have accountability measures established by August 2026.

- **Ineffective time reporting and tracking practices increased the risk of errors, fraud, and abuse—**The Board's former executive director delegated responsibly for payroll-related functions to the Board's COO, but did not establish oversight and accountability measures to ensure staff were only paid for actual hours worked across the Board's various departments. Specifically, although the COO required department managers to approve time reports each pay period, most department managers required staff to submit total hours worked at the end of each pay period, and department managers used inconsistent methods for tracking and/or verifying the number of hours worked reported by their staff. For example, since employees were not required to enter time daily or otherwise support the amount of time actually worked, they had the ability to include hours they did not work in their pay period reporting, which managers may have overlooked and ultimately approved based on inconsistent and informal methods of review. Without consistent and formal time tracking and oversight methods, there is an increased risk of inaccuracies or intentional overreporting, resulting in ongoing payroll errors and potential fraud and waste of public funds.

  As of March 2026, the Board's new executive director reported that processes had not changed since they took the position in April 2025, but that the Board was testing a new approach that would require all staff to record their time daily using a centralized system. Under this new approach, employees would use an online form to log when they start and stop work each day, similar to a timecard system. Employees would be responsible for clocking themselves in and out each day. The executive director also noted that the Board is in the process of determining how to address situations where employees forget to clock in or out, but had not established a process to monitor the daily timesheets to investigate unusual or unexpected time entries. The executive director reported that the new process is expected to be implemented by August 2026.

- **Lack of IT project performance measures resulted in Board spending more than $3.2 million on IT without ensuring systems worked as needed to operate efficiently, potentially wasting public monies—**The Board's former executive director failed to establish documented performance metrics and accountability mechanisms for IT projects, despite the Board spending more than $3.2 million over 2 fiscal years on IT staff and contractors. This lack of oversight and accountability resulted in operational inefficiencies and potential waste of public monies. For example, when we requested information on IT staffing responsibilities, we found that Board IT staff and contracted IT providers had many duplicated responsibilities. Additionally, despite the millions of dollars spent on IT over 2 fiscal years, which largely consisted of paying the salaries of 5 IT staff and 4 IT contractors, during the audit, the Board's website could not process most license applications or accept credit card payments; instead, Board staff had to process applications and credit card payments manually, including 1 employee who spent the majority of their 40-hour work week manually processing credit card payments.

  Our review in March 2026 of the Board's IT department found no significant changes in its operations in response to the findings reported in the PA Board report in September 2025.

Specifically, the Board's website continued to be incapable of processing and accepting license applications or credit card payments. Although the Board's IT director reported this implementation as being a priority, the project has been in-process for more than a year.

The Board's executive director reported that monitoring tools had been developed to improve workload management and accountability; however, the IT director was not aware of a fully implemented tool. Rather, the IT director indicated that preliminary processes have been outlined to evaluate IT projects, but they had not established accountability measures to ensure staff remain productive. For example, the Board did not develop a process to measure IT staff productivity, define performance metrics, or establish a way to hold staff accountable for meeting those expectations. The Board's executive director reported that the Board expects to develop performance metrics and accountability measures for IT staff by August 2026.

- **Staffing resources were mismanaged, contributing to performance shortfalls—**As previously discussed, the Board did not timely investigate and resolve complaints. The Board's former and current executive directors attributed this issue to insufficient staffing. However, they lacked a staffing or workload analysis to support this conclusion. Additionally, they reported that when an investigator experienced a high workload, the Board preferred not to reassign cases so they could use delays as grounds for termination—prioritizing personnel issues over timely resolving complaints to protect the public.

  Although the Board's executive director reported that they intend to conduct a workload analysis for all staff, our March 2026 review found that a process had not yet been established. The executive director reported that, before developing the analysis, the Board plans to first define accountability measures for staff, determine how those measures will align with the workload analysis, and establish appropriate goals. Once the measures and goals are in place, the executive director plans to develop a process to conduct a workload analysis to assess whether staffing adjustments are needed. However, the executive director was unable to provide an estimated completion date for when this process will be implemented.

  Furthermore, the Board's executive director continues to request additional staffing without considering alternative options. Specifically, our March 2026 review found that the executive director had not considered reallocating current staff to align with operational needs. For example, the Board's licensing department had 15 full-time equivalent (FTE) staff and completed most applications significantly faster than what is required. Specifically, although the Board has up to 120 days to approve most initial applications, the Board approved 3,957 of 4,785, or more than 82%, of applications it received in fiscal year 2024 within 10 days.[24] Meanwhile, only 22% of complaints closed by the Board in fiscal year 2024 were closed within 180 days. Had the Board allocated more of its staffing to its investigations department, the Board could have continued to meet its required time frame for approving applications while resolving complaints more timely. When we inquired with the Board's executive director on whether this reallocation would be plausible, they reported that their licensee base has a specific expectation of the Board, and in order for the Board to meet that expectation, it would require them to continue processing applications as fast as possible.

[24] Based on Walker & Armstrong staff analysis of the applications that were received in fiscal year 2024 and approved or denied as of our September 2025 review, more than 98% were processed within the Board's required time frames.

However, because the Board processed most applications within 10 days, if it had reallocated 8 FTE from licensing to investigations, the Board likely could have continued to process most applications within 30 days, while resolving complaints more timely.[25] Additionally, the Board could use Arizona Department of Administration (ADOA) and Central Services Bureau (CSB) services, consistent with other regulatory boards, for accounting and IT services, which could further allow the Board to use its current staffing to more effectively meet its statutory objectives and protect the public by reducing unnecessary expenditures for IT and accounting services (see Table 4 and Table 3, page 17, for more information on potential reallocation of staff and the effect on complaint resolution timeliness).

Table 4: Potential reallocation of FTE staff

Department	Current FTE allocation	Increase (decrease) in FTE	Alternative FTE allocation
Executive	3	-	3
Investigations	18	15	33
Medical consultant	3	-	3
Licensing	15	(8)	7
Board operations	4	-	4
Support services	5	(3)	2
Information technologies	5	(4)	1
Total FTE staff	53	-	53

Source: Walker & Armstrong staff analysis of filled Board FTE positions as of February 2026 and potential changes based on information provided by the Board.

Further, even if the Board was appropriated more FTE, the Board has not been able to fill the positions it has already been appropriated. Specifically, between April 2025 and February 2026, the Board's filled FTE positions decreased by 3. The executive director reported that although the Board had the funding to fill these vacancies, there were other considerations leading to these FTE not being filled. As of March 2026, the Board reported that it had not filled 2 of its 3 open positions because the available candidate pool did not meet the requisites for the positions, and the deputy director position had been intentionally left vacant while the executive director determines the qualities needed for the role. In addition, the Board reported that although it is appropriated 63.5 FTE, it does not have the funding to pay salary and benefits, and therefore continues to request additional FTE to get approved for additional funding. However, our review of the Board's staff salaries found that many of the Board's employees are paid the maximum amount according to the ADOA pay scale for the positions, which uses more of the Board's resources for less people. In addition, as discussed previously, the Board uses a significant amount of its funding for IT, which likely contributed to limiting its available resources for staffing.

- **Staff performance incentive pay program was not aligned with many of the Board's statutory objectives**—The Board's former executive director did not evaluate whether the established performance metrics and related incentive payments were effective to support operational efficiency and the Board's overall objectives. Statute authorizes the Board's executive director to establish a performance incentive pay program based on the Board's goals and

[25] Based on Walker & Armstrong staff analysis, processing of the same number of applications by 7 FTE would result in a marginal increase in the amount of time to issue a license. For example, if the Board processes most applications within 10 days with 15 FTE, it could likely process applications within 22 days with 7 FTE.

objectives for the purpose of promoting efficiency and effectiveness.[26] Despite the Board's staff receiving performance pay of over $1.2 million since 2015, these performance measures excluded several key Board functions, including but not limited to issuing physician assistant licenses, renewing medical doctor and physician licenses, timely investigating complaints, providing licensee information to the public, and completing IT projects to eliminate manual processes and improve the Board's efficiency.[27] As a result, the program provided incentive payments to staff whose work was unrelated to some key performance measures and in some cases, was disbursed despite poor departmental performance, such as investigative staff who did not timely investigate and resolve complaints receiving incentives for timely approval of license applications, which undermines the program's purpose and fails to incentivize staff performance related to several of the Board's statutory objectives and purposes (see Appendix A, pages a-1 and a-2, for more information on the Board's performance incentive program.)

As of March 2026, the Board's executive director reported that the Board has not determined what changes it will make to the performance incentive program metrics to align staff's performance with Board objectives. Although the Board had begun reviewing what metrics could be used to make changes to the performance incentive program, no meaningful progress had been made.

- **Executive directors received incentive pay without formal Board approval, potentially violating Board statute—**Although State law requires the Board to set the executive director's compensation, the Board did not authorize incentive payments the Board's former executive director received as part of their compensation, as required by statute.[28] Specifically, the Board has not modified its incentive pay program since it reviewed and approved the program in 2002. Additionally, as previously discussed, the Board's policy states that all employees receive incentive pay. Our review of the Board's incentive pay program found the Board's former executive director received incentive pay as a Board employee prior to becoming its executive director in March 2014 and continued to receive incentive payments, which may have totaled up to $2,400 annually after assuming this role until they retired. Because the Board's chief operating officer calculates and provides incentive pay information to ADOA payroll, the former executive director did not authorize their own incentive pay. However, according to an inquiry with a Board member, the Board did not approve the pay for the former executive director but was under the understanding that they would receive the incentive pay.

  The Board's current executive director also received incentive pay as a Board employee prior to becoming executive director and continued to receive incentive payments until February 2026. We attended the Board's Executive Director Selection and Retention Committee in February 2026 and found that the executive director had requested that the Committee approve a suspension of incentive program payments to the executive director. The Committee expressed concerns regarding the need to suspend payments to the executive director but continue payments to other Board staff. The executive director clarified that the suspension of their incentive payments is due to the Board not having approved these payments as part of the executive director's

[26] A.R.S. §38-618.

[27] Based on Walker & Armstrong staff analysis of the State of Arizona *Financial Transparency* data files for fiscal years 2015 through 2024.

[28] A.R.S. §§32-1405(B) and 32-2505(B).

compensation. The Committee subsequently approved the suspension of incentive payments to the executive director. Additionally, in March 2026, the Board's current executive director reported that they were actively working with the Board's assistant attorney general to determine whether payments to the previous executive director violated statute.

- **Weak or non-existent internal controls in multiple areas increased the risk of errors, fraud, and diminished confidence in the Board and contributed to operational inefficiencies and statutory noncompliance—**During the audit, we identified multiple areas in which the Board's former executive director and/or Board staff to whom the former executive director delegated responsibilities failed to implement internal controls, including:

    - **Cash handling—**As discussed in Sunset Factor 2 (see page 33), the Board's executive directors failed to establish State-required cash-handling procedures that included separation of duties and verification between payments received and amounts recorded in the Board's licensing system, increasing the risk of errors and fraud. For example, because the Board received a large volume of applications by mail, it also received credit card information on many paper applications. Due to insufficient cash-handling controls, Board staff had the opportunity to conceal applicants' credit card information and potentially use or share it without detection.

    - **Expenditures—**The Board's procedures for processing expenditures failed to follow State requirements, including properly separating duties and ensuring compliance with State travel policies (see Sunset Factor 2, pages 33 and 34, for additional information).

    - **Conflict-of-interest—**The Board's conflict-of-interest policy requires Board staff to submit annual conflict-of-interest disclosure forms; however, the Board's COO, to whom the former executive director delegated responsibility for implementing the policy, stated they were unaware that the State's conflict-of-interest law applies to contracted employees. As a result, none of the Board contracted employees had submitted disclosure forms to the Board, increasing the risk that these employees did not disclose conflicts that could impair or affect their official conduct (see Sunset Factor 8, pages 39 through 41, for additional information).

    - **Public records—**The Board's former executive director also failed to ensure staff responded to public records requests in accordance with statutory and policy requirements, which resulted in providing inaccurate information to the public (see Sunset Factor 5, pages 35 through 38, for additional information), thereby risking diminished public confidence in the Board's transparency and accountability.

Former executive director implemented decentralized management approach that lacked verification and performance monitoring and current executive director has not made substantial changes

The former executive director used a decentralized management approach and reported that empowering department managers to independently oversee operations and manage their teams would motivate them and foster ownership, and reported trusting that managers were following policies and procedures and effectively managing their areas. In practice, this trust was not supported by verification or performance

monitoring, and the former executive director was unaware of several critical issues and, in some instances, was misinformed or not fully apprised of departmental practices.

Since taking the position in April 2025, the Board's current executive director reported that 2 of 6 departments have established preliminary productivity and quality standards, and the executive director will assess the effectiveness of these standards over time to determine any necessary changes prior to formalizing the productivity and quality standards in Board policy. Additionally, they reported that the remaining departments were in the process of developing productivity and accountability measures for staff. However, as of March 2026, the Board had not demonstrated substantial progress in performance monitoring over most Board operations.

Recommendations to the Board

8. Continue to establish and enforce productivity and quality standards for each department and position, and implement accountability measures consistent with Board policy to ensure performance expectations are met.

9. Finalize the development and implementation of policies and procedures for consistently tracking Board staff hours worked to help ensure that staff are compensated only for actual time worked and reduce the risk of abuse.

10. Evaluate the roles and responsibilities of Board IT staff and contractors to identify and eliminate unnecessary duplication and ensure IT expenditures are aligned with Board needs and priorities, including documenting its evaluation.

11. Continue to develop and implement performance monitoring measures, such as comparing budgets for financial resources and staff hours and evaluating adherence to deadlines, and establishing accountability measures for IT projects, including documenting disciplinary actions for missed deadlines, exceeded financial or labor budgets, and delivering poor quality work.

12. Conduct a comprehensive employee productivity and workload analysis to identify process inefficiencies and staffing challenges, support effective resource allocation, and justify staffing and budget requests.

13. Review the Board's performance incentive pay program and related policies to ensure alignment with measurable, meaningful performance outcomes tied to its key statutory objectives and purposes and staff responsibilities, and revise or eliminate components that do not drive accountability or results.

14. Implement a process to annually evaluate whether performance metrics and related incentive payments effectively support operational efficiency and the Board's overall objectives.

15. Continue to work with its assistant attorney general to review performance incentive payments made to the executive director since 2015 to determine if the payments violated statute and seek reimbursement for any unallowable payments.

16. Establish performance monitoring and verification procedures for all responsibilities delegated to department managers to help ensure the executive director can hold the managers accountable for meeting their delegated responsibilities.

Board response: As outlined in its response, the Board agrees with the finding and will implement, or implement in a different manner, the recommendations.

Board did not consistently act within or fully exercise its statutory authority, potentially resulting in unauthorized disciplinary action, premature dismissal of a complaint, and an increased risk to public safety

Statute grants the Board the authority to regulate licensees

A.R.S. Title 32, Chapter 13, Article 3 outlines the Board's authority to regulate licensees. The Board's authority includes investigating complaints, obtaining necessary information to adjudicate complaints, and what disciplinary actions the Board, and its committees, may take. Further, statute allows the Board to establish review committees that are authorized to take certain actions (see textbox). The Board established 2 review committees which it referred to as Committee A and Committee B.

Committee actions authorized by statute:

1. Dismiss the complaint
2. Require continuing education
3. File an advisory letter
4. Impose civil penalties
5. Refer the matter to the full Board

Source: Walker & Armstrong staff review of Board statutes.

However, our review found that the Board committees took actions inconsistent with what was allowed by statute. Additionally, our observations of Board and committee meetings found 2 instances in which the members of the Board were unaware of its authority and therefore did not consider all its options in making decisions. These issues are described below.

Issue 1: Committees fully adjudicated complaints and issued disciplinary actions not authorized by statute, resulting in potentially invalid and inconsistent discipline

Although statute authorizes the Board to establish review committees, the Board established and authorized committees to take actions inconsistent with what was allowed by statute. Specifically, we attended 4 committee meetings in June and August of 2025, and observed the committees issue 4 letters of reprimand and 1 letter of reprimand with probation to licensees without the statutory authority to do so. As a result, some disciplinary actions taken by these committees may not be valid. In addition, this approach results in disciplinary actions being determined by fewer Board members, which creates the risk of inconsistent discipline because committee members' experience, specialties, and statutory knowledge may vary, rather than uniform Board deliberation.

Board members and staff reported that the Board operated under a good-faith interpretation of the statutes, which expressly authorized the Board to delegate formal interviews to a committee, and interpreted that to mean that if a committee could conduct formal interviews, it could also make the determinations based on that interview, including deciding the outcome of the case and issuing disciplinary actions. Additionally, the Board reported that licensees voluntarily agreed in writing to participate in formal interviews conducted by Board committees and, by doing so, agreed to waive their right to a full evidentiary hearing and have the committees determine the outcome of their cases, including any resulting disciplinary action. The Board further reported that licensees were notified of their right to request a rehearing if they disagreed with disciplinary action imposed by a committee. However, our review of the Board's notifications to and written agreements with some licensees found that although the agreements stated that the formal interview process was voluntary, the Board did not consistently inform licensees until after they signed the agreements that their formal interview and any decisions on discipline would be conducted by a committee rather than the full Board. As a result, some licensees may not have fully understood that electing a formal interview allowed a smaller subset of Board members to determine the outcome of their case, potentially exposing them to disciplinary action that was inconsistent with that imposed on similarly situated licensees or requiring them to seek a rehearing if they disagreed with the committee's decision.

Additionally, our review of the Board's policies and procedures found that the Board lacked policies and procedures for formal interviews conducted by a committee established by the Board, including the actions the committee may take.

Upon bringing these issues to the attention of the Board in September 2025, the Board determined it would discontinue the use of committees, concluding that allowing committees to conduct formal interviews would further delay complaint resolution time frames because matters requiring certain disciplinary actions would still need to be scheduled for consideration by the full Board. Our review of the Board's website noted that no formal interviews were conducted in committee meetings subsequent to our August 2025 observation.

Issue 2: Board did not use its authority to enforce a subpoena and committee members failed to consider all options when the committee disagreed on action against a licensee, resulting in an increased risk to public health and safety and dismissal of the complaint

Our observation of an informal settlement conference with a licensee during the August 2025 Board meeting found that the Board had not obtained the medical records necessary to fully investigate a complaint. Although the Board had issued a subpoena requesting medical records be provided in January 2025, the licensee did not provide the requested records prior to the August 2025 Board meeting. Instead, the licensee was contesting the subpoena while seeking a settlement offer. During the public session of the Board meeting, the Board contemplated not entering a settlement offer and moving forward with obtaining its subpoenaed request. Since the licensee had not previously complied with the subpoena, a Board member inquired of its legal counsel what actions are available to enforce the subpoena when a licensee is noncompliant, and legal counsel reported that the Board had no other options available to them other than to find the licensee unregulatable and take the steps necessary to revoke their license. However, A.R.S. §32-1451.01(B)(3) authorizes the Board to apply to the Superior Court of Arizona to request the

court to issue an order to require the person to appear before the Board to produce evidence. The Board decided to provide the licensee more time to provide the records, further delaying the resolution of the complaint, and insisted that the licensee comply with the subpoena or the Board will be required to move forward with revocation.

Additionally, although committees are authorized to refer complaints to the full Board for further review, our observation of the Committee B meeting in June 2025 found that the committee did not consider this option in deciding the outcome of an investigation. Specifically, the Committee, comprised of 4 Board members, were divided on the action it would take after a formal interview with a licensee under investigation for allegations of unprofessional conduct. Two members stated that Board action was warranted and the other 2 members wanted to dismiss the complaint. The Committee performed a roll call vote twice before asking legal counsel, during an open public meeting, for advice on how to move forward when the Committee could not agree. Legal counsel indicated that if there was no finding of unprofessional conduct, there is no action the Board can take, and a member could make a motion to dismiss. However, A.R.S. §32-1451(P)(4) allows the committee to refer the matter for further review by the full Board.

Patient safety may be negatively impacted when the Board fails to use its authority to fully adjudicate complaints and do so in a timely manner. Specifically, by not enforcing subpoenas timely, the Board has contributed to untimely complaint resolution and increasing the risk to public health and safety (see Finding 1, pages 9 through 18, for more information regarding untimely complaint resolution). Furthermore, by failing to consider all its options when disagreeing on actions to take against a licensee, the Board's committee may have prematurely dismissed a complaint that warranted Board action.

The Board provides training to members on formal interviews and the investigation and adjudication processes; however, our review found that the training was not sufficient to address the issue we identified. Specifically, the training focuses on the statutory process in which formal interviews are conducted before the full Board and outlines available non-disciplinary and disciplinary actions the full Board can take, but it does not address procedures for resolving committee disagreements or the Board's role or enforcement authority related to subpoenas.

Recommendations to the Board

17. Develop policies and procedures in alignment with statute for formal interviews conducted by Board established committee, including the actions the committee may take.

18. Work with its Assistant Attorney General to determine what actions the Board should take to rectify the disciplinary actions previously issued by committees.

19. Provide comprehensive training to Board members on the scope of actions the Board is authorized to take in regulating licensees, including the process for issuing subpoenas and enforcing compliance through injunctions, ensuring members understand both common and less frequently utilized options.

Board response: As outlined in its response, the Board agrees with the finding and will implement, or implement in a different manner, the recommendations.

Pursuant to A.R.S. §41-2954(D), the legislative committees of reference shall consider but not be limited to the following factors in determining the need for continuation or termination of the Board. The sunset factor analysis includes additional findings and recommendations not discussed earlier in the report.

Sunset factor 1: The key statutory objectives and purposes in establishing the Board.

The Board's key statutory responsibility is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional MDs by: licensing, registering, and permitting qualified MDs and post-graduate students; investigating and adjudicating complaints about practitioners; and providing information to the public.

Sunset factor 2: The Board's effectiveness and efficiency in fulfilling its key statutory objectives and purposes.

The Board complied with statutory and rule requirements related to its statutory objective and purposes for 3 areas we reviewed. Specifically, the Board:

- **Generally reviewed and approved initial and renewal applications within required time frames—**The Board's administrative rules require it to approve or deny initial and renewal applications for license, registration, or permit between 20 and 240 days, depending on the type of application.[29] Our review of the Board's database for initial applications received in fiscal year 2024 that were issued or denied as of our September 2025 review found that the Board generally approved all 4,785 initial applications for licensure, registration, and permitting within the required time frames.[30] Similarly, our review of 10 of 1,050 renewal applications the Board received in fiscal year 2024 found that the Board approved the renewal applications we reviewed within the required time frames.[31]

- **Verified that initial applicants met licensure requirements for applications we reviewed—** Our review of a stratified random sample of 20 of 4,210 initial applications the Board received and approved in fiscal year 2024 found that the Board verified applicants' qualifications for licensure (see Table 1, page 4).[32]

[29] Arizona Administrative Code (A.A.C.) R4-16-206.

[30] Because the Board's licensing database does not capture the administrative start and stop dates for all application types, we were unable to evaluate whether the Board approved all initial applications for licensure within the required time frames. However, our review of a sample of applications initially identified as untimely indicated that those applications would have been approved within the required time frames had the system captured the administrative start and stop dates.

[31] The Board's licensing database does not capture the date a renewal application is submitted, as the system treats renewals as extensions of an existing license rather than new applications. As a result, the database does not record the date information is received. Due to the limitation of the Board's database, we were unable to assess the renewal application population to determine the Board's overall time frame for applicable applications.

[32] The Board received a total of 4,785 initial applications in fiscal year 2024; however, only 4,210 of those received were approved before fiscal year end. Our sample size was based on initial applications that were received and approved in fiscal year 2024.

- **Conducted continuing medical education audits and verified renewal applicants met licensure requirements for applicants we reviewed—**Our review of a random sample of 10 of 543 renewal applications that the Board selected for continuing medical education (CME) audits in fiscal year 2024 found that the Board conducted audits to ensure that licensees maintained appropriate documentation supporting compliance with CME requirements outlined in rule, and all licensees met continuing education requirements (see Appendix B, pages b-1 through b-3, for more information on our sampling methodology).[33]

However, we identified deficiencies in the Board's processes for 4 areas in which the Board can improve its effectiveness and efficiency in fulfilling its statutory objectives and purposes.

Specifically, the Board:

- **Did not evaluate the appropriateness of its fees, resulting in the Board potentially charging fees in excess of the cost necessary to provide services—**Government fee-setting standards state that fees should be reviewed periodically and align with the cost of providing services.[34] Based on our review of the Board's policies and procedures, financial information, and interviews of Board management and staff, the Board did not evaluate relevant information, such as historical or projected application growth, necessary for budget projections and lacked a formal process for analyzing employee productivity to assess staffing requirements. In addition to not having a well-developed budgeting framework as a basis to establish fees, the Board failed to implement a systematic approach for setting fees to align fees with the actual costs of delivering Board services. Based on our review of the Board's financial information, revenues from the Board's fees have exceeded its operational costs in each of the 3 years shown in Table 2 (see page 7). Board staff reported that fees were not a barrier to licensure and that the Board lacked the appropriate tools, resources, and training to properly assess fees and budgetary projections.

- **Failed to establish productivity and quality metrics for remote workers, resulting in noncompliance with State and Board policy, potentially limiting oversight and operational efficiency, and reducing the Board's ability to demonstrate that remote work arrangements effectively support the Board's objectives—**State remote work policies require boards permitting remote work to establish and enforce employee productivity and accountability standards.[35] Additionally, Board policy requires supervisors to implement performance metrics and monitoring processes to ensure that remote employees meet expected productivity and quality standards. Our observations and interviews of staff and Board management and review of reports provided by the Board found that the Board failed to establish productivity and quality metrics for all employees authorized to work remotely and lacked documentation to support the Board's evaluation of the metrics that are established.

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[33] A.R.S. §32-1434 requires the Board to select 10% of MDs, once every two years, to verify CME compliance. The Board utilizes its application database to randomly select the licensees for audit. The database randomly selects 3% of all renewal-eligible applications twice each year in June and December. Over a two-year period, this results in a 12% selection rate rather than 10% because the database does not capture the submission date of renewal applications. Selecting 12% ensures that the Board effectively audits 10% of licensees through random selection, despite this system limitation.

[34] We reviewed a legislative study on fee setting practices of government agencies. (See Appendix B, page b-2, for more information).

[35] Arizona Department of Administration. (December 2, 2020). *Remote Work Program (Policy #: ASPS/HRD-PA5.01).* Retrieved April 1, 2026, from /https://remotework.az.gov/sites/default/files/2021-09/ASPS-HRD-PA5.01_Remote_Work_Program_policy_12.2.20_PDF.pdf

See additional information in Finding 2, pages 19 through 27, regarding the Board's lack of oversight and performance metrics. We recommended that the Board establish and enforce productivity and quality standards for each department and position and implement accountability measures consistent with Board policy to ensure performance expectations are met.

Since bringing this to the Board's attention, the Board's investigations department has begun creating productivity standards for its investigation process. However, no similar standards have been created for the Board's licensing, medical consultant, Board operations, support services, or IT departments. The Board's executive director reported that because other Board priorities, such as temporarily converting all employees to work remotely due to the Board's workspace being flooded in November 2025, the Board has not yet prioritized creating productivity standards for all departments and hopes to have created these standards by August 2026.

- **Failed to implement an efficient process for accepting credit card payments, increasing the risk of errors and concerns related to data security—**Most of the Board's applications did not allow applicants to use a credit card to pay online. Because of this, the Board required applicants to mail in paper authorization forms with their credit card information. The Board's process required an accountant to manually process the credit card payments using a credit card machine, enter the payment in the licensing system, then shred the forms. Due to the high volume of mailed-in forms, a significant amount of staff time is devoted to this task, increasing the risk of manual entry errors and security concerns if the forms are not properly destroyed.

  The Board's staff have reported that its IT department is implementing a secure electronic payment option, which is expected to be effective in May 2026.

- **Executives were unable to separate incompatible duties, increasing the risk of errors, fraud, and misuse of public resources**—Our March 2026 review of the Board's policies and procedures and walkthroughs of the Board's processes found that the Board's chief operations officer (COO) and executive director did not separate incompatible duties among its staff. Specifically, Board staff handling cash receipts had multiple opportunities to conceal cash receipts without being detected. The Board's COO initially reported that due to the Board's size, separating duties was a challenge. However, the Board had more than 3 staff designated for accounting operations, which provided sufficient staff to properly separate duties. After bringing this to the Board's COO's and executive director's attention, the COO updated the Board's policy, but the policy still neglected to separate duties. In March 2026, the COO and executive director reported that they were in the process of working with the ADOA to update their policies and procedures to separate duties.

- **Failed to follow State requirements for expenditures, increasing the risk of errors, fraud, and misuse of public resources**—Our review of the Board's expenditures found multiple internal control deficiencies and noncompliance with State requirements that lead to wasting public monies, and the Board may have used funds for a non-public purpose.[36]

  Specifically, the Board did not:

[36] See Appendix B, page b-3, for information on our selection methodology.

- Ensure staff complied with State established maximum travel rates, resulting in potential waste.
- Ensure all transactions were properly approved.
- Book travel timely to ensure the most reasonable and economical means.
- Follow its policy to pay for airfare and accommodations in advance for its staff, as opposed to reimbursing staff for travel, and to require staff to submit travel reimbursement requests timely.
- Document a clear public purpose for purchases.

Board staff reported that the reasons for the identified deficiencies in our review period was due to an oversight and misunderstanding in State requirements, processes being overseen by previous management, and Board staff's misunderstanding of Board policies.

- **Did not establish accountability mechanisms for executive director's delegated responsibilities—**Although statute authorizes the executive director to perform the Board's administrative duties and employ staff necessary to carry out its functions, the executive director retains responsibility for internal control and oversight. However, as discussed in Finding 2, pages 19 through 27, the executive director did not implement accountability mechanisms—such as performance monitoring, internal controls, or management reporting—to verify that delegated responsibilities were performed in accordance with statutes, policies, and operational goals. This decentralized approach potentially resulted in inefficient and ineffective Board operations, inconsistent departmental practices, noncompliance with legal requirements, and potential waste of public resources. For example, staff time reporting and productivity tracking varied across departments, key functions lacked oversight, and the Board spent over $3.2 million on IT systems and services without ensuring functionality or accountability. In addition, the Board's incentive pay program lacked performance alignment and was applied inconsistently, and staffing decisions were based on assumptions rather than data. These deficiencies reduced operational control, hindered the Board's ability to fulfill its statutory responsibilities, and may have contributed to public transparency concerns and diminished trust in the Board's governance. We recommended that the Board establish and enforce productivity standards and accountability measures; conduct a comprehensive workload and staffing analysis; evaluate and streamline IT functions; review and revise the performance pay program; and ensure the executive director's compensation complies with statutory requirements (see page 27 for our recommendations to address these issues).

Recommendations to the Board

20. Develop and implement policies and procedures for periodically evaluating and setting fees to ensure its fees are structured based on the actual cost of the Board's operations.

21. Develop and implement a process to use relevant information, including historical and projected data, to develop the Board's annual budget request.

22. Finish implementing a secure electronic payment option to reduce reliance on mailed payments.

23. Develop and implement policies and procedures to separate incompatible duties for business functions including the receiving, depositing, recording, and reconciling of cash receipts; the requesting, approving, and recording of purchases; and entering and approving of accounting transactions.

24. Develop and implement written procedures to ensure compliance with State requirements and Board policy for expenditures, including processes requiring supervisor review and approval for all purchase requests in advance, as well as reviews to ensure each transaction complies with State requirements and has a documented public purpose.

Board response: As outlined in its response, the Board agrees with the findings and will implement the recommendations.

Sunset factor 3: The extent to which the Board's key statutory objectives and purposes duplicate the objectives and purposes of other governmental agencies or private enterprises.

Our review did not identify any other governmental agencies or private enterprises with the same key statutory objectives and purposes as the Board. For example, we did not identify any federal agency or private entity with authority to regulate the licenses overseen by the Board. Additionally, according to the U.S. Bureau of Labor Statistics and the Federation of State Medical Boards, all 50 states require physicians to be licensed by a state regulatory entity.[37,38]

Sunset factor 4: The extent to which rules adopted by the Board are consistent with legislative mandate.

Our review of the Board's statutes and rules found that the Board had adopted rules when required to do so and did not identify any Board rules that are inconsistent with statute.

Sunset factor 5: The extent to which the Board has provided appropriate public access to records, meetings, and rulemakings, including soliciting public input in making rules and decisions.

The Board has encouraged input from the public before adopting its rules and informed the public of its actions and expected impacts including providing licensees' disciplinary and non-disciplinary information on its website. Specifically, the Board:

- **Involved the public in adopting rules—**The Board informed the public of its rulemakings and their expected impacts and provided opportunities for public input for rules it finalized in December 2021 and December 2023. Specifically, the Board published notices of its proposed rulemakings in the Arizona Administrative Register and included a statement detailing the proposed rules' impact on the public. Additionally, the Board provided contact information in the notices for Board staff who would receive public input about the proposed rulemaking in the notices, as well as provided information on the time and place where a public meeting would be held.

[37] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Physicians and Surgeons, at https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4 (visited August 19, 2025).

[38] Federation of State Medical Boards, About Physician Licensure, How physicians gain licenses to practice medicine, https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure/ (visited August 19, 2025).

The Board received public input on its rulemakings finalized in December 2021 and December 2023. Accordingly, the Board's Notice of Final Rulemaking included a summary of the feedback provided, and provided an analysis and response to each comment, as needed.

Additionally, we reviewed the rulemaking finalized in October 2021 and found that this was an exempt rulemaking to align internal functions of the Board with a statutory change requiring the Board to collect a fee and process applications for telehealth within a specific amount of time. We reviewed Laws 2021, Chapter 320, and found the Board was exempt from A.R.S. Title 41, Chapter 6. Therefore, the Board was not required to follow the same requirements as nonexempt rulemakings. Our review found that the Board complied with the Arizona Administrative Code for the rulemaking process for exempt rulemakings.[39]

- **Posted public disciplinary information on its website for complaints we reviewed—**Statute requires the Board to publish certain information pertaining to licensee disciplinary histories, such as final non-disciplinary orders and disciplinary actions, on its website.[40] Our review of 15 of 625 complaints opened and closed in fiscal year 2024 found that the Board had properly posted the required information on its website.[41]

- **Complied with open meeting law requirements we reviewed—**The 4 Board meetings and 5 committee meetings we attended complied with the provisions of open meeting law we tested, such as providing the date and time of the meeting, members present, and description of matters considered.[42,43] The Board also posted required notices, including agendas, at least 24 hours prior to meetings and an audio recording of the minutes within 5 days of meetings and posted a statement on its website indicating the physical location of where its meeting agendas would be posted.[44] Additionally, we found that the Board stated the location of the meeting for the record in accordance with open meeting law requirements for the meetings we attended.

However, we identified 3 areas in which the Board can improve its provision of information to the public. Specifically, the Board:

Did not acknowledge the receipt of all public records requests—Statute requires that State agencies, including the Board, acknowledge the receipt of a public records request within 5 business days.[45] Additionally, Board policy requires acknowledgment of the receipt of public records requests within 24 hours of receiving the request. However, our review of the Board's public records request tracking log found it did not contain a field to document the date on which the Board acknowledged the receipt of a public records request. Additionally, our review of procedures and interviews with Board staff indicated that no acknowledgement of requests are

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[39] A.A.C. R1-1-901.

[40] A.R.S. §32-3214.

[41] A.R.S. §32-4801(A)(2).

[42] A.R.S. §38-431.01(C)(1).

[43] We attended Board meetings held in April, May, June, and August 2025, which included April, May, June and August 2025 Board meetings and April, June, and August 2025 Board Review Committee meetings.

[44] A.R.S. §§38-431.02(A)(1), 38-431.02(G), and 32-4801(A)(2).

[45] A.R.S. §39-171(B).

provided if the request is received by mail or fax; instead staff try to process them as quickly as possible so that the notification of receipt and the delivery of the requested information are satisfied at the same time. However, based on our review of logged requests, the Board took up to 20 days to provide the requested public records and therefore did not comply with statutory requirements to acknowledge the receipt of the request within 5 days or Board policy to acknowledge the receipt of the request within 24 hours.

Subsequent to our initial review, the Board updated its public records request log to include the date on which each public records request is acknowledged. Our review of the updated log found that the Board adopted the revised log in August 2025, which included dates of the request and acknowledgement.

- **Did not track all public records requests to ensure proper oversight—**Our review with Board staff found that the Board's process to document public records requests was not designed to ensure all public records requests received were able to be tracked and were completed. Specifically, Board staff did not add public records requests to the Board's public records request tracking log until after the request was satisfied. Our inquiries found that Board staff were tracking these requests using a variety of different methods, such as tracking them on a whiteboard and in their personal files. However, this process did not allow supervisors to oversee the public records request process, including outstanding requests and timely response to requests. As a result, the Board was unable to ensure all record requests that were received were responded to.

  Subsequent to bringing this to the Board's attention, it reported it changed its process to require staff to input public record requests on its public records request tracking log when the request is received.

- **Did not provide sufficient public information in response to anonymous phone calls we made—**Statute requires the Board to provide public information related to licensees on its website or upon request, such as the name, address of record, status of license, and disciplinary actions taken against the licensee by the Board.[46] As part of our procedures to obtain public information, we placed 5 anonymous phone calls to the Board and found in 3 of 5 calls we made, the Board's instructions on accessing information from its website were inadequate and did not provide us with accurate information. For example, Board staff did not provide the location on the Board's website to obtain the requested information or the details on how to make a public records request for information not available on the Board's website. In another call, Board staff informed us that a licensee had not received disciplinary actions by the Board and had an unrestricted license, despite currently being on probation.

Recommendations to the Board

25. Continue to ensure its staff are following the Board's policy to acknowledge the receipt of all public records requests within 24 hours of receipt of the request.

26. Continue to use its updated tracking log that includes a date in which each public records request is acknowledged.

[46] A.R.S. §32-1403.01.

27. Continue to require staff to input public records requests on its public records request tracking log at the receipt of the request.

28. Provide accurate information to the public regarding licensees as required by statute.

Board response: As outlined in its response, the Board agrees with the findings and will implement the recommendations.

Sunset factor 6: The extent to which the Board timely investigated and resolved complaints that are within its jurisdiction.

As discussed in Finding 1, pages 9 through 18, we found that the Board took longer than 180 days to resolve 487 of 625 complaints it closed in fiscal year 2024. Additionally, as of June 30, 2024, 742 of the Board's 1,214 open complaints had been open for more than 180 days. Although the Board has the statutory authority to subpoena records and request court enforcement when licensees or third parties fail to respond, it had not consistently issued subpoenas timely and did not request court enforcement for licensees that did not respond. Additionally, the Board lacked time frames and performance metrics to ensure timely resolution of complaints. As a result, untimely complaint resolution may negatively impact patient safety when delays allow licensees to continue practicing while under investigation for allegedly violating Board statutes and rules. Further, even when the Board does not substantiate and dismisses complaints, untimely complaint resolution subjects licensees to unproven allegations of unprofessional or harmful conduct for longer than necessary. We recommended that the Board resolve complaints within 180 days, use the full extent of its statutory authority to issue and enforce subpoenas, and establish and monitor time frames for completing key steps in its complaint investigation process.

Sunset factor 7: The extent to which the level of regulation exercised by the Board is appropriate as compared to other states or best practices, or both.

We compared Arizona's level of regulation to all 49 other states and found that the level of regulation the Board exercises is similar to most other states. Specifically:[47]

- **Education requirements—**Arizona and 47 other states require applicants to have graduated from an accredited physician program before becoming licensed, including post-graduate education. Montana and South Dakota require the completion of a residency program and all other states, including Arizona, only require 1 to 3 years of post-graduate training.

- **Examination requirements—**All 50 states require a passing score on the United States Medical Licensing Examination. Arizona, and 23 other states, require applicants to pass all 3 portions of the exam within a 7-year period.

  Thirteen states require applicants to pass all 3 portions of the exam in 10 years. Minnesota allows applicants 5 years between the 2nd and 3rd portion of the exam. The remaining 12 states lack a time requirement to pass the exam.

[47] Federation of State Medical Boards. (n.d.). *State Specific Requirements for initial medical licensure*. Retrieved August 20, 2025, from https://www.fsmb.org/step-3/state-licensure/#MD; American Medical Association. (n.d.). *U.S. State Requirements*. Retrieved August 19, 2025, from https://edhub.ama-assn.org/state-cme; and LocumTenens.com. (n.d.). *Physician Licensing Map*. Retrieved August 19, 2025 from, https://www.locumtenens.com/resource-center/interactive-tools/licensing-map

- **Continuing education requirements—**Arizona and 45 other states require documentation and submission of continuing education prior to license renewal. Specifically, Arizona and 20 other states require 40 hours of continuing education biennially. Twenty-five other states require 30 to 100 hours of continuing education, and Indiana, Montana, New York, and South Dakota do not have continuing education requirements.

- **Background check and fingerprinting—**Arizona and 37 other states require all applicants to provide fingerprints during the background check process for initial licensure, 8 states only require submission of fingerprints with the background check process if the applicant wants to participate in the interstate compact, 1 state requires a background check without fingerprints, and 3 states do not require a background check or fingerprints.

Sunset factor 8: The extent to which the Board has established safeguards against possible conflicts of interest.

We assessed whether the Board safeguards against possible conflicts of interest by reviewing its conflict-of-interest policies and practices. The State's conflict-of-interest requirements exist to remove or limit the possibility of personal influence from impacting a decision of a public agency employee or public officer. Statute requires employees of public agencies and public officers, including Board members, to avoid conflicts of interest that might influence or affect their official conduct.[48] These laws require employees/public officers to disclose substantial financial or decision-making interests in a public agency's official records, either through a signed document or the agency's official minutes. Statute further requires that employees/public officers who have disclosed conflicts refrain from participating in matters related to the disclosed interests.[49] To help ensure compliance with these requirements, the Arizona Department of Administration's (ADOA) State Personnel System employee handbook and conflict-of-interest disclosure form (disclosure form) require State employees to disclose if they have any business or decision-making interests, secondary employment, and relatives employed by the State at the time of initial hire and anytime there is a change.[50] The ADOA disclosure form also requires State employees to attest that they do not have any of these potential conflicts, if applicable, also known as an "affirmative no." Finally, A.R.S. §38-509 requires public agencies to maintain a special file of all documents necessary to memorialize all disclosures of substantial interest and to make this file available for public inspection.

Additionally, in response to conflict-of-interest noncompliance and violations investigated in the past, such as employees/public officers failing to disclose substantial interests and participating in matters related to these interests, the Arizona Auditor General has recommended several practices and actions to various school districts, State agencies, and other public entities.[51] Further, recommended practices for managing conflicts of interest in government and are designed to help ensure compliance with State

[48] A.R.S. §38-503.

[49] A.R.S. §38-509.

[50] Arizona Department of Administration (ADOA). (2024). *State personnel system employee handbook*. Retrieved 3/18/2025 from https://drive.google.com/file/d/12uumNZLSBkfp33AaL9uHym0K9e6I9_II/view

[51] For example, see Auditor General Reports 24-211 *Concho Elementary School District*, 21-404 *Wickenburg Unified School District—Criminal indictment—Conflict of interest, fraudulent schemes, and forgery*, 19-105 *Arizona School Facilities Board—Building Renewal Grant Fund*, and 17-405 *Pine-Strawberry Water Improvement District—Theft and misuse of public monies*.

conflict-of-interest requirements by reminding employees/public officers of the importance of complying with the State's conflict-of-interest laws.[52] Specifically, conflict-of-interest recommended practices indicate that all public agency employees and public officers complete a disclosure form annually. Recommended practices also indicate that the form include a field for the individual to provide an "affirmative no," if applicable.[53] These recommended practices also indicate that agencies provide periodic training to ensure that identified conflicts are appropriately addressed and help ensure conflict-of-interest requirements are met. Finally, recommended practices indicate that publicly disclosing board members' interest as the reason for refraining from participating in decisions is important for fully disclosing and memorializing the disclosure of interest as they relate to those decisions.

Our review found that the Board complied with most State conflict-of-interest requirements. Specifically, our review of the Board's conflict-of-interest forms found that in fiscal year 2024, the Board obtained conflict-of-interest forms from all Board members and staff and obtained attestations of independence from outside medical consultants who reviewed case files for all complaints we reviewed (see additional information on the Board's complaint process in Finding 1, pages 9 through 18). In addition, the form included a field allowing individuals to provide an "affirmative no." Additionally, Board members recused themselves from voting on meeting agenda items for which they had disclosed a substantial interest during 4 public meetings we attended, and the Board maintained a special file of all documents necessary to memorialize all disclosures of substantial interest, consistent with State requirements.[54]

Although the Board complied with most State conflict-of-interest laws, it had to not aligned its conflict-of-interest processes with some State requirements and recommended practices. For example, State conflict-of-interest laws require all State employees—including contracted employees—to disclose any substantial interests, and the Board's policies required Board staff to complete conflict-of-interest training and disclosure forms; however, the Board's policies did not include contract employees in its definition as Board staff.[55] As a result, the Board did not require 24 employees it contracted with in fiscal year 2024 to complete conflict-of-interest disclosure forms. In addition, although the Board's policies and procedures provide for training on conflicts-of-interest at the time a Board member or employee is onboarded, it lacks a requirement for annual conflict-of-interest training for Board members and staff, including contracted employees, inconsistent with recommended practices.

By not requiring contracted employees to complete conflict-of-interest disclosure forms and not implementing the recommended practice to provide periodic conflict-of-interest training to Board members and employees, the Board increased its risk that contracted employees engaged in tasks in which they had an undisclosed conflict. Subsequent to our initial review, the Board obtained conflict-of-

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[52] Recommended practices we reviewed included: The World Bank, Organization for Economic Cooperation and Development (OECD), & United Nations Office on Drugs and Crime (UNODC). (2020). *Preventing and managing conflicts of interest in the public sector: Good practices guide.* Retrieved 6/22/2025 from https://www.unodc.org/documents/corruption/Publications/2020/Preventing-and-Managing-Conflicts-of-Interest-in-the-Public-Sector-Good-Practices-Guide.pdf; Ethics & Compliance Initiative (ECI). (2016). *Conflicts of interest: An ECI benchmarking group resource.* Retrieved 6/22/2025 from https://www.ethics.org/wp-content/uploads/mdocs/2021-ECI-WP-Conflicts-of-Interest-Defining-Preventing-Identifying-Addressing.pdf; and New York State Authorities Budget Office (NYS ABO). (n.d.). *Conflict of interest policy for public authorities.* Retrieved 6/22/2025 from https://www.abo.ny.gov/recommendedpractices/ConflictofInterestPolicy.pdf

[53] As previously discussed, the ADOA disclosure form includes a field for the individual to provide an "affirmative no."

[54] Of the 9 public meetings we attended, the Board identified conflicts of interest in 4 meetings, and Board members appropriately recused themselves in those instances. The Board documented members' recusals within its meeting minutes, and Board members filed a form of the conflict for the Board's special file.

[55] A.R.S. §38-502.

interest disclosure forms from all contracted employees. We reviewed these forms in September 2025 and found that the Board obtained disclosures from all active contracted employees. Additionally, the Board's staff reported that they will provide annual conflict-of-interest training in the future, but have not updated its policy to include this.

Recommendation to the Board

29. Update its policy to require annual training on conflicts of interest for Board members, staff, and contracted employees.

Board response: As outlined in its response, the Board agrees with the finding and will implement the recommendation.

Sunset factor 9: The extent to which changes are necessary for the Board to more efficiently and effectively fulfill its key statutory objectives and purposes or to eliminate statutory responsibilities that are no longer necessary.

This performance audit and sunset review did not identify any statutory changes that are necessary for the Board to more efficiently and effectively fulfill its key statutory objectives and purpose. Nor did we identify any statutory responsibilities that are no longer necessary.

Sunset factor 10: The extent to which the termination of the Board would significantly affect the public health, safety, or welfare.

Terminating the Board would affect the public's health, safety, and welfare if its regulatory responsibilities were not transferred to another entity. As stated in Sunset Factor 1 (see page 31), the Board is responsible for ensuring that MDs are qualified to provide medical services and for investigating and adjudicating complaints against licensees alleging incompetence or unprofessional conduct. Additionally, the Board is responsible for disclosing pertinent information, including disciplinary history, about licensees to the public. These functions help safeguard the public by ensuring patients receive care from qualified practitioners and addressing misconduct that could harm individuals or communities. In 2024, Arizona had approximately 31,000 licensed MDs who provided healthcare services to Arizona residents.[56] Terminating the Board without an alternative regulatory framework could jeopardize the public's access to safe and effective healthcare from these practitioners.

[56] Based on the number reported in the Board's fiscal year 2024 annual report.

Walker & Armstrong makes 29 recommendations to the Board

Recommendations to the Board:

Finding 1 — 9

1. Investigate and resolve complaints within 180 days.
2. Follow its established time frame for requesting subpoena enforcement from the Superior Court of Arizona after deadlines are missed.
3. Request the Superior Court of Arizona enforce subpoenas when licensees and/or third parties miss deadlines for providing subpoenaed information.
4. Finalize the development and implementation of policies and procedures that include required time frames for completing key steps in a complaint investigation, including how long it should take to send initial requests to licensees for a response to a complaint, issue subpoenas, time the Board may grant licensees to respond to complaint allegations or outside medical consultants to accept cases for review, and issue dismissal and closure letters.
5. Finalize the development and implementation of policies and procedures for tracking and monitoring complaint handling, including establishing a mechanism to document and track completion of key steps in the complaint-handling process and assigning responsibilities to Board staff to use management reports to actively monitor the progress of complaint investigations.
6. Continue its development and implementation of a formal process to review its tracking and monitoring of complaint handling to identify and address reasons for delays.
7. Require Board staff to regularly report to the Board on complaint timeliness, the reason for delays, and plans to resolve and prevent such delays in future complaints.

Finding 2 — 19

8. Continue to establish and enforce productivity and quality standards for each department and position, and implement accountability measures consistent with Board policy to ensure performance expectations are met.
9. Finalize the development and implementation of policies and procedures for consistently tracking Board staff hours worked to help ensure that staff are compensated only for actual time worked and reduce the risk of abuse.
10. Evaluate the roles and responsibilities of Board IT staff and contractors to identify and eliminate unnecessary duplication and ensure IT expenditures are aligned with Board needs and priorities, including documenting its evaluation.

11. Continue to develop and implement performance monitoring measures, such as comparing budgets for financial resources and staff hours and evaluating adherence to deadlines, and establishing accountability measures for IT projects, including documenting disciplinary actions for missed deadlines, exceeded financial or labor budgets, and delivering poor quality work.

12. Conduct a comprehensive employee productivity and workload analysis to identify process inefficiencies and staffing challenges, support effective resource allocation, and justify staffing and budget requests.

13. Review the Board's performance incentive pay program and related policies to ensure alignment with measurable, meaningful performance outcomes tied to its key statutory objectives and purposes and staff responsibilities, and revise or eliminate components that do not drive accountability or results.

14. Implement a process to annually evaluate whether performance metrics and related incentive payments effectively support operational efficiency and the Board's overall objectives.

15. Continue to work with its assistant attorney general to review performance incentive payments made to the executive director since 2015 to determine if the payments violated statute and seek reimbursement for any unallowable payments.

16. Establish performance monitoring and verification procedures for all responsibilities delegated to department managers to help ensure the executive director can hold the managers accountable for meeting their delegated responsibilities.

Finding 3 28

17. Develop policies and procedures in alignment with statute for formal interviews conducted by Board established committee, including the actions the committee may take.

18. Work with its Assistant Attorney General to determine what actions the Board should take to rectify the disciplinary actions previously issued by committees.

19. Provide comprehensive training to Board members on the scope of actions the Board is authorized to take in regulating licensees, including the process for issuing subpoenas and enforcing compliance through injunctions, ensuring members understand both common and less frequently utilized options.

Sunset factors 31

20. Develop and implement policies and procedures for periodically evaluating and setting fees to ensure its fees are structured based on the actual cost of the Board's operations.

21. Develop and implement a process to use relevant information, including historical and projected data, to develop the Board's annual budget request.

22. Finish implementing a secure electronic payment option to reduce reliance on mailed payments.

23. Develop and implement policies and procedures to separate incompatible duties for business functions including the receiving, depositing, recording and reconciling of cash receipts; the requesting, approving, and recording of purchases; and entering and approving of accounting transactions.

24. Develop and implement written procedures to ensure compliance with State requirements and Board policy for expenditures, including processes requiring supervisor review and approval for all purchase requests in advance, as well as reviews to ensure each transaction complies with State requirements and has a documented public purpose.

25. Continue to ensure its staff are following the Board's policy to acknowledge the receipt of all public records requests within 24 hours of receipt of the request.

26. Continue to use its updated tracking log that includes a date in which each public records request is acknowledged.

27. Continue to require staff to input public records requests on its public records request tracking log at the receipt of the request.

28. Provide accurate information to the public regarding licensees as required by statute.

29. Update its policy to require annual training on conflicts of interest for Board members, staff, and contracted employees.

APPENDIX A

Details on the Board's performance incentive program

Background and monitoring

The Arizona Department of Administration (ADOA) and Arizona Board of Regents (ABOR) are authorized under A.R.S. §38-618 to establish a performance-based incentives program to improve efficiency and effectiveness across state agencies and universities by implementing performance programs tied to organizational goals. Agencies that elected to participate were required to develop performance measures for approval by the former Performance-based Incentive Program Oversight Committee (Oversight Committee), which conducted biannual reviews of program progress and expenditures. However, legislation repealed the Oversight Committee in 2014, eliminating the formal statewide monitoring structure.[57] As a result, current oversight is decentralized, relying on agency-level administration, ADOA/ABOR coordination, and limited statutory requirements, such as notification of substantive program changes, with no mandated standardized reporting or evaluation of effectiveness.

Our October 2025 and April 2026 inquiries of ADOA personnel and review of State financial records found that there are 5 State agencies, including the Arizona Medical Board, with performance incentive programs and that the ADOA performs routine check-ins with the agencies to ask whether agencies: (1) need to make any revisions or changes to their incentive program, (2) confirm that the program did not provide guaranteed payments to staff, and (3) whether the program is still driving performance.[58] The ADOA reported that the Board's former executive director reported in May 2024 that the Board's incentive program was effective and helped motivate staff. Results of the Board's incentive goals are calculated internally by Board staff and reviewed for payment by its COO; however, there is no Board member or external oversight of the program. Board staff reported that the Board is focused on the performance goals to ensure staff are able to receive the monthly incentives and that its IT department is working to develop a system dashboard that will monitor and display goal progress in real time.

Board's incentive program and goals

The Board established its incentive program and received a separately budgeted appropriation for funding incentives beginning in fiscal year 2003. All Board staff were eligible for incentive pay, including the Board's executive director. The Board reported that it was not aware of any changes to its program goal since the inception of the program. There were 3 measures and goals established to determine the amount of incentive pay eligible to each member of the Board's staff (see Table 5, page a-2).

[57] Laws 2014, Chapter 229.

[58] Based on Walker & Armstrong staff analysis of the State of Arizona, *Arizona Financial Transparency* data files for fiscal years 2021 through 2024, the Arizona Department of Administration, Arizona Department of Transportation, Arizona Game and Fish Department, Arizona Registrar of Contractors, and the Arizona Medical Board received incentive payments through the State's performance-based incentives program.

Table 5: Board performance goals and available monthly incentive

Measure	Goal	Weight	Incentive
The average days to approve a Medical Doctor license from receipt of the application.	30 days	33%	$ 66.67
Percent of resolution letters mailed within 15 days of a Board meeting.	95%	33%	66.67
Percent of cases noticed within 5 days of the date the case is initiated.	75%	33%	66.66
Total available monthly incentive			$ 200.00

Source: Walker & Armstrong staff review of Board-provided information.

Incentive payments

Each staff member was eligible for up to $200 per month, or $2,400 annually, based on the performance of the Board as a whole, regardless of whether an individual staff member contributed directly to the outcome.[59] For example, investigators do not contribute to the process of approving medical doctor licenses; however, if the Board met its goal of approving them in an average of 30 days, investigators would still be eligible to receive the incentive payment. If a measure is not met in a given month, the portion of the incentive attributable to the measure would not be paid out. For example, if the Board did not mail at least 95% of resolution letters within 15 days of the Board meeting for the month, staff would not qualify to receive the $66.67 attributable to the measure.

The Board's support services department calculated and paid the incentive for the previous month using data extracted from the Board's database.

[59] Board staff reported that under certain circumstances, such as part-time employment or leave without pay, the $200 incentive payment is prorated based on actual hours worked.

APPENDIX B

Scope and methodology

We have conducted a performance audit and sunset review of the Board on behalf of the Arizona Auditor General pursuant to a December 10, 2024, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq.

We used various methods to address the audit's objectives. These methods included reviewing the Board's statutes, rules, website, policies and procedures, and supporting documentation and interviewing Board members and staff. In addition, we used the following specific methods to meet the audit objectives:

- **License, registration, and permit issuance and renewal—**To determine whether the Board issued and renewed licenses, registrations, and permits in accordance with statute and rule requirements, we reviewed information from the Board's files and database for samples of applications, including initial and renewal applications approved or denied in fiscal year 2024. Our work included reviewing the application files and associated documents, such as transcripts, exam scores, proof of background check, and other applicable documents. The applications we reviewed were as follows:
    - A stratified random sample of 20 of 4,210 initial applications received and approved or denied in fiscal year 2024. The stratification population was divided by application type, and samples were chosen in proportion to each application's share of the total stratification population.
        - Fifteen applications were selected from initial MD license, postgraduate training permit, transitional training permit, and dental anesthesia registration applications.
        - Five applications were selected from MD universal license, temporary license, telehealth registration, MD education permit, teaching license, and pro bono registration applications.
    - A random sample of 10 of 1,050 renewal applications approved by the Board in fiscal year 2024 for MD license, MD universal license, and telehealth registration renewals.
- **Complaint-handling and timeliness of resolution—**We reviewed the Board's complaint files and database information for all publicly received complaints recorded in the Board's database as opened and closed in fiscal year 2024. Additionally, we used dates for when complaints were received and closed from the Board's database to calculate the number of days the Board took to resolve all complaints it closed in fiscal year 2024 and to identify the number of open complaints as of June 30, 2024, including those that had been open for more than 180 days. Further, we reviewed notes in the Board's database to determine priority levels assigned to complaints. Lastly, we reviewed previous initial and follow-up performance audit reports issued by the Arizona Auditor General between 1981 and 2017.

- **Public information—**We reviewed non-disciplinary and disciplinary information on the Board's website for complaints selected for testing and placed 5 anonymous phone calls from between January 2025 and September 2025 to assess whether the information provided was accurate and consistent with statutory requirements. We assigned 5 Walker & Armstrong staff to call the Board during business hours and ask a series of questions to determine whether Board staff would provide public information and/or non-public information.

  We created 15 questions related to 5 licensees (three questions per licensee) to ask Board staff; some of the questions were items the Board staff should provide and others were items they should not provide. To remain anonymous, so calls were not associated with Walker & Armstrong, the calls were made using our personal phone numbers, instead of using our business lines.

- **Fee setting—**To assess the Board's fee-setting practices, we interviewed the Board's 2024 executive director, deputy director, and chief operating officer; reviewed and compared the Board's statutes, rules, and policies; and reviewed the Board's revenues, expenditures, and fund balance for fiscal years 2023, 2024 and 2025. In addition, to determine whether the Board appropriately established fees, we interviewed Board staff and reviewed the applicable statutes, Board-provided information, rules for the Board's fees, and a study of fee-setting practices of government agencies.[60]

- **Conflicts of interest—**To assess the Board's compliance with State conflict-of-interest requirements, we reviewed the Board's sunset factor response and evaluated whether the Board's conflict-of-interest practices comply with the State's conflict-of-interest statutes (A.R.S. §38-501 et seq. and the Arizona Attorney General's Agency Handbook, Ch. 8) and recommended practices by: reviewing the Board's policies, procedures, and processes for ensuring the Board complies with the State's conflict-of-interest statutes and recommended practices; and reviewing the Board's compliance with State conflict-of-interest requirements and its policies and procedures by reviewing employee/contracted employee/Board member conflict-of-interest disclosure forms for 2024, reviewing the Board's special file of conflict-of-interest forms, reviewing Board meeting minutes for fiscal year 2024, and observing Board and committee meetings held between April 2025 and August 2025 to observe the Board's process during meetings.

- **Introductory information—**To obtain information for the introductory section of our report, we reviewed the Board's website, the Arizona State Library's website for agency history, information provided by the Board regarding staffing, previous open session laws, and active licenses as of February 2026. In addition, we compiled and analyzed unaudited financial information from the Board-provided financial data, the State of Arizona *Arizona Financial Transparency* data files, and the State of Arizona *Annual Financial Report* for fiscal years 2023, 2024, and 2025.

[60] Mississippi Joint Legislative Committee on Performance Evaluation and Expenditure Review. (2002). *State agency fees: FY 2001 collections and potential new fee revenues* (Report No. 442). Retrieved February 18, 2025, from https://www.peer.ms.gov/sites/default/files/peer_publications/rpt442.pdf

- **Other information for sunset factors—**To obtain additional information for the sunset factors section of our report, we reviewed the Arizona Administrative Register regarding the Board's rulemakings finalized in fiscal years 2021 through 2024 and assessed the Board's compliance with various provisions of the State's open meeting law for 9 Board and committee meetings held between April 2025 and August 2025. Additionally, we interviewed Board members and staff and conducted observations of internal procedures. Finally, we reviewed the level of regulation for MDs in all 50 states by reviewing information from the Federation of State Medical Boards and the American Medical Association compiled listings of requirements for licensure by state. Additionally, we utilized LocumTenens.com's interactive licensing map to identify CPE requirements and verified states with no continuing medical education using state boards' websites.

Our evaluation of the Board's internal controls included reviewing the Board's fiscal year 2024 policies and procedures for ensuring compliance with Board statutes and rules. To determine its compliance with these policies and procedures, we made a selection of transactions from the Board's fiscal year cash receipts and expenditures. Specifically, we reviewed supporting documentation for 20 of 1,507 cash receipt transactions, 20 of 1,099 accounts payable transactions, 43 of 5,392 purchasing card transactions, 20 of 787 adjusting journal entries and transfers to other State agencies, and 10 of 76 individuals who received payments through the Board's payroll in fiscal year 2024. Additionally, we reviewed contracts and invoices for all vendors who received payments in excess of $10,000 to verify Board compliance with State procurement requirements. We also analyzed the Board's payroll, vendor, and adjusting entries for fiscal year 2024 and reviewed documentation and interviewed Board staff for any unusual activity identified. Lastly, we reconciled the Board's accounting records with its licensing and investigations database for cash receipts. We reported our conclusions on any internal control deficiencies in our findings and responses to the statutory sunset factors.

We selected our audit samples to provide sufficient evidence to support our findings, conclusions, and recommendations. Unless otherwise noted, the results of our testing of these samples are not intended to be projected to the population as a whole.

We conducted this performance audit and sunset review in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We express our appreciation to the Board, its executive director, and staff for their cooperation and assistance throughout the audit, as well as the Arizona Auditor General for their support.

BOARD RESPONSE

ARIZONA MEDICAL BOARD
1740 W. Adams Street, Ste. 4000 Phoenix, AZ 85007
Phone: (480) 551-2700 · Toll Free (877) 255-2212 · Website: AZMD.GOV

Katie Hobbs
Governor

Raquel Rivera
Executive Director

August 19, 2026

Lisa S. Parke, CPA
Walker & Armstrong
Via email: lparke@wa-cpas.com

Re: Arizona Medical Board – Sunset Review: A.R.S. §41-2951 et seq.

Dear Ms. Parke:

The Arizona Medical Board ("Board") has reviewed and provided responses to the Performance Audit and Sunset Review. The Board's staff, as well as the Board itself, appreciated the professionalism and courtesy of Walker & Armstrong. The Board has begun addressing the findings and implementing the recommendations. The Board looks forward to meeting with the Committees of Reference to discuss the positive changes made.

Respectfully,

Raquel Rivera

Raquel Rivera
Executive Director

Enclosure: Board's Response(s)
Cc: Gary Figge, MD

Finding 1: Board did not resolve most complaints in a timely manner, which may affect patient safety.

Board response: The finding is agreed to.

Response explanation: This finding is acknowledged but it is also important to note the increase in complex complaints necessitating more than 180 days to not only complete the investigation but also adjudicate the case, which requires separate administrative functions conducted outside of the Investigations department. The AMB will review its investigative policies and specifically address the procedure and time frame for subpoena enforcement, along with additional time frames for other key investigative steps. Development of a reporting mechanism to oversee, track, and monitor staff's handling of complaints against the timeframes outlined in the Investigative Timeline has been elevated to a priority project. Board members currently receive the Executive Director's Delegated Authority Report at each in-person AMB meeting, which includes a list of Executive Director dismissals. The AMB will explore adding the average time frame for dismissals to be processed to that report for the Board member's review. Beginning in October 2026, the AMB will also receive a standing report on complaint timeliness at its regular meetings.

Recommendation 1: Investigate and resolve complaints within 180 days.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB is committed to resolving complaints promptly. Five prior audits spanning 43 years confirm that the AMB has consistently been unable to meet the 180-day standard. As early as 1981, when the AMB regulated approximately 5,859 licensees, it was unable to conform to the 180-day timeframe. Today, the AMB regulates over 35,000 licensees and the AMB staff is also responsible for the operations of the Arizona Regulatory Board of Physician Assistants ("PA Board"), which regulates an additional 5,630 licensees, while still being held to the same fixed benchmark. This more than six-fold growth in licensee population, without a corresponding adjustment to the 180-day benchmark, indicates that a uniform 180-day goal is no longer a reasonable or reliable benchmark. A review of AMB and ARBoPA annual report data for FY23 through FY26 shows an average investigation timeframe of 279 days for MD cases and 310 days for PA cases. Given this sustained trend, the AMB will evaluate whether a more data-driven target is warranted that better reflects the Board's actual multi-year averages while still preserving an enforceable ceiling for accountability. As the AMB continues to develop its performance tracking mechanisms, the Board will further explore and refine what constitutes a reasonable benchmark going forward.

Recommendation 2: Follow its established time frame for requesting subpoena enforcement from the Superior Court of Arizona after deadlines are missed.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB acknowledges this recommendation and will follow its established timeframe for requesting subpoena enforcement and will incorporate internal criteria into its policies to guide escalation of missed subpoena deadlines to the AMB's Assistant Attorney General for referral to the Superior Court, as detailed below.

Recommendation 3: Request the Superior Court of Arizona enforce subpoenas when licensees and/or third parties miss deadlines for providing subpoenaed information.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB acknowledges that subpoena compliance is essential to the timely and thorough investigation of complaints. The AMB will seek Superior Court enforcement in cases where subpoenaed information is material to public protection and voluntary compliance efforts have been exhausted. However, the AMB notes that pursuing court enforcement is a resource-intensive process that cannot be applied as a uniform, first-line response to every missed licensee or third-party responsive deadline. Enforcing a subpoena through the Superior Court requires the AMB's Assistant Attorney General to prepare and file a motion to compel, serve the non-complying party, respond to any objections or motions to quash, appear at a hearing, and, in some cases, pursue contempt proceedings or an appeal if the order is not honored. Each of these steps carries meaningful staff and AAG time, filing costs, and scheduling delays which can compound the delay to the underlying investigation and potentially delay other higher priority cases. Given the AAG resources available to the AMB relative to the volume of open investigations, the AMB is concerned that requiring court enforcement for every missed deadline would divert limited legal resources away from higher-priority disciplinary matters and could create case backlogs rather than reduce them. Many missed deadlines are effectively resolved through follow-up correspondence and extensions without the need for judicial intervention. To address the finding, the AMB will: Establish written internal criteria within our policies for escalating a missed subpoena deadline to AAG referral for court enforcement (e.g., based on the materiality of the withheld information, the risk to public safety, and prior noncompliance history); Develop a way to track and report the number of missed subpoena deadlines and the disposition of each (informal resolution vs. AAG referral vs. court enforcement) to allow the AMB and its AAG to monitor volume and resource impact; and Coordinate with the Attorney General's Office to identify whether a streamlined or expedited enforcement procedure is available for repeat or high-priority noncompliance, to reduce the resource burden of individual enforcement actions. The AMB believes a measured, criteria-based approach satisfies the intent of the finding by ensuring subpoenas are applied and enforced when necessary, while accounting for the realistic capacity of legal resources and the multi-step nature of Superior Court enforcement.

Recommendation 4: Finalize the development and implementation of policies and procedures that include required time frames for completing key steps in a complaint investigation, including how long it should take to send initial requests to licensees for a response to a complaint, issue subpoenas, time the Board may grant licensees to respond to complaint allegations or outside medical consultants to accept cases for review, and issue dismissal and closure letters.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will update the existing time frame requirements to include time frames for the formal notice of investigation to the licensee by the investigator; steps and timeframes for licensee responses, and addressing non-responses; and timeframes for medical consultants and processing of dismissed cases. This will strengthen the Investigation Process and Medical Consultant Assignment policies which together already establish required time frames for steps in the complaint-handling process. These established policies include deadlines for: sending the initial notice letter to the licensee within 5 business days of receipt of the complaint; preparing and serving subpoenas within 1–3 weeks of case initiation, with follow-up escalation to the Assistant Attorney General if subpoenaed records are not received within 35 days of the due date; allowing licensees two (2) weeks to submit a supplemental response to a Medical Consultant's findings; allowing Outside Medical Consultants two (2) weeks to accept or

decline a case assignment and four (4) weeks to complete their initial report (one week for a supplemental report).

Recommendation 5: Finalize the development and implementation of policies and procedures for tracking and monitoring complaint handling, including establishing a mechanism to document and track completion of key steps in the complaint-handling process and assigning responsibilities to Board staff to use management reports to actively monitor the progress of complaint investigations.

Board response: The audit recommendation will be implemented.

Response explanation: In August 2025, the AMB developed an Investigative Timeline and will be working with IT to develop a monitoring tool within the AMB database that documents and tracks completion of each of the six stages of the investigative process (Intake, Initiate Investigation, Collect Evidence, Expert Review, Findings Report, and QA and Conclusion) against defined time frame target goals, with a mechanism to capture and report any noted delays for timeframe accountability for each stage of the investigation. In addition, the policy was revised to establish a “Quality Analysis” process requiring bi-annual monitoring of case handling by staff role, including review of a percentage of Intake determinations, Investigator caseloads (with average days-open tracking), subpoenas processed by the Medical Records Technician, and cases assigned to Medical Consultants and reviewed by Managers. Responsibility for actively monitoring case progress using these tracking mechanisms is assigned to the Investigations Manager, who conducts case reviews for accuracy and completion, with oversight escalation to the Executive Director as needed. The development of these tools will greatly assist staff with a documented tracking mechanism paired with designated staff accountability for ongoing monitoring.

Recommendation 6: Continue its development and implementation of a formal process to review its tracking and monitoring of complaint handling to identify and address reasons for delays.

Board response: The audit recommendation will be implemented.

Response explanation: In addition to the tracking and monitoring mechanisms described in Recommendation 5, the AMB has incorporated a "Noted Delays" section within the Investigative Timeline, requiring the Investigations Manager to document the specific reason for any delay before a case can move to the next stage. It is anticipated that these stage-level delay findings will feed into the bi-annual Quality Analysis process established by allowing Managers to identify recurring or systemic causes of delay such as Medical Consultant availability, outstanding subpoena compliance, or extension requests. The AMB is formalizing this into a recurring review process in which the Investigations Manager compiles delay findings across cases each reporting period and brings identified trends, along with recommended process adjustments, to the AMB through the Investigations Update described in Recommendation 7. This is designed to “close the loop” between tracking individual case delays and using that data to identify and address the underlying cause of delays across the investigative process as a whole.

Recommendation 7: Require Board staff to regularly report to the Board on complaint timeliness, the reason for delays, and plans to resolve and prevent such delays in future complaints.

Board response: The audit recommendation will be implemented.

Response explanation: Beginning in October 2026, AMB staff will include a standing Investigations Update on the AMB's meeting agenda. This update will provide the Board

members with the number of complaints received and cases opened since the prior meeting, the number of investigations completed, the average investigation timeframe, identified reasons for any delays, and staff's plans to resolve current delays and prevent similar delays in future complaints.

Finding 2: Inconsistent with recommended practices, Board and executive directors delegated key responsibilities without establishing oversight and accountability mechanisms, potentially resulting in inefficient and ineffective operations, noncompliance with Board statutes and policies, and a waste of public resources.

Board response: The finding is agreed to.

Response explanation: Concerns regarding management and staff delegation were previously identified in the PA Board Audit. The AMB acknowledges that many of the deficiencies identified originated under the direction of prior staff that are no longer with the AMB, and improving oversight and accountability mechanisms have been a priority for the AMB's current Executive Director. However, the current Executive Director's ability to demonstrate significant progress since this concern was identified in the PA Board audit has been constrained by a series of compounding circumstances largely outside the AMB's control. Upon release of the PA Board audit findings in August 2025, the AMB moved immediately to implement corrective changes, including development of the Investigative Timeline. Shortly thereafter, from November 2025 through March 2026, the AMB operated under an activated Continuity of Operations Plan (COOP) due to water damage to the AMB's office and equipment, requiring a five-month transition to virtual operations and temporary offsite relocation to maintain uninterrupted service to the public. During this time period, significant staff time and resources were diverted to the transition and remediation process. During this same period, the AMB also operated near quorum for three months due to AMB vacancies, which limited its ability to timely adjudicate cases. Notwithstanding these unexpected constraints, the AMB took immediate and substantive steps in response to the PA Board audit findings and remains committed to fully addressing the oversight and accountability deficiencies identified in this audit.

Recommendation 8: Continue to establish and enforce productivity and quality standards for each department and position, and implement accountability measures consistent with Board policy to ensure performance expectations are met.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will continue establishing SMART performance goals for all staff, departments, and managers to ensure productivity expectations are clear consistently met. The AMB has already developed and implemented performance standards for Board Operations staff and is working with IT to develop queries that will track and monitor staff performance against these documented goals, providing an objective, data-driven basis for accountability. Building on this framework, the AMB is committed to extending SMART performance standards to all remaining departments by December 2026.

Recommendation 9: Finalize the development and implementation of policies and procedures for consistently tracking Board staff hours worked to help ensure that staff are compensated only for actual time worked and reduce the risk of abuse.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB has developed and is piloting a standardized daily time reporting tool, currently in use with the Executive Team, to provide consistent documentation of employee work hours across the agency. Under this process, employees record each clock-in, clock-out, and leave entry by date, along with their work status giving managers a clear, verifiable record of hours worked and time off taken each day. The AMB will formalize this pilot into written policies and procedures that establish employee and supervisory responsibilities for daily time reporting, approval, verification, and documentation of exceptions, including missed or inaccurate time entries. In addition to the State's Human Resources Information Solution (HRIS) timekeeping system, department managers will use these daily time reports, agency calendars, leave records, and direct supervisory oversight to verify reported hours prior to payroll approval. The Executive Director will periodically review departmental compliance with these procedures to ensure consistent implementation across the agency and reduce the risk of payroll errors, fraud, abuse, or compensation for hours not worked. Following completion of the Executive Team pilot, the AMB anticipates rolling out the standardized daily time reporting process agency-wide by September 2026.

Recommendation 10: Evaluate the roles and responsibilities of Board IT staff and contractors to identify and eliminate unnecessary duplication and ensure IT expenditures are aligned with Board needs and priorities, including documenting its evaluation.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB has initiated a formal evaluation of IT staff and contractor roles by tracking all IT work at the individual-ticket level for infrastructure/onsite support and development (contractor/vendor personnel), which allows management to compare the volume, complexity, and nature of work handled by each staff member and contractor against their assigned role. This ticket-level data will be used to identify tasks that fall outside a staff member's or contractor's core responsibilities, as well as any tasks being duplicated across roles (for example, disciplinary-case file support currently appearing in both the infrastructure and development queues), and to reassign or consolidate that work as appropriate. The AMB has also developed an IT Project tracker to documents each active and proposed IT project by category, priority, funding source, as well as a companion performance dashboard to track key metrics such as percentage of projects completed on time, percentage completed within budget, number of active projects, average time in each status, and projects blocked by dependencies. This portfolio will serve as the documented basis for evaluating whether current and planned IT expenditures are aligned with the AMB's needs and priorities, and will be reviewed and updated by management on an ongoing basis as part of the AMB's broader effort to establish IT performance metrics and accountability measures.

Recommendation 11: Continue to develop and implement performance monitoring measures, such as comparing budgets for financial resources and staff hours and evaluating adherence to deadlines, and establishing accountability measures for IT projects, including documenting disciplinary actions for missed deadlines, exceeded financial or labor budgets, and delivering poor quality work.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will continue to enhance and implement performance monitoring measures for the Support Services and IT Manager through the agency's performance management process. Performance measures will include monitoring adherence

to project timelines and milestones, evaluating progress against established deadlines, documenting weekly reviews of financial resources, agency priorities, staffing needs, and updates to the IT project list, and monitoring project labor and budget utilization. Performance expectations and accountability measures will be incorporated into employee performance goals and evaluations. When performance deficiencies are identified, the AMB will address them in accordance with the State's progressive discipline process and applicable personnel policies, while documenting corrective actions and performance improvement efforts as appropriate. Although the report only identified minimal cost savings since the PA Board Audit results, in FY26, the IT Department made contract changes resulting in anticipated annual savings totaling $176,828 for FY 27.

Recommendation 12: Conduct a comprehensive employee productivity and workload analysis to identify process inefficiencies and staffing challenges, support effective resource allocation, and justify staffing and budget requests.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will conduct a comprehensive employee productivity and workload analysis following the implementation of standardized performance measures across all departments. As part of this initiative, each department will establish SMART performance goals and objective performance metrics that provide reliable baseline data for evaluating employee productivity, workload distribution, process efficiencies, and resource utilization. The results of the analysis will be used to identify operational improvements, assess staffing needs, support effective allocation of agency resources, and provide data-driven justification for future staffing and budget requests. The AMB anticipates completing the workload analysis by June 2027. While the AMB appreciates the auditor’s analysis identifying potential capacity within Licensing Department staff that could theoretically be redirected toward investigative work, the AMB respectfully notes that this reallocation is not operationally feasible without significant additional cost and delay as licensing and investigative staff have materially different competencies, and Licensing staff would need to first obtain and maintain CLEAR certification required by statute for investigative staff. Additionally, reassigning other departmental staff into investigative roles would require lead time and cost for the AMB, so any capacity gain from reallocation would not be realized for a period of time and would likely also coincide with the PA Compact becoming operational. This is anticipated to result in an increase in PA applications for Licensing staff to process. There is also concern for reclassification and pay adjustments, which could raise pay equity concerns across the two departments. Reallocation of Licensing staff would also likely negatively affect the AMB's currently strong licensing metrics showing that over 98% of applications are processed within required time frames. Given the growth in MD applications driven by the Interstate Medical Licensure Compact and the anticipated PA Compact launch in 2027, reducing Licensing capacity risks trading a strength for a weakness rather than producing a net improvement. For these reasons, the AMB's budget requests additional FTEs rather than reallocating existing, differently classified staff between the two functions.

Recommendation 13: Review the Board’s performance incentive pay program and related policies to ensure alignment with measurable, meaningful performance outcomes tied to its key statutory objectives and purposes and staff responsibilities, and revise or eliminate components that do not drive accountability or results.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will conduct a comprehensive review of its Performance Incentive Pay (PIP) Program and related policies after implementing standardized departmental and individual performance metrics. The review will evaluate whether the program appropriately aligns employee performance expectations with the AMB's statutory mission, strategic priorities, and assigned departmental responsibilities. The AMB will assess the effectiveness of existing performance measures in promoting accountability, operational efficiency, and measurable outcomes and will revise or eliminate performance metrics or incentive components that do not effectively support the AMB's statutory objectives or organizational goals.

Recommendation 14: Implement a process to annually evaluate whether performance metrics and related incentive payments effectively support operational efficiency and the Board's overall objectives.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will establish a formal annual review process to evaluate the effectiveness of departmental and individual performance metrics and any related Performance Incentive Pay (PIP) measures. Prior to implementation, proposed performance metrics and incentive criteria will be reviewed to ensure they are measurable, objective, aligned with employee responsibilities, and support the AMB's statutory mission and operational priorities. Thereafter, the AMB will annually evaluate performance outcomes, operational efficiencies, and the effectiveness of incentive measures in achieving organizational objectives. Based on these evaluations, the Board members may direct the Executive Director to modify performance metrics or incentive criteria to ensure continued alignment with the AMB's strategic priorities, accountability expectations, and statutory responsibilities.

Recommendation 15: Continue to work with its assistant attorney general to review performance incentive payments made to the executive director since 2015 to determine if the payments violated statute and seek reimbursement for any unallowable payments.

Board response: The audit recommendation will be implemented in a different manner.

Response explanation: The AMB takes seriously its obligation to ensure that all payments made to staff comply with statute. The AMB notes that this issue was previously examined in connection with HB2731 during the PA Board continuation process, at which time a member of the House Health & Human Services Committee advised, based on consultation with Legislative Council, that the payments did not violate statute. While the AMB recognizes this statement does not constitute a formal legal opinion, it reflects an initial, independent review that did not identify a statutory violation. The AMB will engage with necessary entities to conduct a formal review of the performance incentive payments made to the executive director since 2015. This review will evaluate whether the payments were authorized under applicable statute and Board policy.

Recommendation 16: Establish performance monitoring and verification procedures for all responsibilities delegated to department managers to help ensure the executive director can hold the managers accountable for meeting their delegated responsibilities.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB has initiated a comprehensive review of all staff positions and responsibilities and is collaborating with department managers to develop and implement

standardized SMART performance goals and reports for employees and managers based on their assigned duties. As part of this process, the Executive Director and department managers will establish measurable departmental and managerial performance metrics, including defined performance targets, timelines, and objective measurement methods to verify completion of delegated responsibilities. These measures will include routine monitoring through database queries, management reports, and quality assurance reviews, to verify compliance with established expectations. The Executive Director will work with IT to develop a dashboard for all departmental activity to allow for regular performance reviews with department managers to evaluate progress toward established goals, monitor departmental workloads and performance trends, identify operational risks, and ensure accountability for delegated responsibilities. Performance results will be incorporated into the agency's performance evaluation process, and corrective action or performance improvement measures will be implemented, when appropriate, in accordance with State personnel policies. The AMB will periodically review and refine these performance measures to ensure they remain aligned with agency priorities and operational needs.

Finding 3: Board did not consistently act within or fully exercise its statutory authority potentially resulting in unauthorized disciplinary action, premature dismissal of a complaint, and an increased risk to public safety.

Board response: The finding is agreed to.

Response explanation: The AMB acknowledges the observations regarding committee actions and maintains that formal interviews conducted by review committees complied with statute and comported with due process obligations. Importantly, licensees who participate in formal interviews with the AMB elected this method of resolution. In every case that AMB staff recommends discipline, licensees are provided with a notice letter that includes access to investigative case file documents, which identify the recommended violations and proposed disciplinary action. Licensees are advised of their right to seek a full evidentiary hearing at the Office of Administrative Hearings, and offered the opportunity to enter into a consent agreement to resolve the case. Lastly, licensees are invited, not compelled, to participate in formal interviews. When the AMB was utilizing the committee structure, licensees were advised that formal interviews would be conducted by a Board Review Committee. The notice letter for these cases outlined the process utilized by the Committees, including the potential that the Committee may vote to issue disciplinary action consistent with A.R.S. § 32-1451(I). Licensees who agreed to a formal interview with a Board Review Committee provided a signed statement that they accepted the invitation to appear for a Committee interview and acknowledged that they were waiving their right to a full evidentiary hearing. Since its inception, not a single licensee has challenged the Review Committees' authority to issue disciplinary orders pursuant to A.R.S. § 32-1451(I). The process utilized by the AMB preserved due process for licenses by ensuring that decisions were made by members who had the opportunity to interview the licensee and evaluate questions of credibility firsthand. Regarding the concern about legal advice provided during a settlement conference at the August 2025 AMB meeting, the Board took the measures it deemed appropriate and expedient given the specific circumstances and procedural posture of the case. While Superior Court enforcement was not pursued in this instance the medical records at issue were ultimately provided, which allowed the Board's investigation to be completed. The AMB will provide training and update investigative workflow policies to ensure that Board members and investigative staff are made aware of the option for Superior Court subpoena enforcement going forward.

Recommendation 17: Develop policies and procedures in alignment with statute for formal interviews conducted by Board established committee, including the actions the committee may take.

Board response: The audit recommendation will be implemented in a different manner.

Response explanation: The AMB acknowledges the recommendation and ceased committee formal interviews in August 2025 due to the concerns expressed during the audit and ongoing challenges with quorum. The AMB will not reinstitute this procedure until it obtains legislative clarification. In the event that the AMB obtains legislative clarification, appropriate policies and procedures will also be adopted.

Recommendation 18: Work with its Assistant Attorney General to determine what actions the Board should take to rectify the disciplinary actions previously issued by committees.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB acknowledges that some notices may have been sent utilizing templated language intended for full Board meeting interviews. The AMB does not agree that properly noticed review committee formal interviews require rectification. Licensees who participated in committee interviews voluntarily elected the process and signed a written waiver of their right to a full evidentiary hearing. They were further advised of their right to seek rehearing or review by the full AMB under A.A.C. R4-16-103, or judicial review. To date, no licensee has challenged a Review Committee's authority to issue disciplinary orders under A.R.S. § 32-1451(I). The AMB will review identified cases to determine whether additional action is required.

Recommendation 19: Provide comprehensive training to Board members on the scope of actions the Board is authorized to take in regulating licensees, including the process for issuing subpoenas and enforcing compliance through injunctions, ensuring members understand both common and less frequently utilized options.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB acknowledges this recommendation and will continue to conduct comprehensive training with its assigned Assistant Attorney General to ensure all members understand the full extent of statutory options available, including subpoena enforcement remedies under A.R.S. § 32-1451.01(B)(3).

Sunset factor 2: The Board's effectiveness and efficiency in fulfilling its key statutory objectives and purposes.

Board did not evaluate the appropriateness of its fees, resulting in the Board potentially charging fees in excess of the cost necessary to provide services.

Board response: The finding is agreed to.

Response explanation: The AMB agrees to this finding as the fees have not been raised in over two decades. The AMB will research and evaluate MD licensure fees and renewal timeframes to ensure

the appropriateness of its fees in comparison to the costs for MD licensing, staffing, and investigations undertaken.

Recommendation 20: Develop and implement policies and procedures for periodically evaluating and setting fees to ensure its fees are structured based on the actual cost of the Board's operations.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will develop a process to annually evaluate the fees charged by the AMB.

Recommendation 21: Develop and implement a process to use relevant information, including historical and projected data, to develop the Board's annual budget request.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will develop and implement a formal budgeting policy that utilizes historical operational data, projected licensing growth, and staff productivity metrics to construct its annual budget requests. Additionally, the AMB will implement a periodic fee-review process to compare fee revenues against the actual cost of providing regulatory services.

Board failed to implement an efficient process for accepting credit card payments, increasing the risk of errors and concerns related to data security.

Board response: The finding is agreed to.

Response explanation: The AMB IT department has made significant progress in implementing an online application and payment process to improve the efficiency of credit card payment acceptance while reducing the risk of errors and enhancing data security. The following applications have been successfully deployed with online payment capability: MD Initial Application; MD Renewal PA Renewal; Postgraduate Permit; MD Dispensing Registration; and Dispensing Registration Renewal.

Recommendation 22: Finish implementing a secure electronic payment option to reduce reliance on mailed payments.

Board response: The audit recommendation will be implemented.

Response explanation: The following applications are currently in testing, with deployment anticipated by August 17, 2026: MD Telehealth Application and Renewal; PA Telehealth Application and Renewal; MD Pro Bono; and PA Pro Bono. The AMB also anticipates deploying the following applications by August 30, 2026: MD Temporary Application and MD Transitional Training Application. The AMB is committed to expanding its online application and payment capabilities until all applicable processes have been transitioned to a secure electronic payment platform.

Board executives were unable to separate incompatible duties, increasing the risk of errors, fraud, and misuse of public resources.

Board response: The finding is agreed to.

Response explanation: The AMB has segregated incompatible duties related to cash handling and cash receipts. Responsibility for entering all cash receipts into the AMB's licensing system has been transferred to an Administrative Support Specialist, separating this function from the Accountant 2 role. This segregation of duties reduces the risk of errors, fraud, and misuse of public resources. Additionally, the AMB worked with the Arizona Department of Administration (ADOA) to revise its cash handling policies and procedures to reflect this change. The updated policies have been submitted to ADOA and are currently pending final approval.

Recommendation 23: Develop and implement policies and procedures to separate incompatible duties for business functions including the receiving, depositing, recording and reconciling of cash receipts; the requesting, approving, and recording of purchases; and entering and approving of accounting transactions.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will continue developing strengthened review and approval procedures for all accounting and travel-related transactions. Management is responsible for reviewing and approving all accounting transactions both prior to processing and upon final review, ensuring compliance with state requirements, AMB policies, and supporting documentation requirements.

Board failed to follow State requirements for expenditures, increasing the risk of errors, fraud, and misuse of public resources.

Board response: The finding is agreed to.

Response explanation: All travel requests and travel-related expenditures are reviewed by Management before submission to Central Services Bureau (CSB) for processing. This review includes verifying that: Required approvals have been obtained before expenditures are incurred. Airfare and other travel arrangements are booked in a timely manner to secure the most economical rates, consistent with AMB policy. Conference and travel reimbursements comply with applicable state travel rates and regulations. Purchases include adequate documentation supporting a clear public purpose. Supporting documentation is complete and accurate before payment is processed.

Recommendation 24: Develop and implement written procedures to ensure compliance with State requirements and Board policy for expenditures, including processes requiring supervisor review and approval for all purchase requests in advance, as well as reviews to ensure each transaction complies with State requirements and has a documented public purpose.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB will develop and implement more formal written procedures governing expenditures that require supervisor review and approval. In addition, Management will continue to perform a final review and approval of all purchase requests and related transactions before processing to verify compliance with State requirements, AMB policy, and documentation standards. The review process will ensure that: All purchase requests receive supervisor approval in advance of the expenditure; Management performs a final review prior to processing; Each expenditure complies with applicable State requirements and AMB policy; Each transaction includes sufficient supporting documentation and a clearly documented public purpose. Required approvals and supporting documentation are maintained in accordance with recordkeeping requirements.

Sunset factor 5: The extent to which the Board has provided appropriate public access to records, meetings, and rulemakings, including soliciting public input in making rules and decisions.

Board did not acknowledge the receipt of all public records requests.

Board response: The finding is agreed to.

Response explanation: The AMB adopted a revised log in August 2025, which includes the dates of the public records request and acknowledgement date.

Recommendation 25: Continue to ensure its staff are following the Board's policy to acknowledge the receipt of all public records requests within 24 hours of receipt of the request.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB acknowledges and has implemented this recommendation and established clear performance metrics and supervisory controls for public records requests (PRRs). Specifically, AMB staff are required to acknowledge receipt of all public records requests within 24 hours of receipt. Additionally, the PRR tracking log is updated within 24 hours of any status change to capture new, pending, and closed requests. Management conducts regular audits of the log to monitor compliance, track performance goals, and ensure consistent adherence to AMB policy.

Recommendation 26: Continue to use its updated tracking log that includes a date in which each public records request is acknowledged.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB has implemented this recommendation as the PRR tracking log is updated within 24 hours of any status change to capture new, pending, and closed requests. Management conducts regular audits of the log to monitor compliance, track performance goals, and ensure consistent adherence to AMB policy.

Board did not track all public records requests to ensure proper oversight.

Board response: The finding is agreed to.

Response explanation: The AMB acknowledges that its previous process included decentralized tracking prior to request fulfillment. The AMB has fully remediated this process. The AMB enforces a centralized intake protocol requiring all public records requests to be logged into the official PRR tracking log within 24 hours of receipt. This centralized system provides management with full visibility into all pending, active, and completed requests for oversight.

Recommendation 27: Continue to require staff to input public records requests on its public records request tracking log at the receipt of the request.

Board response: The audit recommendation will be implemented.

Response explanation: The AMB has implemented this recommendation. Staff are strictly required to input all public records requests into the centralized master tracking log immediately upon receipt, eliminating all informal or delayed tracking methods. As detailed in our response to Recommendation 25, this immediate intake requirement is reinforced by daily staff workflows, updated performance metrics, and regular supervisory reviews to ensure continuous, real-time oversight of all incoming requests.

Board did not provide sufficient public information in response to anonymous phone calls we made.

Board response: The finding is agreed to.

Response explanation: The AMB acknowledges that sufficient public information may not have been provided in response to anonymous phone calls.

Recommendation 28: Provide accurate information to the public regarding licensees as required by statute.

Board response: The audit recommendation will be implemented.

Response explanation: In January 2026, the AMB implemented comprehensive retraining through the Arizona Ombudsman for all public records staff who handle requests. Staff were reminded to verify licensee information directly through the database, how to direct callers to specific portal locations for public records, and provide clear instructions on how to submit formal public records requests when necessary.

Sunset factor 8: The extent to which the Board has established safeguards against possible conflicts of interest.

Board policy did not require Board members or staff to complete annual conflict-of-interest training.

Board response: The finding is agreed to.

Response explanation: The AMB instituted annual conflict-of-interest training for all AMB Board members and staff. Additionally, as of September 2025, the AMB was confirmed to have received annual conflict-of-interest disclosures from all staff, Board members, and contractors. The AMB's annual conflict of interest training for FY25 was conducted during its January 2026 meeting.

Recommendation 29: Update its policy to require annual training on conflicts of interest for Board members, staff, and contracted employees.

Board response: The audit recommendation will be implemented.

Response explanation: Since January 2025, the AMB provides annual conflict of interest training for board members and staff. The AMB has updated its policy to formally mandate annual conflict-of-interest training for all Board members, staff, and contracted employees as well as procedures to document attendance of staff present for the training.