ARIZONA Auditor General
Making a Positive Difference

# Joint Legislative Audit Committee

**March 28, 2025—1:00 p.m.**

**Lindsey A. Perry**
Auditor General

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# ARIZONA STATE LEGISLATURE

## INTERIM MEETING NOTICE
## OPEN TO THE PUBLIC

### JOINT LEGISLATIVE AUDIT COMMITTEE

**Date:** **Friday, March 28, 2025**

**Time:** **1:00 P.M.**

**Place:** **SHR 109**

**Members of the public may access a livestream of the meeting here:**
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## AGENDA

Call to order - opening remarks

1. Arizona State Schools for the Deaf and the Blind, February 2025 24-Month Follow-up of Report 22-109
   - Presentation by Arizona Auditor General (Office)
   - Presentation by Arizona State Schools for the Deaf and the Blind
2. Public Safety Personnel Retirement System, February 2025 Initial Follow-up of Report 23-109
   - Presentation by Office
   - Presentation by Public Safety Personnel Retirement System
3. Arizona Department of Health Services—Long-Term Care Complaints and Self Reports, December 2024 48-Month Follow-up of Report 19-112
   - Presentation by Office
   - Presentation by Arizona Department of Health Services
4. State of Arizona fiscal year 2024 financial statement and federal compliance audits' update
   - Presentation by Office
   - Presentation by Arizona Department of Administration
   - Presentation by Arizona Health Care Cost Containment System
   - Presentation by Arizona Department of Economic Security

Adjournment

**Members**:

Senator Mark Finchem, Chair
Senator Flavio Bravo
Senator Timothy "Tim" Dunn
Senator David C. Farnsworth
Senator Catherine Miranda
Senator Warren Petersen, Ex-officio

Representative Matt Gress, Chair
Representative Michael Carbone
Representative Michele Peña
Representative Stephanie Stahl Hamilton
Representative Betty J Villegas
Representative Steve Montenegro, Ex-officio

03/21/2025
hf

**For questions regarding this agenda, please contact Senate Research Department.**
**Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602) 926-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.**

LINDSEY A. PERRY
AUDITOR GENERAL

ARIZONA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

**DATE:** March 26, 2025

**TO:** Senator Mark Finchem, Chair
Representative Matt Gress, Vice Chair
Members, Joint Legislative Audit Committee (JLAC)

**FROM:** Lindsey Perry, Auditor General

**SUBJECT:** Arizona State Schools for the Deaf and the Blind, February 2025 24-month Follow-up Report 22-109

## Background

JLAC is charged with (1) overseeing audit functions of the Legislature and State agencies, including sunset, performance, special, and financial audits and special research requests, and preparing and introducing legislation resulting from audit report findings; (2) requiring State agencies to comply with its findings and directions regarding sunset, performance, special, and financial audits; and (3) receiving reports from the Arizona Auditor General regarding each audit's results (A.R.S. §§41-1279 and 41-1279.03). Additionally, my Office is responsible for conducting sunset reviews of State agencies, boards, and commissions under Arizona's sunset law and as assigned by JLAC. In 2022, my Office conducted and released a performance audit and sunset review report on the Arizona State Schools for the Deaf and the Blind (ASDB) as part of ASDB's sunset review, see Report 22-109.

ASDB was established in 1912 to educate students in Arizona with sensory impairments such as a hearing and/or vision impairment, and provides sensory-impaired students throughout the State with educational and support services through its 2 campus schools and Itinerant Services Program (Program). Our 2022 performance audit and sunset review of ASDB found it had established policies and procedures for maintaining its campus schools' accreditation and for ensuring that its teachers meet State requirements for certification. However, we have found that ASDB:

- Had identified millions of dollars in capital improvement needs, including buildings that were vacant or underutilized or that presented health and safety concerns, but had not developed a multiyear capital plan, hindering its ability to address these needs in a timely and cost-effective manner.

- May have been collecting more revenue than necessary to administer the Program.

- Did not use a consistent approach to assess its post-school outcomes survey data, did not comply with 1 statutory conflict-of-interest requirement, and had not fully aligned its conflict-of-interest process with recommended practices.

We made 15 recommendations to ASDB to address these issues.

Our 24-month follow-up report, issued in February 2025, found that ASDB had implemented 4 recommendations and was in the process of implementing or implementing in a different manner 9 recommendations. For example, ASDB:

- Established a capital review committee that has developed a capital improvement plan identifying nearly $71 million in capital improvements for fiscal years 2026 through 2028 on its Phoenix and Tucson campuses. These improvements include more than $11 million to construct a new Birth-to-5 center on the Phoenix campus.

- Contracted for the development of a master facility plan that includes options for consolidating its Tucson campus via the potential sale, lease, or transfer of nearly half of its land; reducing building space through demolition of antiquated buildings; and renovating remaining buildings and/or building new buildings for uses such as dormitories, classrooms, office spaces, library space, and a preschool.

However, ASDB had not implemented 2 recommendations. For example, ASDB had not implemented our recommendation to align its Program fees with Program costs. As a result, its fiscal year ending balance has increased from approximately $4.4 million in fiscal year 2021 to more than $13 million in fiscal year 2024. Most recently, Program revenues exceeded Program expenses by nearly $2.4 million, according to ASDB's initial review and documentation. By not aligning its Program fees with its Program costs, ASDB continued to receive more monies than needed from public school districts that these districts could instead be using for other purposes, such as to reduce class sizes, increase teacher pay, and provide other special education service needs.

We were asked to present information on the 24-month follow-up report, issued in February 2025. Dale Chapman, Performance Audit Division Special Projects Manager, will provide an overview of the follow-up report.

Attachment A includes ASDB's 24-month follow-up report, issued in February 2025.

## Action required

None. Presented for JLAC's information only.

Attachment A

# Followup

Arizona State Schools for the Deaf and the Blind

ARIZONA Auditor General
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# Arizona State Schools for the Deaf and the Blind

## 24-Month Followup of Report 22-109

The September 2022 Arizona State Schools for the Deaf and the Blind (ASDB) performance audit and sunset review found that ASDB provides sensory impaired students in the State with educational and support services and has processes for maintaining its campus schools' accreditation but has not developed a multiyear capital plan, impacting its ability to address its capital improvement needs, and it may be collecting more revenue than needed to administer its Itinerant Services Program. We made **15** recommendations to ASDB, including subparts to the recommendations.

### Board's status in implementing 15 recommendations

| Implementation status | Number of recommendations |
|---|---|
| Implemented | 4 recommendations |
| In process | 8 recommendations |
| In process in a different manner | 1 recommendation |
| **Not implemented** | **2 recommendations** |

On December 10, 2024, the Joint Legislative Audit Committee authorized the Auditor General to contract for a forensic and performance audit as part of ASDB's sunset review to examine its financial activities, operations, and student outcomes. As a result, rather than conducting a separate followup of the 11 outstanding recommendations, ASDB's efforts to implement these recommendations will be assessed as part of its sunset review, which is due by October 1, 2026.

# Recommendations to the Board

## Finding 1: ASDB has not developed and implemented a multiyear capital plan and projected capital budget, hindering its ability to address capital improvement needs in a timely and cost-effective manner

**1.** ASDB should develop and implement a comprehensive, multi-year capital plan and projected capital budget that assesses, identifies, and documents its capital needs, consistent with GFOA best practices. The comprehensive, multi-year capital plan and projected capital budget should:

**a.** Cover a period of at least 3 years.

- Status: **Implemented at 24 months.**

  ASDB has developed and implemented a capital improvement and planning policy that requires the establishment of a capital review committee with responsibilities for developing and maintaining a comprehensive list of all buildings; developing a 3-year projection of all capital funding projects and budgets, including those for capital improvement and building renewal projects; and annually reviewing ASDB program requirements and student demographic information to adopt any changes to its long-range facility plans.

**Key terms**

**Capital funding—**For the purposes of this followup, capital funding refers to monies appropriated to pay for capital projects and building renewal projects through the State budget process. This definition excludes other types of capital purchases such as vehicles, furniture, and equipment.

**Capital projects—**Buildings, structures, facilities, and areas constructed for use or benefit of the State. Capital projects generally involve new construction, such as new buildings, building additions, or infrastructure, as well as extensive remodeling.

**Building renewal projects—**Major activities that involve the repair or reworking of a building and its supporting infrastructure that will result in maintaining the building's expected useful life. Building renewal does not include new building additions, new infrastructure additions, landscaping and area beautification, routine preventive maintenance, or demolition and removal of a building.

**Capital improvement plan (CIP)—**A plan that assesses capital project and building needs over a multiyear period.

Source: Auditor General staff review of Arizona Revised Statutes (A.R.S.) §§41-790 and 41-793.

**ASDB's capital review committee has developed a 3-year capital improvement plan (CIP)—** Consistent with its policy, ASDB established a capital review committee. This committee has developed and annually updated a CIP, established 5 categories/criteria for prioritizing proposed building construction and renovations, and contracted for the development of a master facility plan, which includes a facility

needs assessment and student demographic information. Specifically, the committee has developed a CIP that identifies ASDB's capital improvement needs, including the full extent of each project's scope, proposed timing of the project, and associated costs and budgets for a period of at least 3 years. According to its fiscal year 2026 CIP, ASDB has identified nearly $71 million in needed capital improvements for fiscal years 2026 through 2028 (see Table 1 below). These improvements include consolidation, renovations, and new construction on its Tucson campus (see page 7); renovating and converting an existing building that is currently unusable due to mold to a new centralized deaf programs center to accommodate American Sign Language (ASL)/Spanish language interpreters; converting and renovating office space to additional classroom space; and demolishing antiquated and unusable buildings that pose a health and safety risk.[1]

**Table 1**
**ASDB's fiscal year 2026 CIP budget request submitted to the Arizona Department of Administration (ADOA) included 13 capital improvement projects for new building construction, renovation, or demolition during fiscal years 2026 through 2028[1,2]**

| Fiscal year | ASDB capital improvement project | Campus | ASDB project description | Costs |
|---|---|---|---|---|
| 2026 | Pre-K - 12th grade school and consolidation of campus | Tucson | Consolidation of campus, renovation of existing buildings, and construction of new Pre-K - 12th grade school to align with Arizona Administrative Code space requirements, reduce costs of utilities, and reduce future building renewal needs due to antiquated campus. | $47,373,304 |
| 2026 | Birth-to-5 center | Phoenix | New construction of Birth-to-5 center to provide additional space for increased populations requiring specialized space and equipment. | 11,342,697 |
| 2026 | Deaf programs building | Phoenix | Renovation of current unsafe building into new deaf programs building to house ASL/Spanish language interpreters and central office for the Deaf Mentor Program. | 791,198 |
| 2026 | Drivers apartment wash bay | Tucson | Demolition of building beyond its usable life and posing a health and safety risk to use the concrete pad as a location to wash other equipment. | 55,000 |
| 2026 | Live-in portable building | Tucson | Demolition of building beyond its usable life and posing a health and safety risk. | 150,000 |
| 2026 | Clifford spa | Tucson | Demolition of building beyond its usable life and posing a health and safety risk. | 55,000 |

[1] According to invoices provided by ASDB, it contracted for remediation of the mold in a building on its Phoenix campus in June 2024.

**Table 1 continued**

| Fiscal year | ASDB capital improvement project | Campus | ASDB project description | Costs |
|---|---|---|---|---|
| 2026 | Spray booth | Tucson | Demolition of building beyond its usable life and posing a health and safety risk. | 15,000 |
| 2026 | Vocational building | Tucson | Demolition of building beyond its usable life and posing a health and safety risk. | 600,000 |
| 2026 | Gym building | Tucson | Renovation of gym building due to age and condition of the building. | 2,180,454 |
| 2026 | Maintenance building | Tucson | Renovation of 2 buildings to house transportation and facilities departments as part of planned campus consolidation. | 861,212 |
| 2027 | Track and field system renovation | Phoenix | Replace current track and field system to accommodate athletic programs | 3,997,551 |
| 2027 | Career and Technical Education Center | Phoenix | Renovate building to a new Career and Technical Education Center. | 1,547,150 |
| 2028 | Occupational therapy, physical therapy, student recreation, and flex classrooms | Phoenix | Renovate building for flexible classrooms, student recreation center, and flexible office space. | 2,025,250 |
| **Total** | | | | **$70,993,815** |

[1] ASDB's CIP also identifies 9 additional capital improvement projects for fiscal years 2029 through 2036 at an estimated cost of nearly $17.3 million. These projects include renovating classrooms and office space in fiscal year 2029, ASDB's sports and performing arts building in fiscal year 2034, and additional buildings in fiscal years 2035 and 2036.

[2] These capital improvement projects are listed in priority order as designated by ASDB.

Source: Auditor General staff review of ASDB documentation.

ASDB has also identified and included in its fiscal year 2026 CIP 19 building renewal projects with an estimated cost of nearly $30 million (see Table 2 on pages 5 through 6). These projects include nearly $5 million to replace antiquated roof systems on various buildings, approximately $6 million to repair all damaged sidewalks and drainage systems, $2.5 million to upgrade current playgrounds to provide Americans with Disabilities Act (ADA) accessibility, and more than $4 million to replace antiquated heating, ventilation, and air conditioning (HVAC) systems.

**Table 2**
**ASDB's fiscal year 2026 capital improvement plan budget request submitted to ADOA included 19 building renewal project requests to replace or repair buildings, equipment, and other infrastructure during fiscal year 2026[1]**

| ASDB building renewal project | Campus | ASDB project description | Costs |
|---|---|---|---|
| Electrical switchgear replacement/service | Phoenix and Tucson | Replace and or service antiquated switchgear | $1,950,000 |
| Kachina building post replacements | Tucson | Replace termite and water damaged porch posts | 90,200 |
| Roof replacements | Phoenix and Tucson | Replace antiquated roof systems on various buildings | 4,950,000 |
| HVAC replacements | Phoenix and Tucson | Replace antiquated HVAC systems that are beyond their useful life | 4,070,000 |
| Light pole replacements | Tucson | Replace damaged/rusted light poles | 80,000 |
| Electrical system replacements | Phoenix and Tucson | Replace all main breaker panels and inspect and repair electrical systems | 730,000 |
| Playground replacements | Phoenix and Tucson | Upgrade current playgrounds and include ADA accessibility | 2,500,000 |
| Classroom/hallway carpet replacement | Phoenix and Tucson | Remove and replace antiquated flooring systems | 551,650 |
| Sidewalk and drainage systems improvements | Phoenix and Tucson | Repair all damaged sidewalks and address drainage concerns | 5,996,635 |
| Window replacements | Phoenix and Tucson | Replace antiquated windows | 1,860,000 |
| Hot water system replacements | Phoenix and Tucson | Replace all antiquated boilers, hot water heaters and related pumps | 605,000 |
| Energy management system (EMS) upgrades | Phoenix and Tucson | Replace local thermostats to cloud based EMS system | 250,000 |
| Perimeter fence repairs and upgrades | Phoenix and Tucson | Upgrade or repair fences | 600,000 |
| Water main replacements | Phoenix and Tucson | Replace all water mains from meter to the building including backflows | 1,000,000 |
| Parking lot repairs and replacements | Phoenix and Tucson | Repair and replace antiquated parking lots and driveways | 2,275,000 |
| Plumbing lining | Phoenix | Line all main lines and laterals on all buildings | 1,000,000 |
| Light-emitting diode (LED) lighting upgrades | Phoenix | Replace all interior and exterior lighting with LED lighting systems | 736,000 |

**Table 2 continued**

| ASDB building renewal project | Campus | ASDB project description | Costs |
|---|---|---|---|
| Marquee replacements | Phoenix and Tucson | Replace the marquees | 150,000 |
| Master meter demise | Phoenix | Demise the master meter to individual meters | 350,000 |
| **Total** | | | **$29,744,485** |

[1] These building renewal projects are listed in priority order as designated by ASDB.

Source: Auditor General staff review of ASDB documentation.

ASDB provided its CIP to the ADOA for inclusion in ADOA's annual State-wide CIP.[2] ADOA compiles and prioritizes a State-wide CIP based on agency requests and submits this CIP to the Governor and Legislature. Although ASDB reported submitting its fiscal year 2026 CIP for inclusion in ADOA's State-wide CIP in June 2024, it has yet to receive funding for the requested capital improvement or projects but reported receiving more than $2.4 million for its building renewal projects in January 2025.[3]

**ASDB prioritizes capital improvement projects based on 5 different categories/criteria—**To help develop its CIPs, ASDB's capital improvement process specifies 5 categories/criteria for prioritizing projects to include in its CIP. In priority order, the 5 categories are health and safety, ADA compliance, purchases involving required equipment, technology needs, and building improvements. For example, among both capital improvement and building renewal projects included in its fiscal year 2026 CIP, ASDB requested approximately $875,000 to address health and safety concerns, nearly $8.5 million to address ADA compliance issues, and approximately $83.8 million for building improvements.[4] Although the committee should prioritize and recommend capital improvement projects based on these categories/criteria in accordance with its capital improvement and planning policy, ASDB reported the committee may consider other factors for prioritizing capital improvement needs and projects. These include considering the criticality of addressing identified building repairs or use limitations, building lifespan, equipment needs, length of time since the capital improvement request was submitted, and available funding. According to its capital improvement and planning policy, the capital review committee should use this information to recommend which capital improvement project requests to fund in a given fiscal year, with ASDB's Superintendent providing the final approval.

[2] The capital review committee developed and ASDB submitted to ADOA a fiscal year 2025 CIP that included approximately $34 million in capital improvement and building renewal project requests. ADOA included approximately $10 million of this request in its State-wide fiscal year 2025 CIP. However, ASDB has not received this requested funding. Through its review process, the capital review committee updated its capital improvement needs in its fiscal year 2026 CIP by adding a new $47 million Pre-K - 12th Grade school project and adjusting the estimated costs of several other projects. This included adding nearly $5.6 million to the estimated costs for its Birth-to-5 Center and decreasing estimated renovation costs for another building by more than $600,000.

[3] The building renewal funding included $950,000 for electrical switchgear replacements, $900,000 for HVAC replacements, $300,000 for roof replacements, $200,000 for EMS upgrades, and $122,000 for fencing and lighting replacements.

[4] These requests include monies to purchase required equipment or technology needs related to some projects.

**ASDB contracted for the development of a master facility plan to assist in planning for its capital improvement needs—**In addition to the capital improvement plan, the committee is responsible for developing and periodically updating a master facility plan. ASDB contracted with LEA Architects and DigStudio to develop a master facility plan that includes a comprehensive list of all ASDB buildings and information such as building use, condition, expected lifespan, and estimated maintenance costs and published this plan on its website in 2024.[5] The plan also includes an evaluation of all mechanical, plumbing, and HVAC systems on its Tucson campus, and an evaluation of current and historical student populations and building utilization for its Tucson and Phoenix campuses. For example, the number of students at ASDB's Tucson campus has decreased from a high of approximately 375 students in 1980 to approximately 150 students in 2023. However, despite this significant decrease in its student population, ASDB's Tucson campus has remained at approximately 346,000 square feet of building space. ASDB's master facility plan identifies the following 2 options for addressing its declining student population and constant and aging building space:

- Option 1: Consolidate the Tucson campus from approximately 50 to 34.1 acres via the potential sale, lease, or transfer of land; reduce 346,000 square feet of building space to 180,000 square feet of usable building space through demolition of antiquated buildings and renovation of other buildings for dormitories, classrooms, office spaces, and library space; and construct a new preschool building.[6] The estimated cost for this option totals approximately $44.5 million and does not account for the proceeds from any sale, lease, or transfer of land. According to ASDB documentation, in July 2023, ASDB received an appraisal of $7,218,000 for the approximately 15.9 acres of land it designated for potential sale, lease, or transfer.

- Option 2: Consolidate the Tucson campus from approximately 50 to 25.2 acres via the potential sale, lease, or transfer of land; demolition of nearly every building with the exception of the existing athletic building, performing arts center, maintenance building, and museum; and the construction of 98,550 square feet in new dormitories, classrooms, office space, and library space across the campus. The estimated cost for this option totals approximately $38.2 million. This cost also does not account for any proceeds, sale, lease, or transfer of land, and ASDB did not obtain an appraised value for the approximately 24.8 acres of land, which includes the 15.9 acres of land discussed in Option 1.[7]

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5 LEA Architects & DigStudio. (2024). Master Facility Plan. Arizona State Schools for the Deaf and Blind (ASDB). Retrieved 12/1/2024 from https://asdb.az.gov/master-facilities-plan/

6 A.R.S. §15-1304 specifies that the grant of 100,000 acres of land for ASDB made by the 1910 Arizona Enabling Act, or the proceeds of such lands if they are sold or otherwise disposed of, is forever reserved for the use and benefit of ASDB. Any sales, exchanges, or commercial leases exceeding 10 years of this land must receive majority approval of the voting members of ASDB's Board of Directors. Additionally, relating to lands donated to ASDB, such as the Tucson campus, A.R.S. §§15-1303(C)(4) and 15-1323 designate ASDB as the trustee of all donated land for the benefit of the school and, according to Arizona Attorney General opinion I84-033, if ASDB determines land is no longer suitable, ASDB may sell or exchange the land and retain those proceeds.

7 ASDB reported that it did not obtain an appraisal for the approximately 24.8 acres of land because it was not included in the contractor's original scope of work. Although not required to obtain an appraisal, doing so would provide ASDB information on the market value of its land and improvements.

**ASDB has identified potential funding sources—**Finally, ASDB's capital improvement and planning policy identifies sources of available financing to help fund capital improvement projects and ongoing operating and maintenance costs. These sources include State monies through the ADOA CIP request process, separately requesting funding from the Legislature, and submitting capital improvement needs information to the Governor's Office of Strategic Planning and Budgeting. Although ASDB reported it is still working to develop the necessary financing strategies to fully fund its identified capital improvement projects following reductions to its fiscal year 2025 budget, as previously mentioned, in June 2024, it developed and reported submitting a formal fiscal year 2026 capital improvement budget request for inclusion in ADOA's State-wide CIP. Additionally, as part of its master facility plan, ASDB indicated it may consider the following funding sources: continued submissions to ADOA for inclusion in the State-wide CIP; State General Fund appropriations; grant funds from federal, State, and local sources; anticipated surplus property and/or land sales, leases, or transfers; and public-private partnerships, capital fundraising, and philanthropic contributions from donors.

Although not specifically indicated in its master facility plan as potential funding sources for capital improvement, statute authorizes various funds for ASDB's use. Statutes for some of these funds do not restrict the use of these monies, and these monies may be available to help pay for capital improvement costs. As of June 30, 2024, monies in these funds totaled nearly $3.9 million (see Table 3 on page 9).[8] Specifically:

- The Schools for the Deaf and Blind Fund consists of monies collected from the expendable earnings of the land grant managed by the Arizona State Land Department (see footnote 4, page 6, for more information on the land grant), Arizona Department of Education (ADE) educational vouchers for deaf and blind students, and over-age and nonresident student fees. As of June 30, 2024, this fund had a balance of more than $3.3 million. Although statute does not restrict the use of monies in this fund, the Legislature must appropriate monies from this fund for ASDB's use.

- The Enterprise Fund consists of monies received from fees, rentals, and other charges from the nonschool use of facilities. As of June 30, 2024, this fund had a balance of nearly $380,000. Statute does not restrict the use of these monies, and these monies are not appropriated by the Legislature.

- The Trust Fund consists of monies received from private endowment, which are outside the control of the State Treasurer and are held by the ASDB Board. As of June 30, 2024, this fund had a balance of more than $160,000. Statute does not restrict the use of these monies, and these monies are not appropriated by the Legislature. However, ASDB policy lists some intended uses of monies in this fund and limits annual spending from this fund to 6 percent of the principal amount. Intended uses include providing assistance devices necessary for student education that parents may not be able to afford; outdoor activities that

[8] According to ASDB documentation, it has used monies from 2 of the funds to pay for capital improvement projects, such as HVAC repair and maintenance.

will assist students in developing self-confidence and enhance their motivation for learning and that parents may not be able to afford, such as skiing, rafting, hiking, and camping; and staff development activities that encourage the development of new techniques and strategies to increase the effectiveness of ASDB programs.

**Table 3**
**ASDB fund monies potentially available for capital improvement and building renewal projects**

| Fund name | Fund type | Statute | June 30, 2024 ending balance |
|---|---|---|---|
| Schools for the Deaf and Blind Fund | Permanent Trust Funds | A.R.S. §15-1304 | $3,343,134 |
| Enterprise Fund | General | A.R.S. §15-1323 | 377,734 |
| Trust Fund | General | A.R.S. §15-1303 | 161,465 |
| **Total** | | | **$3,882,333** |

Source: Auditor General staff review of the *State of Arizona Annual Financial Report* for fiscal year 2024 and statute.

**b.** Identify and prioritize expected capital needs by creating a schedule for those needs based on each major capital asset's lifespan.

- Status: **Implemented at 24 months.**

  See explanation for recommendation 1a.

**c.** Determine the full extent of each project's scope, timing, and cost.

- Status: **Implemented at 24 months.**

  See explanation for recommendation 1a.

**d.** Develop financing strategies to implement projects and fund ongoing operating and maintenance costs.

- Status: **Implementation in process.**

  See explanation for recommendation 1a. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

**e.** Adopt a formal capital budget as part of ASDB's annual or biannual budget process that is directly linked to, and flows from, the multiyear capital plan.

- Status: **Implementation in process.**

  See explanation for recommendation 1a. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

**2.** ASDB should develop and/or update and implement multi-year capital planning policies and procedures that include the following:

**a.** Guidelines for creating and updating a multi-year capital plan and budget, and for coordinating multiyear capital projects, including the promotion of long-term operational and capital financing strategies.

- Status: **Implementation in process.**

  Although ASDB's capital improvement and planning policy specifies several processes for developing and maintaining a multiyear capital improvement plan and associated budgets, the policy does not include guidelines for coordinating multiyear capital projects or promoting long-term operational and capital financing strategies. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

**b.** Requirements for regularly updating planning and associated documentation to determine development or infrastructure needs as conditions change.

- Status: **Implementation in process.**

  See explanation for recommendation 1a. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

## Sunset Factor 2: The extent to which the agency has met its statutory objective and purpose and the efficiency with which it has operated.

**3.** ASDB should develop and implement policies and procedures to periodically review the appropriateness of its Itinerant Services Program (Program) fees and voucher reimbursement amount, including analyzing the costs of its processes and the services it provides, comparing these costs to the associated fees, and determining the appropriate fees and reimbursement amounts, and revise its fees and reimbursement amounts accordingly.

- Status: **Not implemented.**

  In January 2024, ASDB adopted a policy that requires its finance office to develop and implement policies and procedures for periodically reviewing its Program fees and voucher reimbursement amount. As of February 2025, ASDB developed an additional draft policy and procedures that require regular cost analysis of all fees, reimbursements, and services, including direct and indirect costs associated with providing each service. This policy also requires a comparison of forecasted revenues with actual revenues, including assessing any fluctuations in revenue and analyzing revenues generated by fees and services against its associated costs to identify potential areas for optimization. Although ASDB performed a review of Program revenues and expenses as of July 2024 prior to developing the draft policy and procedures and found its revenues exceeded expenses, it has not revised Program fees or voucher reimbursement amounts. As a result, its Cooperative Services Fund balance continues to increase. Specifically, as shown in Table 4 (see page 11), this Fund's

fiscal year ending balance has increased from approximately $4.4 million in fiscal year 2021 to more than $13 million in fiscal year 2024. Most recently, Program revenues exceeded Program expenses by nearly $2.4 million, according to ASDB's initial review and documentation. By not aligning its Program fees with its Program costs, ASDB continues to receive more monies from public school districts that these districts could instead be using for other purposes, such as to reduce class sizes, increase teacher pay, and provide other special education service needs.

**Table 4**
**ASDB's Program revenues exceeded expenditures for fiscal years 2021 through 2024, continually increasing its Cooperative Services Fund balance**

| | Fiscal year | | | |
|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 |
| Total net revenues | $16,964,134 | $18,567,363 | $17,391,692 | $17,808,034 |
| Total expenditures | 15,575,192 | 14,279,178 | 15,403,406 | 15,420,945 |
| Budget surplus | 1,388,942 | 4,288,185 | 1,988,286 | 2,387,089 |
| **Cooperative Services Fund ending balance** | **$4,417,370** | **$8,705,555** | **$10,693,841** | **$13,080,930** |

Source: Auditor General staff review of ASDB documentation and State of Arizona Annual Financial Report for fiscal years 2021 through 2024.

ASDB reported that it plans to increase voucher reimbursement amounts and eliminate the membership fee for participating schools beginning in fiscal year 2026. ASDB also reported that it has met with various internal and external stakeholders, including school districts, to discuss revising its Program funding model. ASDB reported that potential changes include eliminating the membership fee, eliminating the current fee-for-service structure for a voucher-based system, or eliminating voucher reimbursements and moving to a full fee-for-service structure. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

**4.** ASDB should develop and implement policies and procedures for analyzing post-school outcomes (PSO) surveys agency-wide, including using ADE's PSO data-based action planning template to help it identify predictors of post-school success and to develop standardized action planning steps for improving transition services.

- Status: **Implementation in process in a different manner.**

  Although ASDB's response to the sunset review report indicated it would implement this recommendation, during this followup, it reported that it is no longer planning to develop a formal policy but has developed a procedure for analyzing PSO surveys agency-wide. This procedure requires ASDB to identify and inform students about the upcoming survey, identify staff responsible for gathering information, annually obtain information from recent graduates, and use ADE's PSO data-based action-planning template to create an action plan on key areas. These key areas include career

development, student skills, transition-planning process, motivation, and collaboration with parents and the community. Finally, ASDB's procedure for developing its action plan includes steps for staff to identify trends among student groups, compare results to State-level data, observe other school programs that are getting better results, and ensure staff have the needed expertise. In December 2023, ASDB reported it used this process and created an action plan to provide a series of transition workshops to its high school students that would introduce them to concepts of goal setting, self-advocacy, self-determination, autonomy, self-realization, and empowerment. In April 2024, ASDB provided workshops to high school students at both of its campuses focused on self-determination and developing related skills and, in August 2024, began providing weekly skills instruction on self-determination and self-efficacy to its Phoenix campus students. ASDB reported that it plans to annually perform an analysis of PSO survey data. However, in 2024, ASDB reported working with ADE to jointly develop a corrective action plan that includes action items addressing PSO and other special education action items jointly identified with ADE, such as ensuring its Individualized Education Programs document the student's eligibility for alternate assessments, and did not conduct a separate PSO analysis. ASDB's processes for assessing student educational outcomes, including PSO, and taking action to improve these outcomes will be further assessed during its sunset review, which is due by October 1, 2026.

## Sunset Factor 3: The extent to which the agency serves the entire State rather than specific interests.

**5.** ASDB should develop and implement conflict-of-interest policies and procedures to help ensure it complies with State conflict-of-interest requirements and follows recommended practices, including:

**a.** Requiring all employees and Board members to complete a conflict-of-interest disclosure form upon hire/appointment, and reminding them at least annually to update their form when their circumstances change, including attesting that no conflicts exist, if applicable, consistent with State requirements and recommended practices.

- Status: **Implementation in process.**

  ASDB revised its conflict-of-interest policies and procedures to require employees and Board members to complete a conflict-of-interest disclosure form (disclosure form) upon hire or appointment and when their circumstances change. Additionally, ASDB revised its employee and Board member disclosure forms to include an "affirmative no" statement, requiring employees and Board members to attest that they do not have any potential conflicts of interest. As of September 2023, all ASDB Board members had completed the required disclosure form. Additionally, as of February 2025, ASDB reported that it had obtained disclosure forms from 664 of 708 employees, or approximately 94 percent of its employees. Additionally, ASDB revised its conflict-of-interest policies to require annual conflict-of-interest training, which includes a reminder for employees and Board members to update their form when their circumstances change. ASDB began implementing this annual training in July 2023, and as of February 2025, our review of ASDB's training log found

that 704 of 708 ASDB employees have completed the training after January 2024.[9] Finally, in August 2023, ASDB provided this training to 6 of 7 Board members. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

**b.** Storing all substantial interest disclosures in a special file available for public inspection, as required by statute.

- Status: **Not implemented.**

  ASDB has not established a special file available for public inspection for substantial interest disclosures, including substantial interest disclosures made on completed disclosure forms and Board member recusals during Board meetings. Although it reported all completed disclosure forms, including those that do not report a substantial interest disclosure, are retained in its personnel system and can be queried for public inspection, this process does not satisfy the statutory requirement to establish a special file. Additionally, ASDB's personnel system does not have information on Board member recusals. ASDB reported it will establish the required special file by the end of fiscal year 2025. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

**c.** Establishing a process to review and remediate disclosed conflicts, consistent with recommended practices.

- Status: **Implementation in process.**

  ASDB has revised its conflict-of-interest policies to outline a process for reviewing and remediating conflicts disclosed by employees or Board members. According to the policies, if an employee discloses a conflict, the employee's supervisor and ASDB's assistant superintendent must review and determine whether any remediation is necessary and, if so, work with ASDB's human resources department to develop a plan to remediate the conflict. These policies further specify that ASDB's legal counsel may assist its Superintendent or Board President in reviewing potential conflicts disclosed by Board members and state that Board members must recuse themselves from all discussions and votes related to a disclosed conflict. Our review of 5 employee disclosure forms submitted between November 2023 and May 2024 that disclosed conflicts found that ASDB adhered to its policies for reviewing and determining the need to remediate the disclosed conflicts. However, none of the 7 Board member disclosure forms submitted in August and September 2023 included disclosed conflicts that would have required review or remediation. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

[9] According to ASDB's conflict-of-interest training tracker, 1 of the remaining 4 employees took this training in September 2023, and 3 did not receive training as they were either out of the country or were separating from ASDB.

**6.** ASDB should provide periodic training on its conflict-of-interest requirements, process, and form, including providing training to all employees and Board members on how the State's conflict-of-interest requirements relate to their unique program, function, or responsibilities.

- Status: **Implementation in process.**

  In March 2023, ASDB revised its conflict-of-interest policies to require annual employee training on ASDB's conflict-of-interest policies. This training provides information on the State's conflict-of-interest requirements related to ASDB employees' unique programs, functions, and responsibilities. As discussed in recommendation 5a, ASDB began implementing the annual employee training in July 2023 and, as of February 2025, our review of ASDB's training log found that 704 of 708 ASDB employees have completed the training after January 2024.[10] Finally, as discussed in recommendation 5a, in August 2023, ASDB provided training to 6 of 7 Board members on their unique statutory roles and responsibilities and relevant Board conflict-of-interest policies. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

## Sunset Factor 6: The extent to which the agency has been able to investigate and resolve complaints that are within its jurisdiction and the ability of the agency to timely investigate and resolve complaints within its jurisdiction.

**7.** ASDB should develop and implement policies and procedures for tracking all complaints throughout the complaint resolution process, including establishing time frames for investigating and resolving all complaints.

- Status: **Implementation in process.**

  ASDB has developed several policies related to complaint-handling. These policies outline roles and responsibilities for investigating complaints, steps for processing/investigating complaints, steps for parties to complaints to appeal ASDB decisions, and time frames for resolving some types of complaints, ranging between 10 to 30 days depending on the nature of the complaint. However, ASDB has not yet established specific time frames for investigating and resolving all types of complaints it receives. For example, some complaint policies reference a nonspecific time frame for resolving a complaint, such as "as soon as reasonable." Additionally, although ASDB's complaint-handling policies establish different time frames for investigating some complaints based on the nature of the complaint allegations, its policies do not establish requirements for prioritizing complaints for review and investigation based on the severity of the complaint and/or complaint allegations. ASDB hired a complaint administrator in February 2024 to oversee some of its complaint-handling processes, including assisting with the implementation of its complaint-tracking system to track and monitor the investigation and resolution of all complaints. ASDB also contracted for the development of a complaint-tracking system and, in August 2024, reported implementing its new complaint-tracking system that includes a web-based portal

[10] According to ASDB's conflict-of-interest training tracker, 1 of the remaining 4 employees took this training in September 2023, and 3 did not receive training as they were either out of the country or were separating from ASDB.

available to the public for submitting complaints and the ability to generate reports to assist employees with complaint tracking.

Prior to implementing its complaint-tracking system, ASDB used manual complaint logs to record and track complaints it received. Our review of all 46 complaints that were received and recorded on ASDB's complaint logs between January 1, 2024 and July 30, 2024, found that, according to the complaint logs, ASDB resolved 12 of these complaints within 10 days and another 12 within 11 to 30 days.[11] However, it required 31 days or more to resolve 13 complaints, and the remaining 9 complaints had been open between 70 and 148 days as of July 30, 2024, which exceed the time frames in policy. Additionally, although the complaint logs included the complaint open and closed dates and resolution for the 37 of 46 complaints that were closed, they did not include sufficient information for some of the 46 complaints to ascertain the nature and severity of the complaint, the source of the complaint or complainant, and the applicable complaint-handling policy.

Our further review of a stratified random sample of 7 of the 46 complaints, consisting of 2 ADA noncompliance complaints and 5 other complaints, found that ASDB documented the nature of the complaint, the complainant, and ASDB's handling of the complaint investigation for the 2 ADA complaints in accordance with its policies. However, at the time of our review, these 2 complaints were open, and we were thus unable to review if ASDB took all steps required by its policies to resolve the complaints. Additionally, our review of the remaining 5 complaints involving concerns about employee behavior, including alleged reporting to work under the influence of alcohol and inappropriate conduct with students, and found that ASDB did not fully document key complaint-handling information, such as describing the original complaint or steps ASDB took to investigate and resolve the complaints. For example, although ASDB provided a summary document for all 5 complaints that included brief descriptions of the complaints and how they were resolved, including dismissal of the complaint, requiring supervisor meetings, and memos of concern and direction, it did not provide documentation of the original complaint, its complaint investigation, or its process for resolving the complaint, including determining any disciplinary action. Absent this documentation, we were unable to determine whether ASDB staff followed ASDB's complaint-handling policies and appropriately resolved the complaint. ASDB's implementation of this recommendation will be further assessed during its sunset review, which is due by October 1, 2026.

**8.** ASDB should make complaint-handling information readily available on its website, including a description of ASDB's complaint-handling process and forms.

- Status: **Implemented at 24 months.**

  As of December 2024, ASDB has updated its website to provide more readily available complaint-handling information. Specifically, ASDB includes a link to its complaint-handling policies and forms on its website and developed a web-based portal for its staff and members of the public to submit complaints.

[11] These complaints include allegations of ADA noncompliance and administrative complaints against teachers for allegations of inappropriate conduct, neglect of duty, and discourteous treatment.

LINDSEY A. PERRY
AUDITOR GENERAL

ARIZONA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

**DATE:** March 26, 2025

**TO:** Senator Mark Finchem, Chair
Representative Matt Gress, Vice Chair
Members, JLAC

**FROM:** Lindsey Perry, Auditor General

**SUBJECT:** Public Safety Personnel Retirement System, February 2025 Initial Follow-up of Report 23-109

## Background

My Office is responsible for conducting sunset reviews of State agencies, boards, and commissions under Arizona's sunset law and as assigned by JLAC. As a result, in 2023, my Office conducted and released a performance audit and sunset review report on the Public Safety Personnel Retirement System (System) as part of the System's sunset review, see Report 23-109.

The System is responsible for administering 5 retirement plans for various Arizona public safety personnel, elected officials, and court personnel, including police officers, firefighters, correctional officers, elected Arizona officials, members of the Arizona Supreme Court, Superior Court, and Court of Appeals, and court commissioners. Our 2023 performance audit and sunset review found that the System and Legislature had taken various steps to improve its pension plans' sustainability and ability of public safety and corrections officers' pension plans to meet retirement obligations for plan members. However, we also found that:

- Former System administrators failed to disclose relationships/conflicts and engaged in System business related to them—We reported that a former System administrator entered business relationships with 2 former System board members, and all 3 failed to disclose and refrain from participating in System decisions that could have been influenced by these relationships, such as a retroactive pay increase for the former administrator and unsupported travel reimbursements to the former System board members. We made 3 recommendations to address this issue, including that the System develop and implement comprehensive conflict-of-interest policies and procedures.

- System needed additional improvements to ensure accurate member data—The System had taken steps to help ensure the accuracy of its member data, which is important for estimating pension liability and ensuring required contribution rates can cover future benefit payments. However, we found that additional steps were needed, and we made 2 recommendations to the System.

- System did not comply with 1 State open meeting law provision—The System did not make meeting minutes or recordings available within 3 working days as required by statute for the meetings we reviewed, and we made 1 recommendation to the System to address this issue.

Our initial follow-up report, issued in February 2025, found that the System had implemented our 3 recommendations related to member data and open meeting law and had also implemented 1 recommendation to remind its employees at least annually to update their conflict-of-interest disclosure form if/when their circumstances change.

However, our initial followup also identified several additional issues related to conflicts of interest, including that the System:

- Had several employees and Board members who disclosed potential substantial interests that could influence or affect their official conduct, including business and investment interests, but lacked evidence it had reviewed these disclosures to address and/or mitigate potential conflicts of interest.

- Was not following its conflict-of-interest policies.

- Lacked sufficient policies and procedures to help ensure it complied with State conflict-of-interest requirements and followed recommended practices.

We were asked to present information on the initial follow-up report, issued in February 2025. Patrick Jennett, Performance Audit Division Deputy Manager, will provide an overview of the follow-up report.

Attachment A includes the System's initial follow-up report, issued in February 2025.

## Action required

None. Presented for JLAC's information only.

Attachment A

# Followup

## Public Safety Personnel Retirement System

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# Public Safety Personnel Retirement System

## Initial Followup of Report 23-109

The September 2023 Arizona Public Safety Personnel Retirement System (System) performance audit and sunset review found that the System and Legislature have taken various steps to improve pension plans' sustainability and ability of public safety and corrections officers' pension plans to meet retirement obligations for plan members, but despite these efforts, the elected officials' pension plan's status declined further, the System's former administrator entered into business relationships with 2 former Board members, and all 3 participated in decisions that could have been influenced by these relationships. We made **6** recommendations to the System.

### System's status in implementing 6 recommendations

| Implementation status | Number of recommendations |
|---|---|
| Implemented | 4 recommendations |
| In process | 1 recommendation |
| **Not implemented** | **1 recommendation** |

We will conduct a 24-month followup in the Fall 2025, on the status of the recommendations that have not yet been implemented.

# Recommendations to the System

## Finding 1: Former System Administrator entered business relationships with 2 former Board members and all 3 failed to disclose and refrain from participating in decisions that could be influenced by their relationships.

**1.** The System should develop and/or revise and implement conflict-of-interest policies and procedures to help ensure it complies with State conflict-of-interest requirements and follows recommended practices, including:

**a.** Storing and tracking all substantial interest disclosures in a special file available for public inspection.

- Status: **Not implemented.**

  The System has developed some policies and procedures that require any substantial interest disclosures made by its employees to be stored in a special file available for public inspection. However, the System's policies and procedures do not require Board members' substantial interest disclosures to be stored in its special file. Instead, contrary to statute, which requires all substantial interests made by a public officer to be stored in a special file available for public inspection, the System's policies and procedures state that Board members' substantial interest disclosures are not subject to public disclosure.

  Additionally, as of October 2024, the System reported it has not stored any substantial interest disclosures in its special file because it has not received any; however, our review of System employees' and Board members' completed disclosure forms from calendar years 2023 and 2024 found multiple instances of System employees and Board members disclosing potential substantial interests for which the System did not document its review and determination of whether the disclosures were substantial and should be stored in its special file. These disclosures included the following:

  - 1 Board member and 1 executive investment employee, who disclosed an investment-related business relationship they indicated might influence their independence. Not only did these disclosures include a potential substantial interest, the relationship they disclosed was also potentially prohibited by the System's Code of Ethics. Specifically, the executive investment employee disclosed receiving compensation from a Board member for an investment-related business relationship and indicated it might influence their independence, despite the System's Code of Ethics prohibiting a System employee from accepting compensation that could be expected to impair independence.
  - 1 senior portfolio manager who disclosed ownership of a security investment-related business.
  - 1 Board member who disclosed personal investments in securities that are also held in the System's investment portfolio.

- 1 executive employee with authority to approve all System investments who disclosed that an immediate family member is a member of 1 of the System's pension funds.

Further, our review of Board members' and employees' disclosure forms found that 2 Board members and 1 employee disclosed business and investment-related relationships with 3 other Board members that were potentially conflicts-of-interest, such as providing investment advisory services to a Board member. However, these 3 Board members did not similarly disclose these relationships on their own disclosure forms.

Although the System has developed some conflict-of-interest policies and procedures as previously discussed, it lacks comprehensive policies and procedures to ensure full compliance with all State conflict-of-interest requirements. Specifically, the System has not yet established policies and procedures and/or guidance for:

- Ensuring System employees and Board members disclose all potential conflicts of interest.
- Requiring Board member disclosures to be included in the special file, as required by statute.
- Reviewing disclosed interests to determine whether any disclosures meet the statutory definition of a substantial interest and storing all substantial interest disclosures made by Board members and employees in the System's special file.
- Remediating disclosed interests as necessary, including documenting its review and remediation of substantial interests.

As a result, the System and its Board members and employees are at risk of violating State conflict-of-interest laws and requirements and that substantial interests might improperly influence official employee and Board member conduct and System decisions. We will assess the System's development and implementation of comprehensive conflict-of-interest policies and procedures to help ensure compliance with all State conflict-of-interest laws and requirements during our 24-month followup.

**b.** Reminding employees at least annually to update their disclosure form if/when their circumstances change.

▶ Status: **Implemented at 12 months.**

The System updated its policies and procedures in December 2023 to require its employees to complete a conflict-of-interest disclosure form when hired and annually within the first month of each calendar year thereafter, or within 30 days if or when an employee's circumstances change. In January 2024 and 2025, the System sent an email requiring its employees to complete a disclosure form.

**2.** The System should develop and provide periodic training on its conflict-of-interest requirements, process, and disclosure form, including providing training to all employees on how the State's conflict-of-interest requirements relate to their unique programs, functions, or responsibilities.

- Status: **Implementation in process.**

  In April 2024, the System developed and began providing training to employees on its conflict-of-interest requirements, process, and disclosure form. However, the training does not include information about how the State's conflict-of-interest requirements relate to the System's unique programs, functions, or responsibilities. Additionally, as discussed in the explanation for recommendation 1a, the System has not developed comprehensive conflict-of-interest policies and procedures to help ensure compliance with all State conflict-of-interest laws and requirements. We will further assess the Department's implementation of this recommendation during our 24-month followup.

## Sunset Factor 2: The extent to which the System has met its statutory objective and purpose and the efficiency with which it has operated.

**3.** The System should continue providing quarterly census data to and working with the Arizona Department of Administration to reconcile the active member personnel data between the State's payroll records and the data provided to the System's actuaries and investigate and resolve any errors prior to providing the information to its actuaries.

- Status: **Implemented at 12 months.**

  The System has developed an automated process for providing quarterly census data to the Arizona Department of Administration (ADOA) to help reconcile the active member personnel data between the State's payroll records and the data provided to the System's actuaries, and reported that it has provided ADOA the ability to correct any identified errors in the System's pension administration system.

**4.** The System should continue including member data in employer and local board internal audits and implement its plans to expand the audit work to include comparing member data reviewed to the data provided to the actuaries to help identify inaccuracies in the data.

- Status: **Implemented at 12 months.**

  The System has continued to include member data in employer and local board internal audits and expanded the audit work to include comparing member data reviewed to the data provided to the actuaries to help identify inaccuracies. Specifically, our review of 5 employer and local board internal audits the System reported were in process as of February 2025, found that the audits included this expanded audit work.

## Sunset Factor 5: The extent to which the System has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

**5.** The System should ensure that meeting minutes, or digital recordings, are available upon request within 3 working days of public meetings, as required by statute.

- Status: **Implemented at 12 months.**

  Our review of Board meeting minutes for the Board's May and June 2024 meetings found that the System made its meeting recordings available for public inspection within 3 working days after the meeting, as required by statute.

LINDSEY A. PERRY
AUDITOR GENERAL

ARIZONA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

**DATE:** March 26, 2025

**TO:** Senator Mark Finchem, Chair
Representative Matt Gress, Vice Chair
Members, JLAC

**FROM:** Lindsey Perry, Auditor General

**SUBJECT:** Arizona Department of Health Services—Long-Term Care Complaints and Self Reports, December 2024 48-month Follow-up of Report 19-112

## Background

My Office is responsible for conducting sunset reviews of State agencies, boards, and commissions under Arizona's sunset law and as assigned by JLAC. As a result, in 2019, my Office conducted and released a performance audit and sunset review report on the Arizona Department of Health Services (Department) as part of the Department's sunset review.

The Department is responsible for investigating complaints and self-reports (complaints) that may contain regulatory violation allegations at State and federally licensed long-term care facilities (i.e., nursing homes), including allegations of resident neglect and abuse.[1] Our 2019 performance audit and sunset review of the Department and subsequent follow-up reports have found multiple and ongoing serious problems related to this responsibility, as follows:

- Our September 2019 performance audit and sunset review found that the Department put long-term care facility residents at risk by failing to investigate or timely investigate some long-term care facility complaints. We made 5 recommendations to the Department to address these issues. See Report 19-112.

- Our May 2022 30-month follow-up report found that the Department had not implemented any of the 5 recommendations, and we identified additional significant complaint-prioritization and investigation failures that continued to put long-term care facility residents' health, safety, and welfare at risk. We made 4 additional recommendations related to the inaccurate prioritization and closure of most high-priority complaints. See 30-month Follow-up Report.

- Our May 2023 36-month follow-up report found that the Department had begun implementing 6 of the 9 recommendations, but we continued to see some problems with its long-term care facility-complaint-prioritization and resolution processes that may put

[1] The Department is the State licensing agency and the Centers for Medicare and Medicaid Services' State Survey Agency for long-term care facilities.

long-term care facility residents' health, safety, and welfare at risk. See 36-month Follow-up Report.

Our most recent report on this issue was our December 2024 48-month follow-up report. This report found that, although the Department was in the process of implementing most of our recommendations and changed some of its processes in response to our recommendations, we continued to identify problems with its long-term care facility complaint prioritization that may put long-term care facility residents' health, safety, and welfare at risk

We were asked to present information on the 48-month follow-up report, issued in December 2024. Jeff Gove, Performance Audit Division Director, will provide an overview of the follow-up report.

Attachment A includes the Department's 48-month follow-up report, issued in December 2024.

## Action required

None. Presented for JLAC's information only.

Attachment A

# Followup

## Arizona Department of Health Services—Long-Term Care Complaints and Self-Reports

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# Arizona Department of Health Services Long-Term Care Complaints and Self-Reports 48-Month Follow-Up Report

Our 2019 performance audit and sunset review of the Arizona Department of Health Services (Department) found that the Department put long-term care facility residents at risk by failing to investigate or timely investigate some long-term care facility complaints and self-reports. We made 5 recommendations to the Department to address these issues. In May 2022, our 30-month follow-up report found that the Department had not implemented any of the 5 recommendations, and we identified additional significant complaint-prioritization and investigation failures that continued to put long-term care facility residents' health, safety, and welfare at risk; we made 4 additional recommendations related to the inaccurate prioritization and closure of most High-Priority complaints and self-reports. Our 36-month follow-up, issued in May 2023, found that the Department had not implemented 3 of 9 recommendations and was in the process of implementing the remaining 6 recommendations.

This report focuses on our work to assess the Department's process for prioritizing long-term care facility complaints and self-reports and whether the Department has implemented applicable recommendations. During this followup, we also began work to review the Department's long-term care facility complaint/self-report investigation and resolution process. To help conduct this review, for 11 months we worked with the Department and the federal Centers for Medicare and Medicaid Services (CMS) to obtain access to unredacted long-term care facility investigation and resolution records needed to assess the Department's investigations. However, as of November 2024, CMS had not approved our access to these unredacted records. As such, we were unable to assess the Department's investigations process or determine the status of 2 of 9 recommendations, and our work to assess the status of some of the remaining 7 recommendations was limited to information related to the Department's prioritization process (see pages 7 through 12 for detailed information about these recommendations). We will continue to work with the Department and CMS to access these records, and we will issue a separate follow-up report on the Department's long-term care facility-investigation and resolution process after we obtain these records.

The Department's status in implementing the 9 recommendations is as follows:

## Status of 9 recommendations

| | |
|---|---|
| In process | 7 |
| **Unable to determine at this time** | **2** |

Although we found that the Department was in the process of implementing most of our recommendations and changed some of its processes in response to our recommendations after we issued our 36-month followup, we continued to identify problems with its long-term care facility complaint and self-report prioritization that may put long-term care facility residents' health, safety, and welfare at risk (see table, page 2, for key issues we have identified through our audit and related follow-up work at the Department and if/when the Department resolved each issue). We will continue to follow up with the Department on the status of the recommendations that have not been fully implemented.

## Department has resolved 3 key issues identified in our previous reports, but additional work remains to resolve 2 outstanding issues

| Key issue | 30-month followup | 36-month followup | 48-month followup | Report pages |
|---|---|---|---|---|
| | Issue resolved? | | | |
| Inappropriately closed complaints and/or self-reports to not require an on-site investigation.[1] | No | No | Yes | 11 |
| Inappropriately prioritized serious complaints and/or self-reports as a lower priority.[2] | n/a | No | No | 4-5 |
| Inappropriately changed open High Priority complaints/self-reports to lower priorities. | No | Yes | Yes | 11 |
| Assigned much higher percentage of complaints and self-reports to a lower priority than in the past. | No | No | Yes | 12 |
| Did not consistently collect needed information to prioritize complaints.[2] | n/a | No | No | 5 |

[1] Our May 2023 36-month follow-up report found that the Department continued to close most High- or Medium-Priority self-reports without an on-site investigation, but it stopped this practice in July 2022.

[2] We first identified this issue during the 36-month followup.

# Although the Department changed some of its processes in response to our recommendations, its continued complaint-prioritization issues may put long-term care facility residents' health, safety, and welfare at risk

In March 2023, the Department received a complaint about a long-term care facility resident who was found unattended, shaking, and turning red and purple by the complainant. The resident was also having a hard time breathing and had a neck pillow that was pushing the resident's head forward onto their trachea and possibly depriving them of oxygen. The facility's doctor assessed the resident and had a nurse give the resident pain medication. Later in the day, another individual found the resident in distress and with the same symptoms. The individual asked to see the doctor, but the doctor had left, and the nurse was taking a lunch break. The individual called 911, and the resident was taken to the hospital. Medical staff at the hospital determined that the resident had an infection, dehydration, and a clogged shunt drain, and admitted the resident to the hospital's intensive care unit.

According to CMS guidance, because the facility's alleged failure to provide adequate care to the resident resulted in serious injury/harm and because there was a likelihood of other residents also being impacted, the Department should have prioritized this complaint as Immediate Jeopardy, which requires it to initiate an on-site investigation within 3 working days. Instead, upon receiving the complaint, the Department prioritized the complaint as a Medium Priority, which allows it up to 45 calendar days to initiate an on-site investigation. Additionally, according to Department records, although the Department received the complaint in March 2023, it had not initiated an investigation as of April 2024, more than 1 year later.[1]

[1] As previously discussed (see page 1), we were unable to assess the Department's investigations process, including determining why the Department had not started investigating this complaint, because CMS had not approved our access to unredacted investigation records.

This complaint is 1 of several long-term care facility complaints and self-reports we found during this followup that the Department failed to accurately prioritize according to the CMS requirements, which placed residents' health, safety, and welfare at risk.[2] See textbox for the Department's complaint and self-report priority levels.

## Department continued to inaccurately assign some complaints and self-reports a lower priority and failed to collect important information for making some priority assignments, but assigned Medium Priority to a lower percentage of complaints than in previous followups

CMS views state long-term care facility regulatory agencies, including the Department, as the front-line responders to address concerns, including complaints, raised by long-term care facility residents, their families, and facility staff to help protect vulnerable residents from abuse, neglect, exploitation, or inadequate care.[3] Accordingly, CMS' operation manual for states outlines a detailed process for handling complaints and self-reports. This process requires the Department to collect comprehensive information to allow for accurate prioritization of complaints and self-reports, such as the complainant's concerns, views about the frequency and pervasiveness of the allegation, and how/why the event occurred.[4] Additionally, the process includes specific requirements for prioritizing complaints, including the criteria and time frames for initiating on-site investigations or taking other action, such as referring the complaint or self-report to another agency (see textbox for priority levels requiring an on-site investigation).

### Complaint and self-report priority levels that require an on-site investigation[1]

**Immediate Jeopardy—**Alleged noncompliance has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Specifically, adverse outcomes that result in or are likely to result in death; a significant decline in physical, mental, or psychosocial functioning; loss of limb or disfigurement; excruciating pain; or life-threatening complications or conditions. The Department must start its on-site investigation within 3 working days of receipt of the initial report.

**High Priority—**Alleged noncompliance may have caused harm that negatively impacts a resident's mental, physical, and/or psychosocial status and are of such consequence to the person's well-being that a rapid response is indicated. Usually specific rather than general information, such as names, date/time/location, and description of harm, factors into the assignment of this level. The Department must start its on-site investigation within an annual average of 15 working days, not to exceed 18 working days of receiving the initial report.

**Medium Priority—**Alleged noncompliance may have caused no actual physical and/or psychosocial harm, but there is the potential for more than minimal harm to the residents. The Department must start its investigation within 45 calendar days of receipt of the initial report.

[1] Federal standards also establish 1 priority (Low) for use when alleged noncompliance may have caused no actual harm. The Department is not required to conduct an on-site investigation but must track and trend allegations for potential followup during its next on-site survey and 4 other priorities that do not require an on-site investigation, such as when the Department is required to refer the intake to another agency or if the allegations are outside of the Department's regulatory authority.

Source: Auditor General staff review of CMS' State Operations Manual Chapter 5 and Appendix Q.

[2] A self-report is an incident that a long-term care facility must report to the Department. Specifically, facilities must report incidents that involve potential regulatory violations, including resident injuries of an unknown origin, allegations of resident neglect and/or abuse, and misappropriation of resident property.

[3] The Department operates as the State agency responsible for ensuring long-term care facilities meet applicable federal requirements for Medicare and Medicaid participation. This responsibility includes conducting initial certification surveys and complaint investigations.

[4] According to CMS' State Operations Manual, the Department may need to communicate with the complainant to obtain additional information.

**Department continued to inaccurately assign some serious complaints and self-reports a lower priority—**Similar to the issues we identified in our 36-month follow-up report, the Department has continued to inaccurately assign lower priorities to some Immediate Jeopardy and High-Priority complaints and self-reports.[5] Specifically, our contractor's review of a random sample of 135 complaints and self-reports that the Department received between January and September 2023 and prioritized as Medium Priority or High Priority identified 51 complaints/self-reports that should have been prioritized higher to Immediate Jeopardy or High Priority, according to CMS' requirements (see Table 1, page 5).[6,7] The Department prioritized 28 complaints as Medium Priority or High Priority that should have been prioritized as Immediate Jeopardy. For example:[8]

> In June 2023, the Department received a complaint related to a long-term care resident alleging that while assisting the resident, a nursing assistant fondled the resident's genitalia and tried kissing the resident.
>
> According to CMS guidance, because the complaint included an allegation of sexual abuse, the Department should have prioritized this complaint as Immediate Jeopardy, which requires it to initiate an on-site investigation within 3 working days. Instead, the Department prioritized the complaint as Medium Priority, which allows it up to 45 calendar days to initiate an on-site investigation, citing quality-of-care and treatment allegations. According to Department records, although the Department received the complaint in June 2023, it had not initiated an investigation as of April 2024, more than 300 calendar days later.

In addition, the Department also prioritized 23 complaints as Medium Priority that should have been prioritized as High Priority. For example:

> In February 2023, the Department received a complaint alleging that a long-term care facility resident had been found in a bed with feces all over. The complaint also alleged that the resident was in pain, crying, and had an infection that can cause diarrhea. According to the complaint, the resident's family member brought these concerns to facility staff, and most staff members were rude and not alarmed about the resident's condition. Facility staff also allegedly broke the resident's glasses and took away their do-not-resuscitate bracelet.
>
> According to CMS guidance, because the complaint alleged resident harm and due to the need for a quick response, the Department should have prioritized this complaint as High Priority, which requires it to initiate an on-site investigation within 18 working days. Instead, the Department prioritized this complaint as Medium Priority, which allows up to 45 calendar days to initiate the investigation. According to Department records, although the Department received the complaint in February 2023, it had not initiated an investigation as of April 2024, more than 1 year later.[9]

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[5] Our 36-month follow-up report reviewed 119 complaints/self-reports the Department prioritized as Medium Priority and identified 41 complaints/self-reports that contained allegations of abuse, sexual assault, and neglect, and thus could have been prioritized higher than a Medium Priority according to CMS' requirements. The 119 complaints and self-reports we reviewed comprised 2 different samples. The first sample consisted of a random sample of 59 of 213 federal complaints and self-reports the Department received prior to July 1, 2022, and investigated in August 2022. The second sample consisted of 60 of 906 federal complaints and self-reports the Department received between August 1, 2022 and October 20, 2022, and prioritized as Medium Priority.

[6] We contracted with an experienced healthcare management firm to conduct this review. The contractor's staff who conducted this review were certified to have successfully completed the Surveyor Minimum Qualifications Test (SMQT). The SMQT addresses the knowledge, skills, and abilities needed to conduct surveys in long-term care facilities, including prioritizing, investigating, and resolving complaints.

[7] Our contractor reviewed a random sample of 135 of 2,837 complaints and self-reports the Department received and assigned as Medium Priority and High Priority between January 1, 2023 and September 30, 2023.

[8] As previously discussed (see page 1), we were unable to assess the Department's investigations process, including determining why the Department had not started investigating this complaint, because CMS had not approved our access to unredacted investigation records.

[9] As previously discussed (see page 1), we were unable to assess the Department's investigations process, including determining why the Department had not started investigating this complaint, because CMS had not approved our access to unredacted investigation records.

**Table 1**
**Department assigned a lower priority to 51 of 135 sampled complaints and self-reports that should have been prioritized as Immediate Jeopardy or High Priority**

| Department-assigned priority | Number of complaints that should have been Immediate Jeopardy Priority | Number of complaints that should have been High Priority |
|---|---|---|
| High | 7 | |
| Medium | 21 | 23 |

Source: Auditor General staff summary of 135 sampled complaints and self-reports prioritized as Medium Priority and High Priority that should have been prioritized as Immediate Jeopardy or High Priority.

**Department did not collect necessary information to prioritize 41 complaints and self-reports reviewed—**As previously discussed, CMS requires the Department to collect comprehensive information to allow for accurate prioritization of complaints and self-reports and indicates that subsequent communications may be necessary to obtain this information. Additionally, our 36-month follow-up report found that several complaint records lacked specific information to allow for accurate prioritization. At the time of the 36-month followup, the Department also reported that since February 2023, it has directed its staff to make every effort to obtain additional information to allow for accurate prioritization, and if they cannot quickly obtain that information, the Department will err on the side of caution and prioritize the complaint higher than a Medium Priority. The Department also indicated at that time that its staff began including notes in intake records documenting their attempts to obtain additional information. However, despite these reported changes, during this followup, the Department did not collect necessary information to prioritize some complaints and self-reports. Specifically, our contractor's review of a random sample of 135 complaints and self-reports found that the Department did not collect important information necessary to help it make priority assignments or document its unsuccessful attempt to obtain this information for 41 complaints/self-reports the Department received between February 2023 and September 2023. These complaint/self-reports included 4 complaints/self-reports for which our contractor could not determine a priority level because of a lack of information.[10] Some of the complaints and self-reports that our contractor reviewed were missing important information to allow for accurate prioritization. For example:

> In March 2023, the Department received a self-report from a facility that stated a resident was on antibiotics for an infection but reported that there was no adverse reaction. The resident also denied having pain or discomfort, and the facility did not provide an explanation for why it was self-reporting this information.
>
> The Department prioritized this complaint as Medium Priority and categorized the allegation as "neglect." However, the self-report did not have enough information for the Department to determine that the facility was reporting neglect. According to Department records, the Department initiated an investigation in May 2023 and closed the complaint in October 2023 with no substantiated findings.

**Department has assigned Medium Priority to a lower percentage of complaints and self-reports since October 2022 and reported that, as of fiscal year 2024, this trend has continued—**As reported in our 30-month follow-up report, in the last half of calendar year 2020, the Department prioritized the majority, or 95 percent of complaints and self-reports, as Medium Priority compared to only 51 percent in the last half of calendar year 2019, despite no changes in prioritization requirements. Similarly, our 36-month follow-up report found that the Department continued to prioritize approximately 95 percent of complaints and self-reports as Medium Priority from April 2021 through October 2022, thereby substantially reducing the number of complaints requiring an investigation within 10 days.

[10] See Footnotes 6 and 7 for more information about our contractor and the sample of 135 complaints, respectively.

During this followup, our review of the Department's complaint and self-report data from October 1, 2022 through September 30, 2023, found that the Department assigned a Medium Priority to a smaller percentage of complaints and self-reports than we found in previous followups. Specifically, the Department prioritized 70 percent of complaints and self-reports it received during this 1-year period as Medium Priority. After we had completed most of our follow-up work, in December 2024, the Department reported that it was assigning Medium Priority to an even smaller percentage to complaints and self-reports. Specifically, for fiscal year 2024, the Department reported assigning approximately 52 percent of complaints/self-reports Medium Priority, which represented further improvement in this area.

## Department's complaint-prioritization failures continue to put long-term care residents' health, safety, and welfare at risk

As illustrated by the case example below, when the Department fails to prioritize and investigate complaints in accordance with CMS requirements, it fails to meet 2 of CMS' objectives for the long-term care complaint system: (1) protective oversight, which is accomplished by identifying and responding to those complaints/self-reports that appear to pose the greatest risk to residents; and (2) prevention, which is accomplished by investigating complaints/self-reports to determine if a problem exists that could have a negative impact on the healthcare services provided to all residents and to prevent the escalation of the problems into more serious situations that would threaten their health, safety, and welfare. Further, not collecting enough information and incorrectly prioritizing or using a lower priority for an Immediate Jeopardy or High Priority complaint/self-report can have severe, adverse effects, including compromised investigations impacting the Department's ability to substantiate allegations such as neglect, sexual abuse, and factors leading to death where time is of the essence, and failing to take actions necessary to help protect that resident and other residents of the facility. For example:

> In February 2023, the Department received a complaint alleging that a long-term care facility resident was not eating, drinking, or participating in rehabilitation activities and had been hallucinating since being admitted to the facility. Further, the resident had lost a significant amount of weight and had had 3 infections. The complainant also reported observing 2 bruises on the side of the resident's face. According to the complainant, the resident had to be taken to the hospital, and the facility lost several of the resident's personal effects, including their glasses.
>
> According to CMS guidance, because the facility's alleged failure to provide adequate care to the resident had potentially resulted in serious injury/harm and because there was a likelihood of other residents being impacted, the Department should have prioritized this complaint as Immediate Jeopardy, which requires it to initiate an on-site investigation within 3 working days. Instead, the Department prioritized this complaint as a Medium Priority, which allows it up to 45 calendar days to initiate the investigation. According to Department records, although the Department received the complaint in February 2023, it had still not initiated an investigation as of April 2024, more than 1 year later.[11]

## Department's lack of process for monitoring its staff's complaint and self-report prioritization accuracy has allowed complaint prioritization issues to continue

Although the Department has taken some steps to implement our 30-month follow-up report recommendation to monitor its long-term care facility staff to ensure they comply with CMS requirements, the Department's lack of a comprehensive process to monitor its staff's complaint and self-report prioritization accuracy has allowed its complaint-prioritization issues outlined in this follow-up report to continue. Specifically, the Department has developed policies and procedures that require its staff to inform their supervisor when they prioritize Immediate Jeopardy or High-Priority complaints and self-reports or any complex or challenging complaints and self-reports. In addition, the Department has implemented daily and weekly complaint-prioritization and review meetings during which its staff, supervisors, and managers discuss and prioritize these complex or challenging complaints and self-reports.

[11] As previously discussed (see page 1), we were unable to assess the Department's investigations process, including determining why the Department had not started investigating this complaint, because CMS had not approved our access to unredacted investigation records.

However, the Department's process requires reviews only of complaints and self-reports that staff bring to their supervisors' attention, and does not include procedures for systematically reviewing and/or monitoring its staff's prioritization accuracy. For example, the Department lacks a process for selecting and reviewing complaints and self-reports its staff have assigned a Medium Priority, despite our 3 followups consistently identifying that Department staff inaccurately used Medium Priority for some Immediate Jeopardy and High-Priority complaints and self-reports, inconsistent with CMS requirements. Implementing such a process could be instrumental in helping the Department identify and correct the prioritization issues we have consistently identified during our 3 followups.

## Although the Department is in process of implementing most prior report and follow-up recommendations, additional work remains to fully implement them

During this followup, we found that the Department still has additional work to do to fully implement the recommendations from the 2019 performance audit and sunset review as well as the additional recommendations from the 30-month followup on that report, which are intended to better protect the health, safety, and welfare of long-term care residents.

### Status of 2019 performance audit and sunset review recommendations:

**1.** To help ensure all long-term care facility complaints and self-reports are prioritized, investigated, and resolved in a timely manner, the Department should:

**a.** Continue with its efforts to allocate new or reallocate existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis.

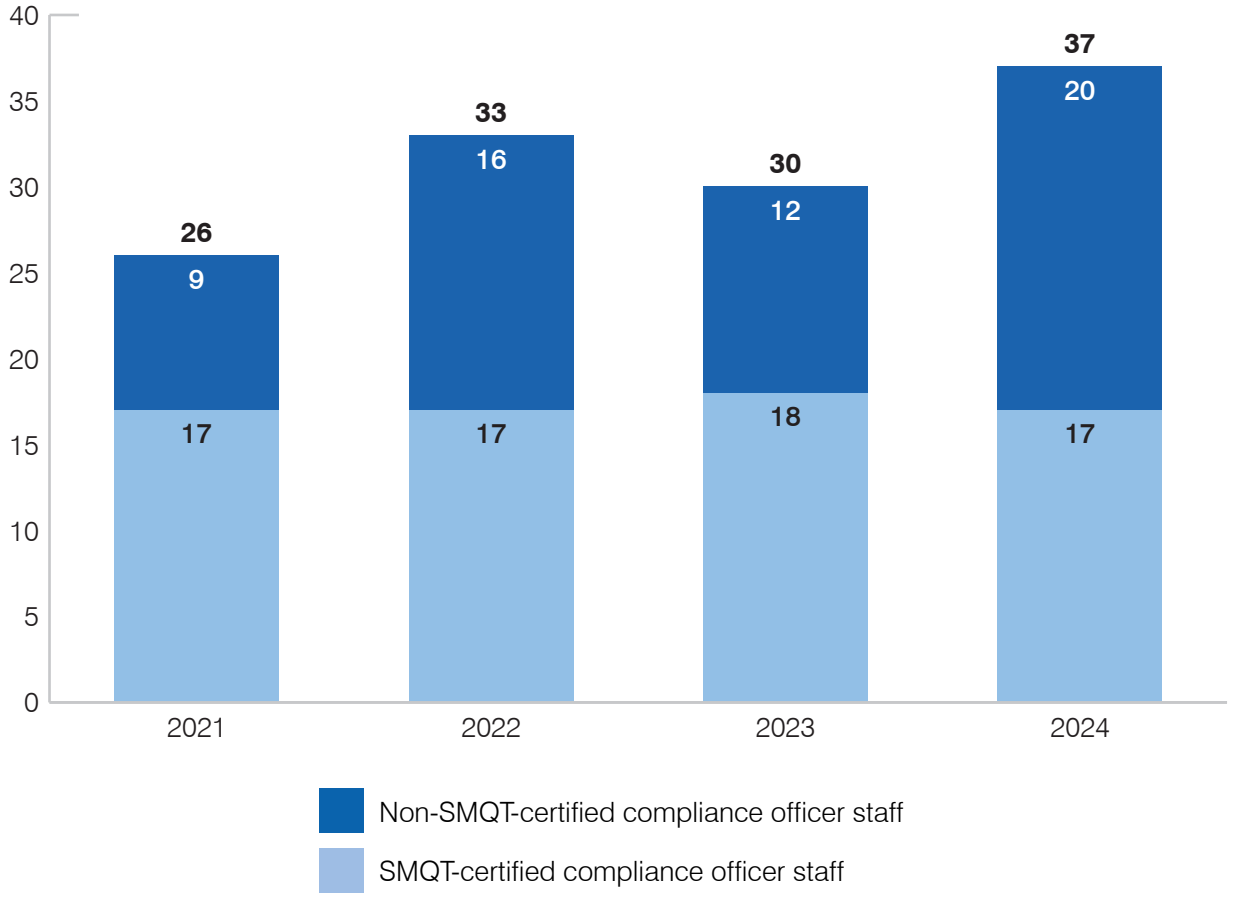
**Implementation in process—**As reported in our 36-month followup, rather than allocating staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis, the Department had assigned all compliance officer positions to perform these responsibilities, in addition to completing other responsibilities such as conducting certification and recertification surveys. As of December 2024, 37 of 50 Department compliance officer staff positions were filled, including 17 compliance officers with an SMQT certification (see Figure 1, page 8, for information on the Department's compliance officer staffing levels in calendar years 2021 through 2024).[12,13] However, according to the Department, it has continued to struggle with hiring and retaining compliance officers despite implementing strategies such as improved pay, promotional opportunities, and hiring incentives. For example, between January and December 2024, the Department increased its total number of compliance officer staff but also experienced significant turnover. Specifically, the Department increased its compliance officer staffing from 26 in January 2024 to 37 in December 2024, but it also lost 15 compliance officer staff during that same time period. Further, most of the compliance officer staff hired in calendar year 2024 were not SMQT certified.

We will continue to follow up on the Department's efforts to allocate staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports during a future followup.

[12] As reported in our 36-month followup, as of April 2023, 29 of the Department's 42 compliance officer positions were filled.

[13] The SMQT addresses the knowledge, skills, and abilities needed to conduct surveys in long-term care facilities, including prioritizing, investigating and resolving complaints and self-reports.

**Figure 1**
**Department increased its total compliance officer staffing level and the number of SMQT-certified compliance officers has remained the same**
**Calendar years 2021 through 2024**[1]
(Unaudited)




[1] Staffing levels reported are as of the end of the calendar year except for calendar year 2024, which is as of December 6, 2024.

Source: Auditor General staff analysis of Department-provided long-term care compliance officer data for calendar years 2021 through 2024.

**b.** Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.

**Unable to determine at this time**—As previously discussed (see page 1), we will issue a separate follow-up report on the Department's complaint-investigation and resolution process. Additionally, as reported on pages 4 and 5, the Department continues to inaccurately assign some Immediate Jeopardy and High-Priority complaints and self-reports a lower, Medium Priority, and this inaccurate prioritization artificially extends the Department's time frame for completing complaint/self-report investigations and closures. In addition, as illustrated by the case examples included in this follow-up report (see pages 2 through 6), the Department did not initiate investigations for some of the complaints/self-reports we reviewed within CMS' required time frames, and thus continues to not timely investigate and resolve complaints and self-reports.

**c.** Regularly update its policies and procedures to reflect changes in its current long-term care facility complaint and self-report investigation and resolution practices and CMS requirements.

**Implementation in process**—The Department has updated its long-term care complaint and self-report prioritization policies and procedures to reflect changes to its practices and CMS requirements. Specifically, the Department updated its complaint-prioritization policy in April 2023 to remove a provision that allowed Department staff to assign an Off-site Investigation Priority to complaints/self-reports from public agencies. Our review of Department long-term care prioritization data from October 2022 through September 2023 found that it did not assign an Off-site Investigation Priority to any complaints/self-reports. However, as discussed on pages 4 and 5 the Department continues to inaccurately assign some Immediate Jeopardy and High-Priority complaints and self-reports a lower priority, inconsistent with CMS requirements.

In addition, the Department's policies and procedures related to collecting information during the complaint-prioritization process align with CMS requirements, which outline that Department staff should collect comprehensive information to allow for accurate prioritization of complaints and self-reports and indicates that subsequent communications may be necessary to obtain this information. However, as discussed on page 5, the Department did not collect or document its unsuccessful attempt to obtain important information necessary to help it make priority assignments for 41 sampled complaints and self-reports our contractor reviewed.

Finally, as previously reported, we will issue a separate follow-up report on the Department's complaint-investigation and resolution process, including any applicable information from our review of the Department's complaint/self-report investigation and resolution policies, procedures, and practices.

**d.** Develop and implement additional bimonthly management reports to monitor whether and how quickly its long-term care facility complaints and self-reports are being prioritized, investigated, and resolved.

**Implementation in process**—The Department has developed and implemented policies and procedures requiring its staff to create a monthly internal report for executive management of various long-term care facility complaints and self-report metrics. Department executive management is required to document its review and any applicable feedback monthly. Our review of monthly reports for May 2024 through July 2024 found that Department staff prepared, and executive management documented its review of these monthly reports. The reports included information on how quickly long-term care facility complaints and self-reports were being prioritized, investigated, and resolved, including clearly indicating when the Department is not complying with applicable time frames. The reports also included information on the number of complaints and self-reports closed without a required on-site investigation, the number of complaints and self-reports received, the number assigned to Immediate Jeopardy or High Priority, and the percentage of complaints and self-reports reprioritized, investigated, and closed within required time frames.

However, as previously reported, we will issue a separate follow-up report on the Department's complaint-investigation and resolution process, including reviewing whether the information related to completed investigations in its management reports is accurate and reliable.

**e.** Ensure that any complaints and self-reports that are investigated during an annual survey or outside of the annual survey are initiated and investigated according to the time frames required by the assigned priority level.

**Unable to determine at this time**—As previously discussed (see page 1), we will issue a separate follow-up report on the Department's complaint-investigation and resolution process. In addition, as illustrated by the case examples included in this follow-up report (see pages 2 through 6), the Department did not initiate investigations for some of the complaints and self-reports we reviewed within the time frames required by the assigned priority level.

## Status of 30-month follow-up report recommendations:

**2.** To better protect the health, safety, and welfare of long-term care residents, the Department should also address the additional deficiencies we identified as a part of our 30-month followup. Specifically, the Department should:

**a.** Use a risk-based approach to review and reassess the 543 complaints originally prioritized as High Priority and closed without an investigation, the 1,078 self-reports originally prioritized as High or Medium Priority and closed as No Action Necessary, and the 130 open complaints originally prioritized as High Priority and changed to Medium or Low Priority and ensure appropriate action is taken on the most serious complaints and self-reports.[14]

**Implementation in process—**Since our 36-month follow-up report, the Department modified and began implementing its risk-based process for reviewing the 3,666 closed or reprioritized complaints and self-reports identified in our 30- and 36-month follow-up reports. The Department modified its review process to require its staff to:

- **Step 1—**Identify the complaints and self-reports that included 1 or more high-risk allegations for re-review. According to the Department, it identified 25 allegation categories that it considers high-risk, including death, abuse, neglect, and accidents.
- **Step 2—**Review each of the identified complaints and self-reports with high-risk allegations to determine the appropriate priority assignment.
- **Step 3—**Identify all complaints/self-reports from step 2 that were prioritized as Immediate Jeopardy or High Priority.
- **Step 4—**Re-open and investigate all complaints and self-reports that it assigned as Immediate Jeopardy or High Priority.

As of August 2024, the Department was still in the process of completing its risk-based review of the 3,666 complaints and self-reports identified in our 30- and 36-month follow-up (see textbox for more information on the Department's progress reviewing the 3,666 complaints/self-reports). We will continue to assess the Department's efforts to implement this recommendation during a future followup.

### Department's risk-based review status as of August 2024

**Step 1—**Completed review of 3,666 complaints and self-reports and identified 1,976 with 1 or more High-Risk allegations.[1]

**Step 2—**Determined priority level for 886 of 1,976 complaints and self-reports identified in step 1. The Department had not yet determined the priority level for the remaining 1,090.

**Step 3—** Determined that 591 of the 886 complaints and self-reports prioritized in step 2 were Immediate Jeopardy or High Priority.[2]

**Step 4—**Completed investigations of 177 of 591 complaints and self-reports identified in step 3.[3] The Department had not yet investigated the remaining 414 complaints and self-reports.

[1] The Department reported that it would not re-review the priority or re-open for investigation any of the remaining 1,690 complaints and self-reports because the complaint or self-report did not include a High-Risk allegation or the associated facility had closed or changed ownership.

[2] The Department determined that the remaining 295 complaints/self-reports were not Immediate Jeopardy or High Priority, and thus it did not re-open them for investigation.

[3] As previously discussed (see page 1), we were unable to assess the Department's investigations process because CMS had not approved our access to unredacted investigation records. Therefore, we will issue a separate follow-up report on the Department's complaint investigation and resolution process, including reviewing investigations completed as part of its risk-based review process.

Source: Auditor General staff review of Department risk-based review data.

[14] Our 36-month followup reported another 1,897 High- or Medium-Priority self-reports that the Department closed without an on-site investigation and stated that the Department would also need to incorporate these self-reports into its risk-based review and assessment process.

b. Use a risk-based approach to identify those long-term care facilities that would require additional oversight and then determine the additional actions the Department should take to help bring those facilities into compliance.

**Implementation in process—**As reported in our 36-month follow-up report, the Department developed procedures to identify long-term care facilities that require additional oversight. Specifically, the Department selected the facilities with the most open, uninvestigated complaints and self-reports. As of July 2024, the Department had identified 29 higher-risk facilities that required additional oversight. Further, the Department developed procedures to review noncompliance trends and identify ways to help bring those facilities into compliance. In addition, Department procedures state that it will monitor and work with these facilities until it determines that they are not 1 of the top 10 facilities with the highest number of uninvestigated complaints and self-reports for 6 months. Our review of Department documentation for 5 facilities that the Department determined required additional oversight found that it reviewed trends related to these 5 facilities' complaints/self-reports and took additional actions to help bring facilities into compliance, as applicable, such as meeting with facility administrators.[15] However, these facilities had not met the Department's criteria for not requiring its additional oversight and thus had not been brought into compliance. As such, we will continue to follow up on the Department's efforts to bring facilities into compliance during a future followup.

c. Stop using undocumented, unofficial, unwritten, or contrary protocols and requirements for processing complaints and self-reports and instead follow CMS requirements.

**Implementation in process—**Our 30-month and 36-month follow-up reports found that the Department was using undocumented, unofficial, unwritten, or contrary protocols and requirements for processing complaints and self-reports. Our review of Department long-term care data found that the Department has stopped some of these activities. Specifically, the Department:

- **Continued to reprioritize and assign No Action Necessary Priority to complaints but for a smaller percentage of complaints than previous followups and stopped using the Off-site Investigation Priority—**Our 30- and 36-month follow-up reports found that, inconsistent with CMS requirements, the Department reprioritized hundreds of High- and Medium-Priority complaints and/or self-reports to No Action Necessary or Off-site Investigation priorities, thus eliminating the need for an on-site investigation. For example, our 30-month follow-up report found that for the 1,438 self-reports the Department closed between October 21, 2020 and April 21, 2021, it closed 1,186 of them, or 82 percent, as No Action Necessary, which means the Department did not conduct an on-site investigation as required by CMS. Further, our 36-month follow-up report found that for the 2,119 self-reports it closed between April 22, 2021 and October 20, 2022, that required an on-site investigation, the Department closed 1,897 of them, or 90 percent, without conducting an on-site investigation even though they were initially prioritized as High or Medium Priority.

  During this followup, our review of Department data for 7,694 complaints and self-reports received from October 1, 2022 through September 30, 2023, found the Department did not prioritize or reprioritize any complaints and self-reports to Off-site Investigation. Additionally, the Department reprioritized fewer complaints/self-reports and assigned No Action Necessary Priority to a smaller number of complaints/self-reports than during our previous followups. Specifically, of the 7,694 complaints and self-reports received from October 1, 2022 through September 30, 2023, the Department did not prioritize or reprioritize any complaints and self-reports to Off-site Investigation. Additionally, the Department changed the priority for 206, or 2.7 percent, of these complaints and self-reports and prioritized or reprioritized 403, or 5.2 percent, of the complaints and self-reports to No Action Necessary, a significant decrease from our previous followups. However, Department data did not indicate why the Department took these actions. As a result, we will further assess the Department's efforts to implement this recommendation, including reviewing the appropriateness of its reprioritization of complaints/self-reports and use of the No Action Necessary priority, during our work to assess the Department's long-term care facility-investigation and resolution process, which will be included in a separate report.

[15] We randomly selected 5 of the 23 facilities that the Department determined needed additional oversight between August 2022 and December 2023. The Department added 6 facilities to its list of facilities that need additional oversight between December 2023 and July 2024.

- **Assigned Medium Priority to a lower percentage of complaints and self-reports—**As reported in our 30-month follow-up report, in the last half of calendar year 2020, the Department prioritized the majority, or 95 percent, of complaints and self-reports as Medium Priority compared to only 51 percent in the last half of calendar year 2019, despite no changes in prioritization requirements. Similarly, our 36-month follow-up report found that the Department continued to prioritize a high percentage, or 95 percent, of complaints and self-reports as Medium Priority from April 2021 through October 2022.

  During this followup, our review of the Department's complaint and self-report data from October 1, 2022 through September 30, 2023, found that the Department assigned a Medium Priority to a smaller percentage of complaints and self-reports than previously reported. Specifically, the Department prioritized 70 percent of its complaints and self-reports as Medium Priority for this 1-year period.

However, as reported on pages 4 and 5 the Department continues to inaccurately assign some Immediate Jeopardy and High-Priority complaints and self-reports to a lower priority, such as Medium Priority, inconsistent with CMS requirements.

As previously discussed, we will issue a separate follow-up report on the Department's complaint-investigation and resolution process, including whether the Department is following CMS requirements applicable to the investigation and resolution process.

**d.** Ensure Department long-term care facility staff and management are trained on CMS requirements and monitored to ensure they comply with the requirements.

**Implementation in process—**In October 2023, the Department updated its training program for new staff members to include CMS-required trainings, Department-required trainings, and on-site experience for complaint handling. In addition, from April 2023 to January 2024, CMS representatives provided 5 trainings to all Department long-term care staff members that included information related to complaint handling.

However, as reported on pages 6 and 7, the Department lacks a comprehensive process to monitor its staff's complaint and self-report prioritization for accuracy and consistency with CMS requirements. Specifically, Department policies and procedures require its staff to inform their supervisor when they prioritize Immediate Jeopardy or High-Priority complaints and self-reports or any complex or challenging complaints. However, Department supervisors are not required to review complaint prioritizations for accuracy other than those that Department staff bring to their attention. For example, the Department lacks a process for selecting and reviewing complaints and self-reports its staff have assigned a Medium Priority, despite our 3 followups consistently identifying that Department staff inaccurately used Medium Priority for some Immediate Jeopardy and High-Priority complaints and self-reports, inconsistent with CMS requirements. Implementing such a process could be instrumental in helping the Department identify and correct the prioritization issues we have consistently identified during our 3 followups.

In addition, as previously discussed, we will issue a separate follow-up report on the Department's complaint-investigation and resolution process, including reporting on whether the Department is monitoring Department's staff compliance with applicable CMS requirements related to complaint investigations and resolutions.

LINDSEY A. PERRY
AUDITOR GENERAL

ARIZONA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

**DATE:** March 26, 2025

**TO:** Senator Mark Finchem, Chair
Representative Matt Gress, Vice Chair
Members, JLAC

**FROM:** Lindsey Perry, Auditor General

**SUBJECT:** State of Arizona fiscal year 2024 financial statements and federal compliance audits' updates

## Background

The Office is responsible for conducting annual financial and federal compliance audits of all State agencies subject to federal single audit requirements pursuant to A.R.S. §41-1279.03(2). The Arizona Department of Administration (ADOA) is the State agency responsible for preparing and issuing the State's financial statements report, also known as the Annual Comprehensive Financial Report, or ACFR, and preparing the State's schedule of expenditures of federal awards, or SEFA, which is the basis of a federal compliance audit, also known as the Single Audit, using information provided by the State's agencies. Federal law requires Arizona to issue a Single Audit by March 31 of each year, which keeps federal dollars flowing into the State.

The State's financial statements are a part of the State's Single Audit submission to the federal government. Further, our opinion on the State's SEFA is in relation to the State's financial statements. Therefore, until the State's financial statements for a given fiscal year are issued, we cannot complete our audit and issue the State's Single Audit.

We were asked to present the State's financial statement and federal compliance audits' status for fiscal year 2024. The following are updates for agencies that have significant activity for the financial or federal compliance single audits:

- Because the State issued its fiscal year 2023 financial statement and federal compliance single audits 7 to 8 months late, on November 7 and December 17, 2024, respectively, the State's fiscal year 2024 audits will not be issued by March 31, 2025, as required.

- We are currently in the fieldwork stage for the State's fiscal year 2024 financial statement and federal compliance single audits.

- ADOA received draft financial information and schedule of federal awards from the State agencies at or near ADOA's established deadlines and is working closely with the Department of Economic Security (DES) and the Arizona Health Care Cost Containment

System (AHCCCS) on submission of final information to them. Final information includes items such as complete and accurate required final financial statements, associated note disclosures, supporting schedules, and final schedule of federal awards to ADOA.

- DES reported they would submit final information by the end of April 2025.

- AHCCCS submitted its final draft report for review to ADOA and us on March 14, 2025, and we anticipate providing our review comments back to AHCCCS' contract auditors by March 31.

- ADOA has informed us that it is unable to provide estimated dates for submitting to us the remaining financial information and a final State SEFA for audit until it receives outstanding information from the DES and the issued report for AHCCCS, which is needed to finalize the State's financial statements and SEFA.

Due to the delays mentioned in receiving final information, we are unable to determine agreed-upon report-issuance dates with ADOA for the State's financial statements or federal compliance single audits.

The State's delay in meeting its financial reporting and audit requirements may affect decision makers' ability to rely on financial information that is not provided timely or may result in the credit rating agencies lowering the State's credit ratings for its bonds and certificates of participation. Further, the State, including its 3 universities, could potentially face actions by federal agencies that may affect the State's and universities' future federal awards, such as additional cash monitoring, other compliance monitoring, and funding restrictions or penalties.

We have prepared 4 graphics shown in Attachment A to illustrate:

Figure 1: Financial statement and federal compliance audits' phases by month based on March 31 federal issuance deadline.

Figure 2: State agency delays increased time to issue State's FYs 2020 through 2023 financial statement and federal compliance audits, causing delayed start of each subsequent years' audits and missed federal deadlines.

Figure 3: State agencies missed deadlines to provide final FYs 2019 through 2024 financial information and SEFA to ADOA by 0 to 343 days.

Figure 4: ADOA missed deadlines to provide final FYs 2019 through 2024 State financial statements and SEFA to Auditor General by 0 to 272 days.

**Action required**

None. Presented for JLAC's information only.

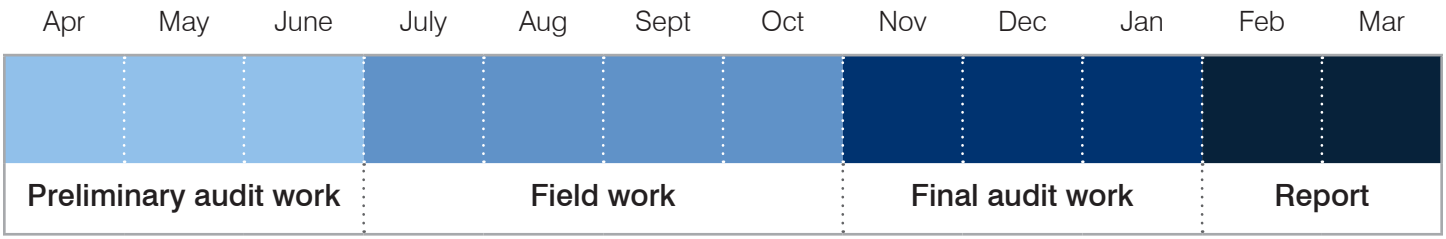
Attachment A

# Figures

Audit phases by month, State Agency delays and missed deadlines, and ADOA missed deadlines

## Figure 1

**Financial statement and federal compliance audits' phases by month based on March 31 federal issuance deadline**




### Preliminary audit work

The preliminary audit work phase is based on the State's accounting information (AZ360) or State agency subsystem transaction information and from meetings with agency personnel on our required risk assessment and fraud inquiry procedures. This work helps us determine the preliminary audit extent and scope, including the audit procedures needed, and which areas are of greater risk and require more work. We also gain our understanding of internal controls and procedures, including controls over significant information technology systems for the State's financial statement and federal compliance audits. This may involve testing of controls for both the financial statement and federal compliance audits.

### Field work

During the fieldwork phase, we do the majority of the data analytics and testing of transactions, including major program testing and review of agency supporting records. We conduct interviews with agency personnel and review agency records and practices. We also perform other procedures necessary to accomplish the objectives of the audits.

### Final audit work

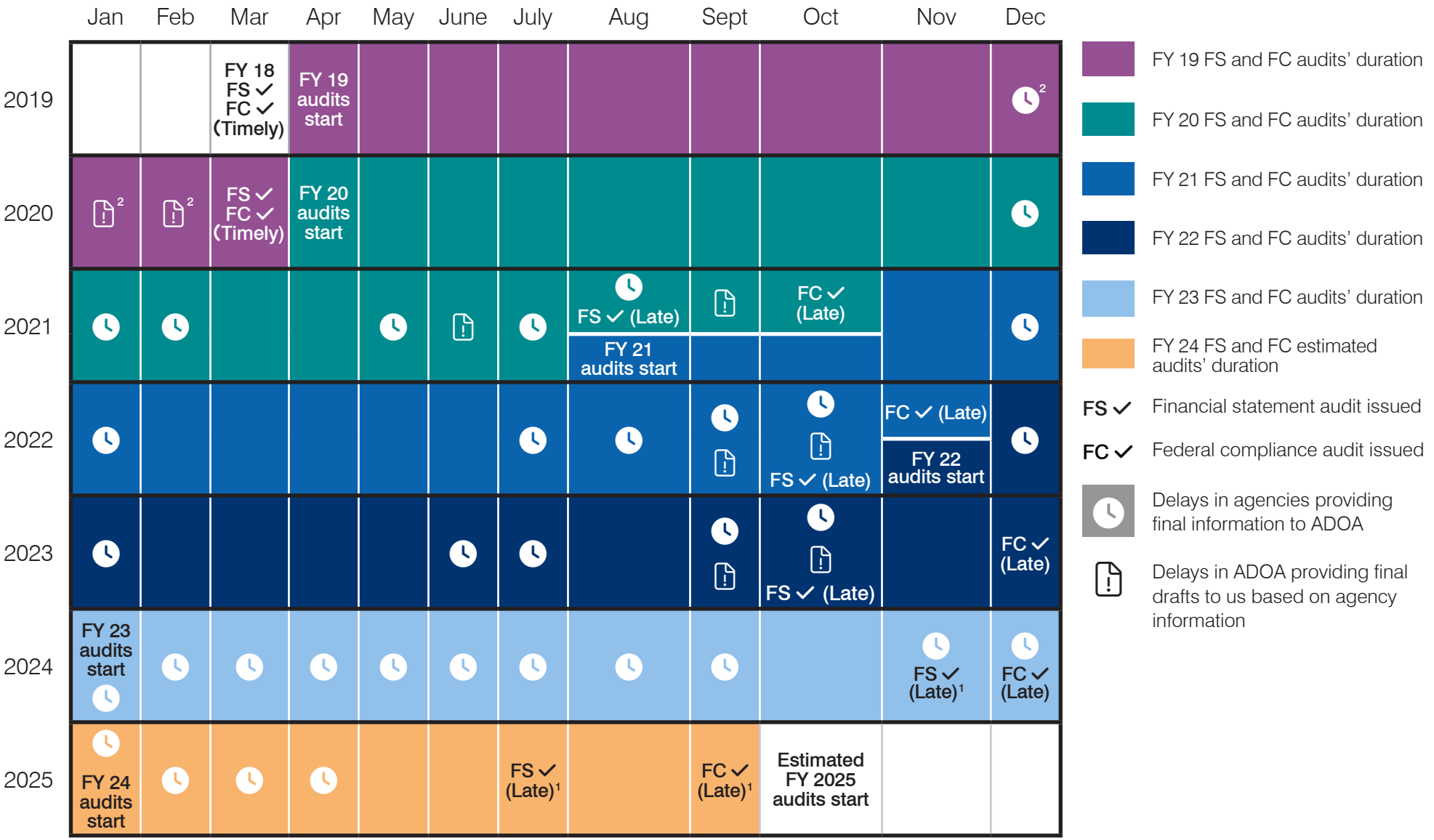
The final audit work phase includes receiving draft financial statements and draft schedule of expenditures of federal awards (SEFA) from the Arizona Department of Administration (ADOA), final journal entries, schedules, and related notes. Based on these, we perform additional audit procedures, risk assessments, and testwork, as applicable. In addition, we communicate any findings noted during the audits and receive State agencies' corrective action plans to the findings.

### Report

The report phase includes reviewing the final financial statements and federal compliance audit reports, ensuring that all required information is included and they are materially correct. We perform a quality control process to check the reports for completeness, accuracy, and conformity with Office standards, Generally Accepted Accounting Principles (GAAP), Generally Accepted Auditing Standards (GAAS), Generally Accepted Government Auditing Standards (GAGAS), and other reporting requirements.

## Figure 2

**State agency delays increased time to issue State's FYs 2020 through 2023 financial statement and federal compliance audits, causing delayed start of each subsequent years' audits and missed federal deadlines[1]**




[1] As of 3/28/2025, we are unable to determine agreed-upon report issuance dates with ADOA for the FY 2024 financial statement audits. However, we have estimated the issuance dates above based on agencies submitting the required final financial information and SEFA to ADOA by the estimated dates in Figure 3 footnote 3 and ADOA submitting the final financial information and SEFA to us by the estimated date in Figure 4 footnote 1, but the issuance dates are estimates, not confirmed, and subject to change. The start date of the FY 2025 audits is based on the issuance date of the FY 2024 federal compliance audit.

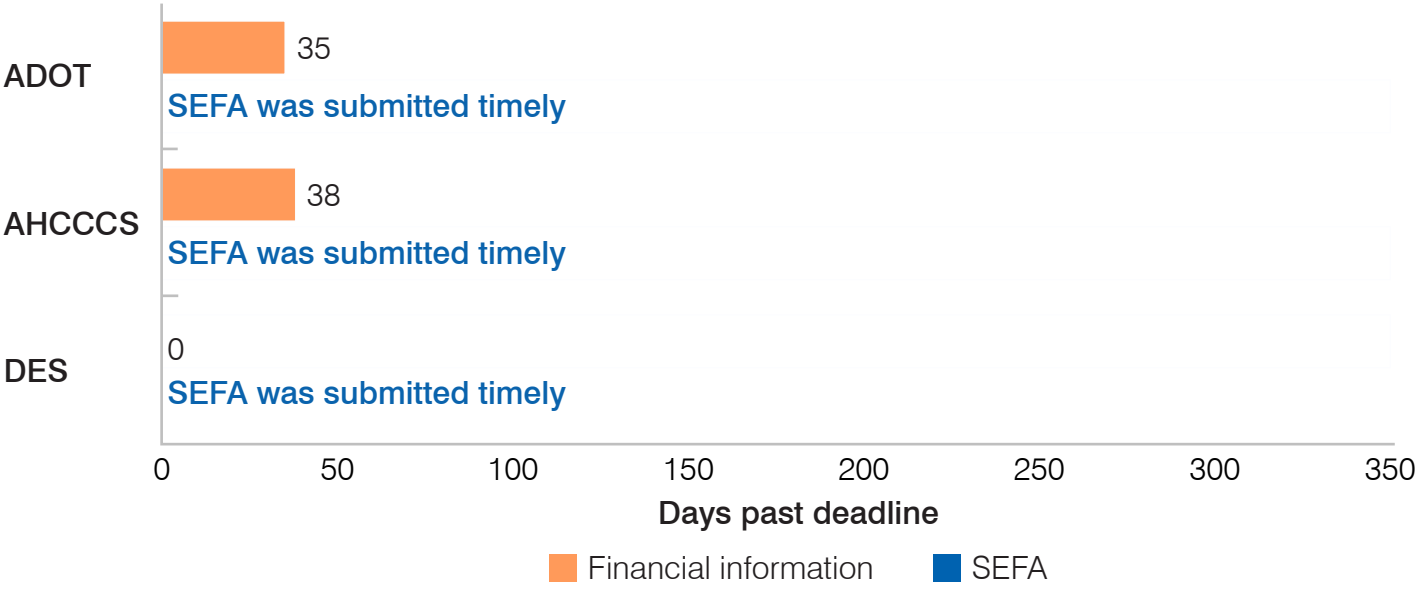
[2] Even with delays, we were able to issue the FY 2019 audit reports on time.

## Figure 3

**State agencies missed deadlines to provide final FYs 2019 through 2024 financial information and SEFA to ADOA by 0 to 343 days**

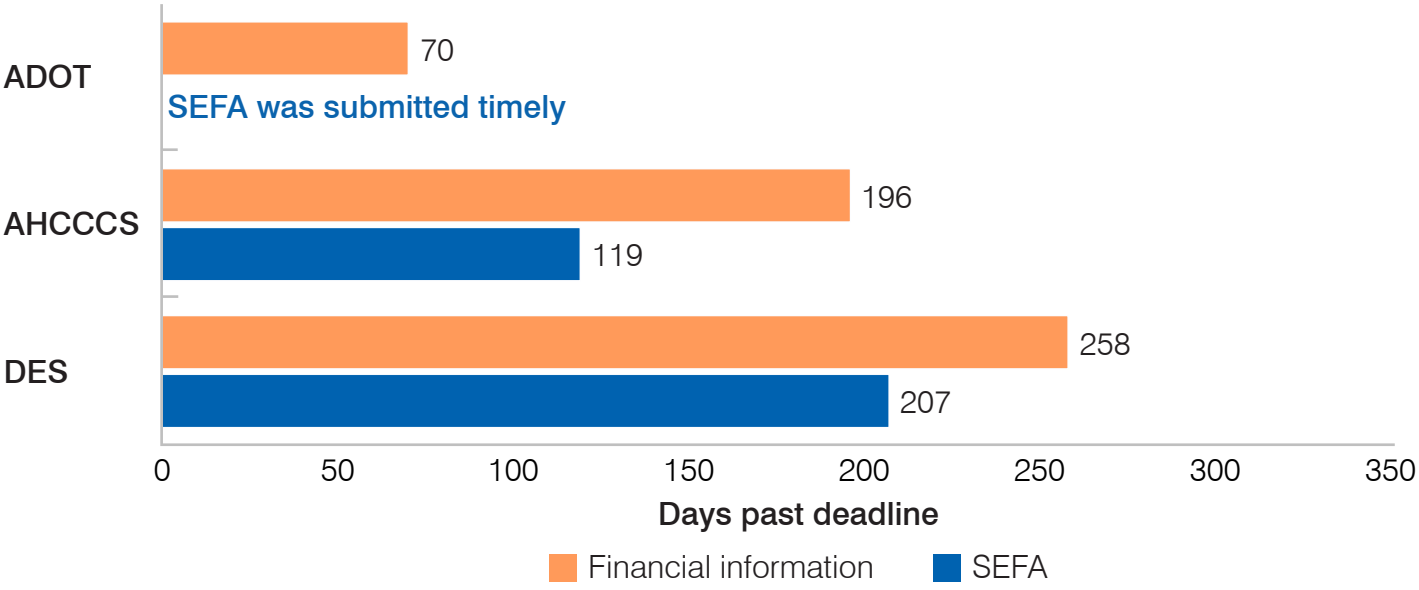
### FY 2019

Financial information deadlines: 11/12/2019 (ADOT and AHCCCS) and 10/21/2019 (DES).
SEFA deadline: 01/31/2020.




### FY 2020

Financial information deadlines: 11/13/2020 (ADOT and AHCCCS) and 10/23/2020 (DES).
SEFA deadline: 01/29/2021.

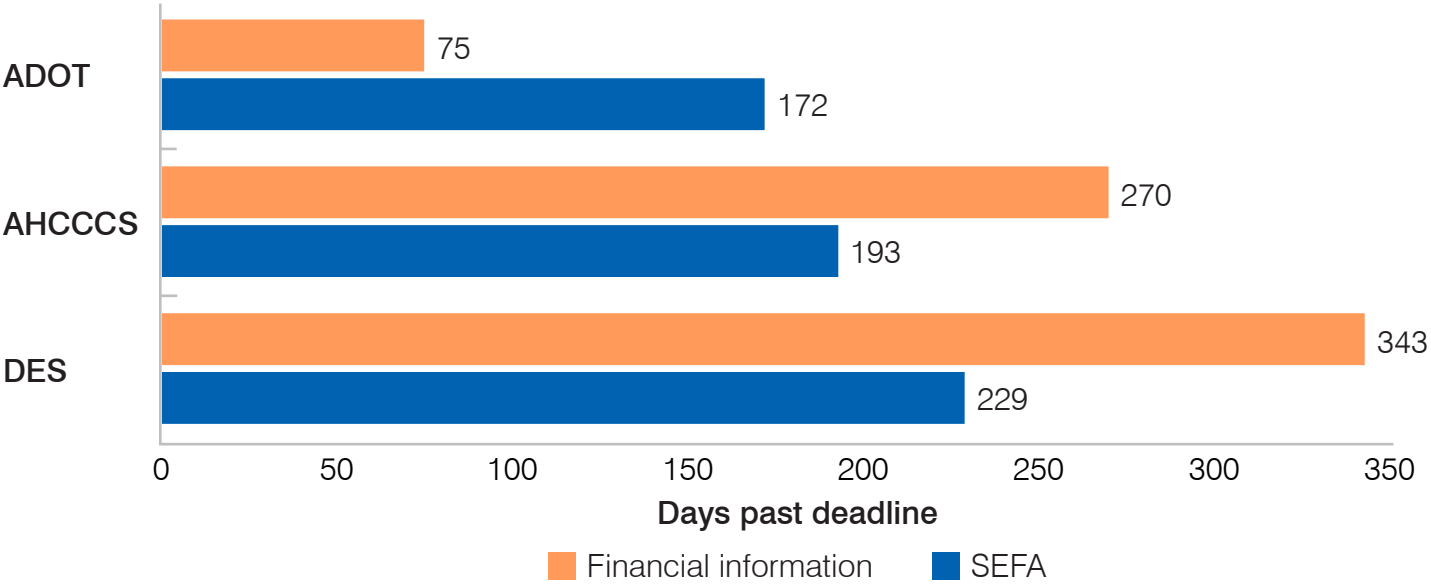


## Figure 3 (continued)

**State agencies missed deadlines to provide final FYs 2019 through 2024 financial information and SEFA to ADOA by 0 to 343 days**

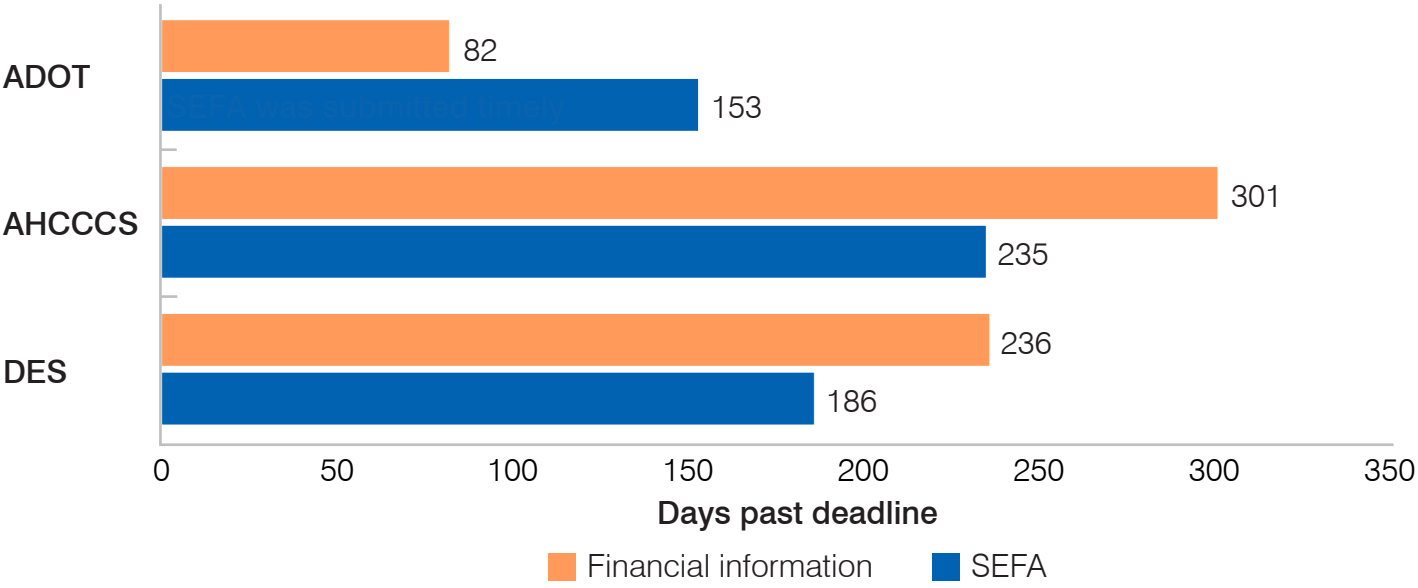
### FY 2021

Financial information deadlines: 11/12/2021 (ADOT and AHCCCS) and 10/22/2021 (DES).
SEFA deadline: 01/28/2022.[1]




### FY 2022

Financial information deadlines: 11/10/2022 (ADOT and AHCCCS) and 10/21/2022 (DES).
SEFA deadline: 01/27/2023.[1]



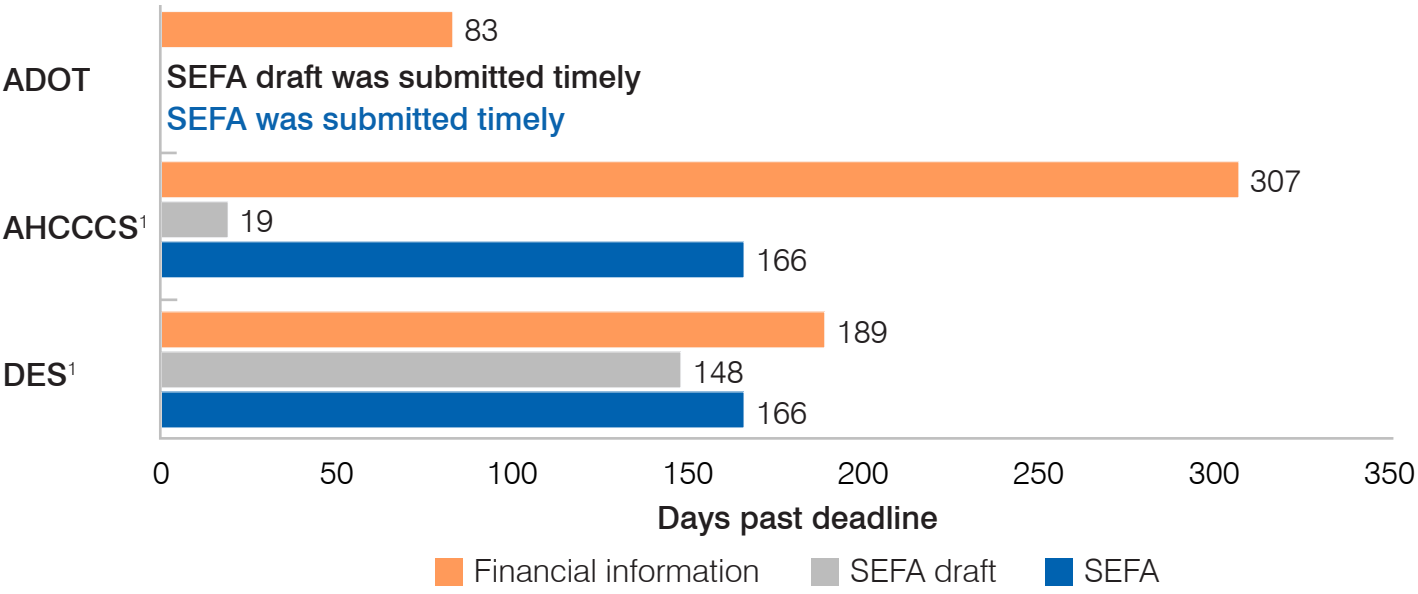

[1] In FYs 2021 and 2022, ADOA did not communicate a specific due date to agencies for their final SEFA, so we used a historical date.

## Figure 3 (continued)

**State agencies missed deadlines to provide final FYs 2019 through 2024 financial information and SEFA to ADOA by 0 to 343 days**

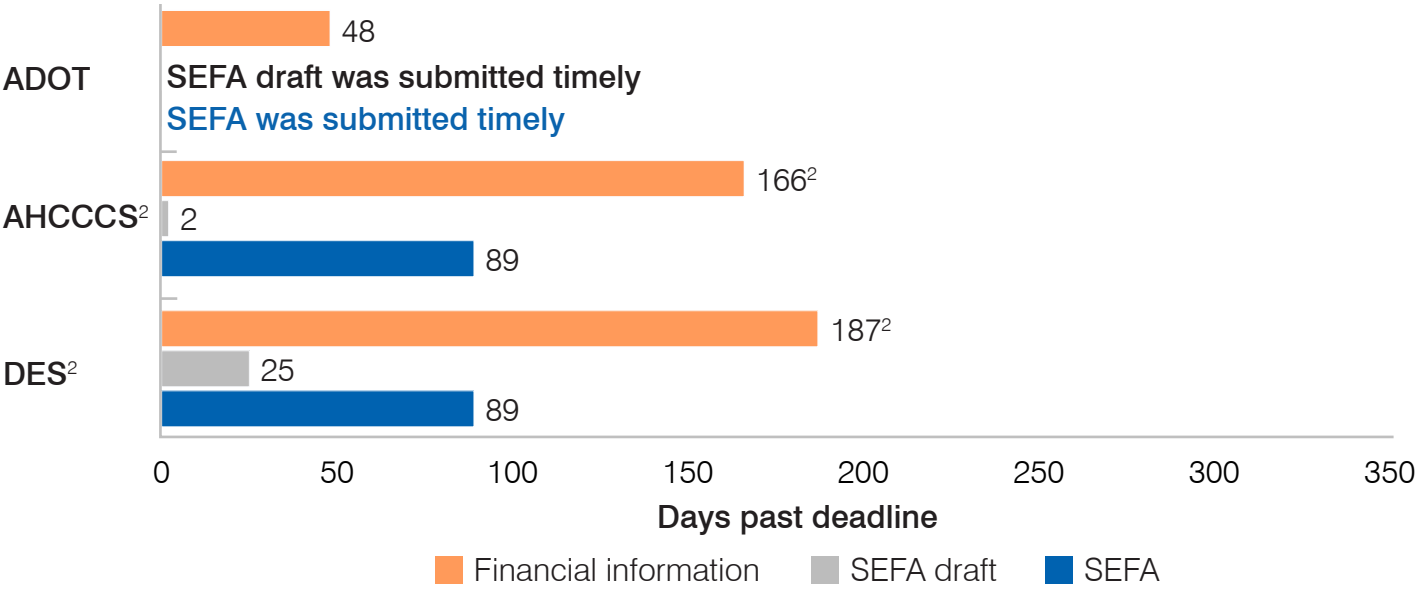
### FY 2023

Financial information deadlines: 11/9/2023 (ADOT and AHCCCS) and 10/20/2023 (DES).
SEFA draft deadline: 11/30/2024. Final SEFA deadline: 03/29/2024.




### FY 2024

Financial information deadlines: 11/15/2024 (ADOT and AHCCCS) and 10/25/2024 (DES).
SEFA draft deadline: 9/30/2024. Final SEFA deadline: 01/31/2025.

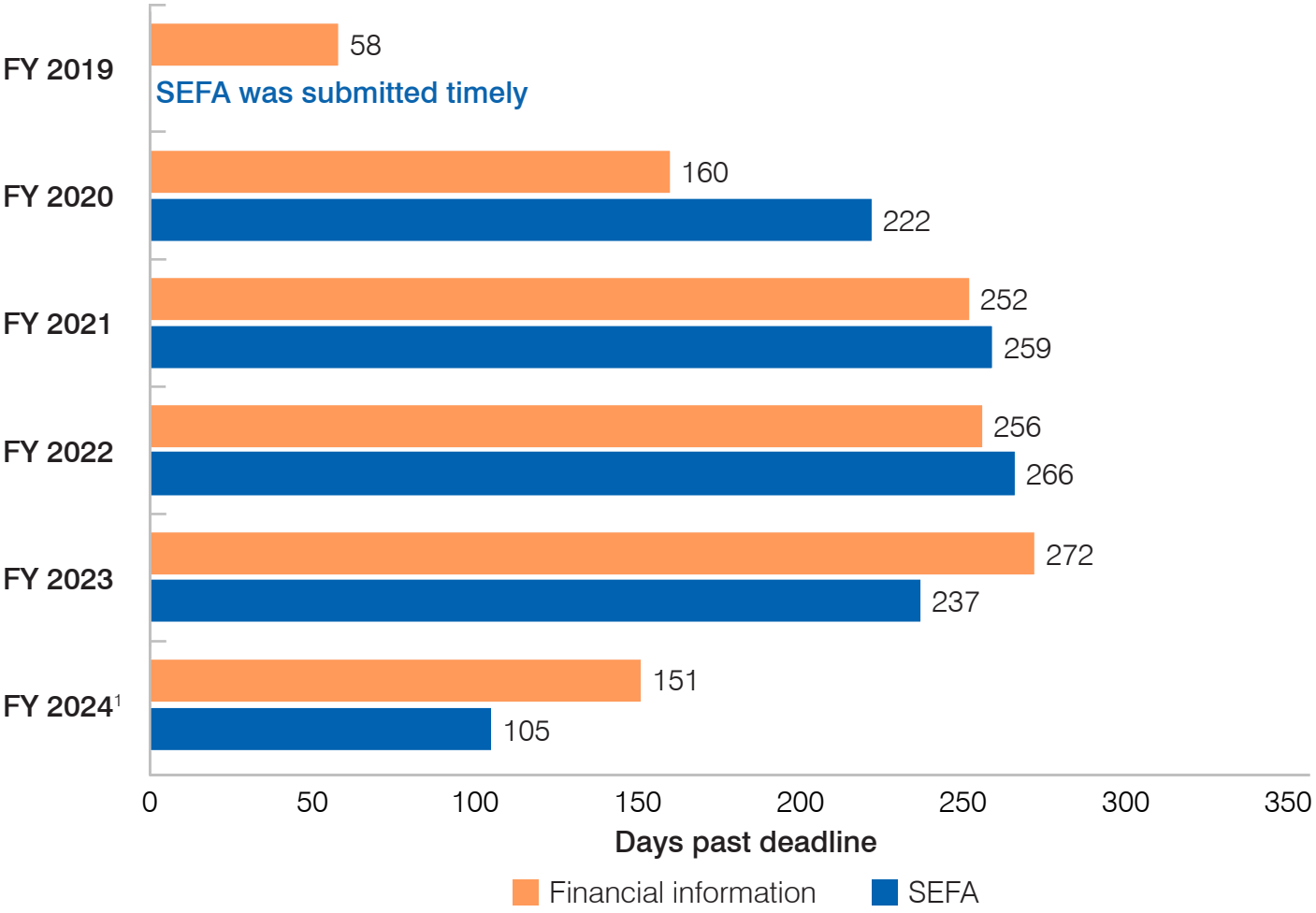



[1] Days late were measured from the original ADOA agency deadlines. A revised 4/26/2024 deadline for financial information was established with AHCCCS and DES. DES met the revised date for financial information but AHCCCS experienced additional delays finalizing its financial information.

[2] As of 3/28/2025, AHCCCS and DES have not submitted its final financial information or final SEFA to ADOA. An estimated submittal date of 4/30/2025 was used for AHCCCS and DES to calculate days late.

## Figure 4

**ADOA missed deadlines to provide final FYs 2019 through 2024 State financial statements and SEFA to Auditor General by 0 to 272 days**




| | Financial information deadline | SEFA deadline |
|---|---|---|
| FY 2019 | 12/30/2019 | 01/31/2020 |
| FY 2020 | 01/19/2021 | 01/29/2021 |
| FY 2021 | 12/30/2021 | 01/28/2022 |
| FY 2022 | 12/30/2022 | 01/27/2023 |
| FY 2023 | 12/30/2023 | 01/31/2024 |
| FY 2024 | 12/30/2024 | 02/14/2025 |

[1] The days late for FY 2024 are estimated based on ADOA submitting the State's final 2024 financial information and SEFA to us by 5/30/2024. This date is dependent on the date they receive final financial information and final SEFAs from AHCCCS and DES.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