HEALTH NET ACCESS, INC. D/B/A ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

FINANCIAL STATEMENTS, SUPPLEMENTAL INFORMATION, ADDITIONAL INFORMATION, AND UNIFORM GUIDANCE SUPPLEMENTARY REPORTS

Year Ended December 31, 2018

HEALTH NET ACCESS, INC. D/B/A
ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

FINANCIAL STATEMENTS, SUPPLEMENTAL INFORMATION, ADDITIONAL INFORMATION, AND UNIFORM GUIDANCE SUPPLEMENTARY REPORTS

Year Ended December 31, 2018

TABLE OF CONTENTS

4722 North 24th Street, Suite 300 ■ Phoenix, AZ 85016
Main: 602.264.6835 ■ Fax: 602.265.7631 ■ www.mhmcpa.com

INDEPENDENT AUDITORS' REPORT

The Board of Directors and Stockholder of:

HEALTH NET ACCESS, INC. D/B/A ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

We have audited the accompanying financial statements of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan***, which comprise the balance sheet as of December 31, 2018, and the related statements of comprehensive income, stockholder's equity, and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan*** as of December 31, 2018, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated September 20, 2019 on our consideration of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control over financial reporting and compliance.

September 20, 2019

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

BALANCE SHEET

December 31, 2018

A S S E T S

CURRENT ASSETS	
Cash and cash equivalents	$ 113,509,871
Capitation and supplement receivables	2,485,442
Health insurer fee receivable	5,194,088
Reinsurance receivables	4,301,515
Provider receivables	13,779,757
Pharmacy receivables	5,466,574
Reconciliation receivables	1,774,314
Income taxes receivable from affiliate	9,568,193
Short-term investments	4,029,002
Prepaid expenses and other current assets	1,925,234
Due from affiliates	6,027,561
TOTAL CURRENT ASSETS	168,061,551
LONG-TERM INVESTMENTS	33,211,302
RECONCILIATION RECEIVABLES	3,654,035
DEFERRED INCOME TAX ASSET, net	1,106,874
TOTAL ASSETS	$ 206,033,762

L I A B I L I T I E S A N D S T O C K H O L D E R ' S E Q U I T Y

CURRENT LIABILITIES	
Medical claims payable	$ 150,187,788
Reconciliation payables	1,755,158
Payable to providers	6,658,699
Other current liabilities	4,516,683
TOTAL CURRENT LIABILITIES	163,118,328
RECONCILIATION PAYABLES	9,451,071
UNRECOGNIZED TAX BENEFIT LIABILITY	800,458
ALTERNATIVE PAYMENT MODEL LIABILITY	2,093,263
TOTAL LIABILITIES	175,463,120
STOCKHOLDER'S EQUITY	
Common stock (no par value, 100 shares authorized, issued and outstanding) at December 31, 2018	-
Additional paid-in capital	59,500,000
Accumulated other comprehensive loss	(373,886)
Accumulated deficit	(28,555,472)
TOTAL STOCKHOLDER'S EQUITY	30,570,642
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 206,033,762

See Notes to Financial Statements

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

STATEMENT OF COMPREHENSIVE INCOME

Year Ended December 31, 2018

REVENUES	
Capitation premiums	$ 486,022,441
Delivery supplement	11,130,733
Health insurer fee revenue	5,194,088
Investment and other income	1,615,811
TOTAL REVENUES	503,963,073
EXPENSES	
Health care services:	
Hospitalization	94,847,715
Medical compensation	98,529,072
Other medical services	248,481,842
Less: reinsurance recoveries	(8,835,534)
Total health care services, net of reinsurance recoveries	433,023,095
Premium tax	9,937,436
Health insurer fee	4,125,145
Administrative	49,950,818
Interest	209,523
TOTAL EXPENSES	497,246,017
NET INCOME BEFORE INCOME TAXES	6,717,056
INCOME TAX EXPENSE	2,360,321
NET INCOME	4,356,735
OTHER COMPREHENSIVE LOSS	
Unrealized losses on available-for-sale investments, net of tax	(325,689)
TOTAL COMPREHENSIVE INCOME	$ 4,031,046

See Notes to Financial Statements

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

STATEMENT OF STOCKHOLDER'S EQUITY

Year Ended December 31, 2018

	Common Stock	Additional Paid-in Capital	Accumulated Deficit	Accumulated Other Comprehensive Loss	Total Stockholder's Equity
Balance at December 31, 2017	-	59,500,000	(32,912,207)	(48,197)	26,539,596
Net income	-	-	4,356,735	-	4,356,735
Unrealized losses on available-for - sale investments, net of tax	-	-	-	(325,689)	(325,689)
Balance at December 31, 2018	-	$ 59,500,000	$ (28,555,472)	$ (373,886)	$ 30,570,642

See Notes to Financial Statements

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

STATEMENT OF CASH FLOWS

Year Ended December 31, 2018

CASH FLOWS FROM OPERATING ACTIVITIES:	
Net income	$ 4,356,735
Adjustments to reconcile net income to net cash provided by operating activities:	
Deferred federal income taxes	(334,822)
Change in assets and liabilities:	
Capitation and supplement receivables	(2,312,691)
Health insurer fee receivable	(5,194,088)
Reinsurance receivables	(1,746,615)
Reconciliation receivables and payables	17,014,263
Provider receivables	(13,604,251)
Pharmacy receivables	(4,995,764)
Income taxes receivable from affiliate	(2,468,725)
Prepaid expenses and other current assets	(1,010,017)
Due to/from affiliates	(3,979,927)
Medical claims payable	118,121,921
Payable to providers	6,658,699
Risk adjustment payable	(7,233,209)
Unrecognized tax benefit liability	557,347
Other current liabilities	3,487,086
Alternative payment model liability	(3,655,770)
Net cash provided by operating activities	103,660,172
CASH FLOWS FROM INVESTING ACTIVITIES:	
Proceeds from sales of investments	4,277,653
Purchases of investments	(7,207,560)
Net cash used in investing activities	(2,929,907)
NET CHANGE IN CASH AND CASH EQUIVALENTS	100,730,265
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	12,779,606
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 113,509,871
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION	
Income taxes paid to affiliate	$ 3,151,623
SUPPLEMENTAL DISCLOSURE OF NON-CASH INVESTING ACTIVITIES	
Unrealized losses on available-for-sale investments, net of tax	$ (325,689)

See Notes to Financial Statements

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

NOTES TO FINANCIAL STATEMENTS

Year Ended December 31, 2018

(1) Company, operations, and significant accounting policies

Nature of operations - Health Net Access, Inc. dba Arizona Complete Health – Complete Care Plan (the "Company" or the "Plan") was incorporated in Arizona on April 23, 2013, and commenced operations on October 1, 2013. The Company is a wholly-owned subsidiary of Health Net, Inc. ("HNI" or "Parent"). On March 24, 2016, HNI was acquired by Centene Corporation ("Centene") and the Company became an indirect wholly-owned subsidiary of Centene. There were no changes to the capitalization structure of the Company as a result of the acquisition.

The Company is regulated by the Arizona Health Care Cost Containment System ("AHCCCS"), Arizona's Medicaid program. AHCCCS is approved by the Secretary of Health and Human Services and the Centers for Medicare and Medicaid Services, as a Section 1115 of the Social Security Act, Waiver Demonstration Program, which gives Arizona additional flexibility to design and improve its program, while still receiving Federal Medicaid funding.

Effective October 1, 2013, the Company became a contractor for AHCCCS, by entering into a prepaid capitated contract, pursuant to Arizona Revised Statutes Title 36 Chapter 29, and thereby started to administer acute health care services to qualified Medicaid members in Maricopa County, Arizona, in accordance with AHCCCS statute and rules, and federal law and regulations. Through September 30, 2018, the Company administered an AHCCCS contract for acute health care services to qualified members.

In March 2018, the Company was selected to provide physical and behavioral healthcare services through the AHCCCS Complete Care program in the Central and Southern regions of Arizona. The AHCCCS Complete Care program integrates physical and behavioral health care contracts under managed care plans for the majority of the AHCCCS members. The integrated delivery model offers a more cohesive health care system for members incentivizing quality health care outcomes with value based purchasing, and leverages health information technology for improved care coordination. Additionally, integrating physical health and behavioral healthcare contracts will drive strategic, innovative health care initiatives forward. The Company began administering the Complete Care contract on October 1, 2018. The contract is a three-year agreement, with the possibility of two two-year extensions.

Effective October 1, 2018, Cenpatico of Arizona, Inc. d/b/a Cenpatico Integrated Care ("Cenpatico"), a related party under common control, received approval from AHCCCS to assign the remaining term of the Southern Arizona Integrated Regional Behavioral Health Authority ("RBHA") contract to the Company. The Company began administering the Cenpatico RBHA contract on October 1, 2018. Under the RBHA contract, the Company is responsible for managing and maintaining an organized, comprehensive integrated healthcare delivery system for the benefit of eligible members within its geographic service area through September 30, 2020. Pursuant to the assignment of the RBHA contract from Cenpatico, the Company is obligated only for the activities under the contract effective October 1, 2018 and forward. Obligations under the contract for periods prior to October 1, 2018 are the responsibility of Cenpatico.

The Financial Accounting Standards Board ("FASB") sets accounting principles generally accepted in the United States of America ("GAAP") to ensure consistent reporting. References to GAAP are to the Financial Accounting Standards Codification ("FASB ASC").

(1) Company, operations, and significant accounting policies (continued)

The significant accounting policies followed by the Company are as follows:

Basis of presentation - The accompanying financial statements are prepared in accordance with FASB ASC 954-205, *Health Care Entities – Presentation of Financial Statements*.

Management's use of estimates - The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Material estimates particularly susceptible to change in the near term include revenue recognition (including the reconciliation settlements described below), health care service costs, including the medical claims payable, and income taxes.

Cash and cash equivalents - Cash includes cash deposits in banks and cash equivalents. Cash equivalents include all highly liquid investments with maturities of three months or less when purchased. Accounts at each institution are insured in limited amounts by the Federal Deposit Insurance Corporation ("FDIC"). As of December 31, 2018, cash and cash equivalents consisted of cash and money market accounts.

Revenue recognition - Revenue includes the following amounts:

Prospective Capitation - Prospective capitation premiums are based on multi-year contracts with AHCCCS to provide care to Medicaid recipients.

Prior Period Coverage ("PPC") Capitation - PPC capitation premiums cover eligible health care costs of members related to the period prior to their enrollment in the Plan. Such premiums are recognized upon receipt.

Delivery Supplement - Delivery supplement premiums are intended to cover the costs of maternity care for deliveries during the prospective enrollment period. Such premiums are recognized in the period the delivery occurs.

Reconciliation Settlements - AHCCCS has risk sharing programs which include reconciliation settlements, which impact revenue, and are due to, or from, AHCCCS, based on predetermined profit/(loss) thresholds before income tax.

Prior to October 1, 2018, if the profit or loss is less than or equal to 3% of the prospective capitation revenues, then the Company's share is 100%. If the profit is between 3% and 6%, then the Company's share is 50% of the amount over 3%, for a maximum of 4.5% of total profits. If the profit is over 6%, then the Company's share of the profits over 6% is 0%, for a maximum share of 4.5% of total profits. If the losses are in excess of 3%, then the Company's share over 3% of the losses is 0%, for a maximum share of 3% of total losses. Separate reconciliations are performed for regular prospective members, PPC members, and for membership of adults above 106% of the federal poverty level for contract years prior to October 1, 2018. PPC and the population of those adults over 106% of the federal poverty level are subject to different profit and loss corridors than described above (2% and 1% risk corridors, respectively, instead of 3%, and other differences).

(1) Company, operations, and significant accounting policies (continued)

Effective October 1, 2018, under the Complete Care contract, if the profit is less than or equal to 2% of the prospective capitation revenues, then the Company's share is 100%. If the profit is between 2% and 6%, then the Company's share is 50% of the amount over 2%, for a maximum of 4% of total profits. If the profit is over 6%, then the Company's share of the profits over 6% is 0%, for a maximum share of 4% of total profits. If the losses are in excess of 2%, then the Company's share over 2% of the losses is 0%, for a maximum share of 2% of total losses. Profits in excess of the percentages set forth above will be recouped by AHCCCS and losses in excess of the percentages set forth above will be paid to the Company.

Revenue is recognized in the month in which the related enrollees are entitled to health care services. All of the Company's revenue is earned in Arizona from its Medicaid contracts with AHCCCS.

Capitation and supplement receivables due from AHCCCS are stated at the amount management expects to collect. The Company establishes an allowance for doubtful accounts, if necessary, based upon factors including credit risk, historical trends, and other information. As of December 31, 2018, capitation and supplement receivables due from AHCCCS are considered by management to be fully collectible and, accordingly, an allowance for doubtful accounts has not been provided.

Estimated reconciliation settlement balances are recorded as a net receivable or payable on the balance sheets by risk population. A summary of the balances as of December 31, 2018 for all open contract years is as follows. It is expected that a final settlement with AHCCCS will not be reached until over a year after the end of the specific contract year.

	Reconciliation Receivable	Reconciliation Payable
Prospective	$ -	$ 9,932,103
Prior period coverage	5,428,349	-
Over 106% of federal poverty level	-	1,274,126
Total	5,428,349	11,206,229
Less current portion	(1,774,314)	(1,755,158)
Non-current portion	$ 3,654,035	$ 9,451,071

Reconciliation receivables due from AHCCCS are stated at the amount management expects to collect. The Company establishes an allowance for doubtful accounts, if necessary, based upon factors including credit risk, historical trends, and other information. As of December 31, 2018, reconciliation receivables due from AHCCCS are considered by management to be fully collectible and, accordingly, an allowance for doubtful accounts has not been provided.

Health care services - The cost of health care services is recognized in the period in which services are provided and includes an estimate of the cost of services that have been incurred but not yet reported. Such costs include payments to primary care physicians, specialists, hospitals, outpatient care facilities, pharmaceuticals, and other medical services and the costs associated with managing the extent of such care. The Company's health care costs can also include, from time to time, remediation of certain claims as a result of periodic reviews by various regulatory agencies.

(1) Company, operations, and significant accounting policies (continued)

The Company estimates the amount of the provision for health care service costs incurred but not reported and the unpaid loss adjustment expenses using standard actuarial methodologies based upon historical data, including the period between the date services are rendered and the date claims are received and paid, denied claim activity, expected medical cost inflation, seasonality patterns, and changes in membership. The estimates for service costs incurred but not reported are made on an accrual basis and adjusted in future periods as required. Any adjustments to the prior period estimates are included in the current period. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amounts of claims and losses paid are dependent on future developments, management is of the opinion that the recorded medical claims payable is adequate to cover such costs.

Under the RBHA contract, the Company contracts with various at-risk providers for the provision of a full range of integrated healthcare services to eligible adults and children for Title XIX, Title XXI and Non-Title XIX programs, and physical healthcare services to Seriously Mentally Ill Title XIX eligible adults. Health care services are purchased under fee-for-service or block purchase arrangements. Fee-for-service contract expenses are accrued as incurred. Healthcare services provided under block purchase arrangements are accrued based upon contract terms. From time to time, the Company amends their provider contracts. The effects of these amendments are recorded in the period in which the amendment was executed.

The Company contracts with various providers, including medical groups, to provide professional care to certain of its enrollees on a capitated or fixed fee per member per month basis. Additionally, the Company also contracts with hospitals, physicians, and other providers of health care, pursuant to discounted fee-for-service arrangements, hospital per diem arrangements, and case rate arrangements, under which providers bill the Company for each individual service provided to enrollees.

Amounts incurred related to prior periods represents the change in medical claims payable attributable to the difference between the original estimate of incurred claims for prior periods and the revised estimate. In developing the revised estimate, there have been no changes in the approach used to determine the key actuarial assumptions, which are the completion factor and medical cost trend. Medical claims payable are estimated under actuarial standards of practice and GAAP. The majority of the medical claims payable balance held at each year-end is associated with the most recent months' incurred services because these are the services for which the fewest claims have been paid. The degree of uncertainty in the estimates of incurred claims is greater for the most recent months' incurred services. Revised estimates for prior periods are determined in each month based on the most recent updates of paid claims for prior periods.

The medical claims payable estimates from prior years related specifically to services performed under the AHCCCS acute contract. As of December 31, 2018, amounts incurred under the acute services contract related to prior periods were estimated to be lower than originally estimated by approximately $6,818,000. The majority of these amounts were due to adjustments to the medical claims payable that related to variables and uncertainties associated with the Company's assumptions.

Expense allocation - Certain direct, indirect and administrative expenses are incurred which benefit more than one program. Such common expenses are allocated based upon an AHCCCS approved cost allocation plan as submitted by the Company, which is primarily based upon enrollment, claims and costs by lines of business.

(1) Company, operations, and significant accounting policies (continued)

Premium deficiency reserve - The Company assesses the profitability of contracts for providing health care services when operating results or forecasts indicate probable future losses. Contracts are grouped in a manner consistent with the method of determining premium rates. Losses are determined by comparing anticipated premiums to the total of estimated health care related costs, less reinsurance recoveries, if any, and the cost of maintaining the contracts. Losses, if any, would be recognized in the period the loss is determined and classified as health care services expenses. As of December 31, 2018, the Company did not report a premium deficiency reserve for the contracts administered by the Company.

Reinsurance - AHCCCS provides a stop-loss reinsurance program for the Company for partial reimbursement of reinsurable covered medical services incurred for members. The program includes a deductible, which varies based on the Company's enrollment and the eligibility category of the members. AHCCCS reimburses the Company based on a coinsurance amount for reinsurable covered services incurred above the deductible. Coinsurance percentages vary by nature of the claim for Medicare claims. Reinsurance is stated at the actual and estimated amounts due to the Company pursuant to the applicable AHCCCS contract. Reinsurance under the AHCCCS Acute contract was subject to a $25,000 deductible for claims through September 30, 2018 and reinsurance under the AHCCCS Complete Care contract is subject to a $35,000 deductible for claims effective October 1, 2018. All claims are subject to a 75% coinsurance for the year ended December 31, 2018.

To be eligible for reinsurance billing, qualified healthcare expenses must be incurred during the contract year. Reinsurance is recorded based on actual billed reinsurance claims and expected reinsurance for claims not yet paid. Reinsurance is subject to review by AHCCCS, and as a result, there is at least a reasonable possibility that recorded reinsurance will change by a material amount in the near future.

Reinsurance receivables represent the expected payment from AHCCCS to the Company for certain enrollees whose qualifying medical expenses paid by the Company were in excess of specified deductible limits. Reinsurance receivables are stated at the amount management expects to collect. Balances that are still outstanding after management has used reasonable collection efforts are written off. Management considers reinsurance receivables to be fully collectible as of December 31, 2018 and, accordingly, an allowance for doubtful accounts is not considered necessary.

Pharmacy receivables - Pharmacy receivables include rebates the Company expects to receive from its pharmacy benefit manager, a related party under common control, based on the volume of drugs purchased. The Company records a receivable and a reduction of other medical services expenses for estimated rebates due based on purchase information. Pharmaceutical rebates totaled approximately $1,367,000 for the year ended December 31, 2018, which are included as reductions in other medical services expenses in the accompanying statement of comprehensive income. Pharmacy rebates receivable totaled approximately $1,455,000 at December 31, 2018. Additionally, pharmacy receivables include balances due to the Company from the pharmacy benefit manager for routine monthly services provided based on timing and amounts of payments. Such receivables totaled approximately $4,012,000 at December 31, 2018.

As of December 31, 2018, management believes the pharmacy receivable balances are fully collectible and accordingly, an allowance has not been established.

(1) Company, operations, and significant accounting policies (continued)

Provider receivables - In the normal course of business, provider receivables are created through advances or claims overpayments. In 2018, pursuant to an AHCCCS initiative to ensure those behavioral health providers transitioning from a block payment model to a fee-for-service model would have an adequate cash position through the transition, the Company increased its advanced funding to certain providers. Those providers experiencing significant cash flow deficiencies (less than 60 days cash on hand) were able to request up to the entire quarter's expected claims funding. The repayment plan is to be no shorter than three months and no longer than six months, with extensions subject to approval by the Company. Amounts due from providers are expected to be collected within one year. Provider receivables may be recouped through withholding payments in future periods. Provider receivables are stated at the amount management expects to collect. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to earnings and a credit to provider receivables. As of December 31, 2018, management believes the provider receivable balances are fully collectible and accordingly, an allowance has not been established.

Investments - Investments as of December 31, 2018 are classified, and accounted for, as available-for-sale investments. Government, corporate and asset-backed bonds, notes, and certificates are classified as available-for-sale when the Company anticipates that the securities could be sold in response to rate changes, prepayment risk, liquidity, availability of and the yield on alternative investments, and other market and economic factors. Unrealized gains and losses on available-for-sale investments are recognized as direct increases or decreases in other comprehensive income. For the year ended December 31, 2018, the Company recognized approximately $326,000 of unrealized losses, net of tax effect, on available-for-sale investments which have been recorded in the accompanying statement of comprehensive income. Cost of investments sold is recognized using the specific identification method.

Investment securities in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the near term could materially affect account balances and the amounts reported in the accompanying financial statements.

Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold.

Premium taxes - The Company is subject to a 2% premium tax on all payments received from AHCCCS for premiums, reinsurance and reconciliations. Total premium tax expense for the year ended December 31, 2018 was approximately $9,937,000. At December 31, 2018, premium taxes receivable, resulting from overpayments of premium taxes by the Company, totaled approximately $697,000 and are included in prepaid expenses and other current assets in the accompanying balance sheet.

Health insurer fee - Under the Patient Protection and Affordable Care Act (“ACA”), the Company qualifies as a covered entity of a controlled group engaged in providing health insurance for U.S. health risks. Centene is the designated entity of the controlled group and pooled the premiums of all its subsidiaries to calculate its premium for purposes of determining its share of the health insurer fee under ACA provision 9010.

(1) Company, operations, and significant accounting policies (continued)

The annual fee equals net premiums written for health insurance during the applicable 'fee year' divided by aggregate net premiums written for all covered entities during the applicable 'fee year' multiplied by the annual applicable amount. Each health insurer's fee is a proportionate share of the total for all health insurers.

The designated entity of the controlled group passes the fee down to its subsidiaries based on an allocation of net premiums written. The health insurer fee is considered an excise tax and thus is nondeductible for income tax purposes. Effective January 1, 2017, the Internal Revenue Service ("IRS") issued a moratorium on the health insurer fee whereby collection of the health insurer fee for calendar year 2017 was suspended. Effective January 1, 2018, the moratorium was lifted and the fee was reinstated for calendar year 2018.

In October 2018, the Company funded approximately $4,021,000 to the designated entity of the controlled group to pay the fees for the calendar year ended December 31, 2018.

AHCCCS has agreed to reimburse the health insurers for this fee and applicable taxes by adjusting the contract premiums by an amount that approximates the annual fee grossed up by the Company's effective tax rate. Accordingly, as of and for the year ended December 31, 2018, the Company recorded health insurance fee revenue and a related health insurer fee receivable from AHCCCS of approximately $5,090,000, related to the health insurer fee, and an additional $104,000 for expected premium taxes. The health insurer fee receivable is expected to be collected from AHCCCS in 2019 and management believes the receivable to be fully collectible.

Reserves for contingent liabilities - In the course of the Company's operations, the Company is involved on a routine basis in various disputes with members, health care providers, and other entities, as well as audits by government agencies and elected officials that relate to the Company's services and/or business practices that expose the Company to potential losses.

The Company recognizes an estimated loss, which may represent damages, assessment of regulatory fines or penalties, settlement costs, future legal expenses, or a combination of the foregoing, as appropriate, from such loss contingencies when it is both probable that a loss will be incurred and that the amount of the loss can be reasonably estimated. The Company's loss estimates are based in part on an analysis of potential results, the stage of the proceedings, consultation with outside counsel, and any other relevant information available.

Payable to providers - The contracts with certain providers allow for the providers to earn certain value based incentives on performance pursuant to defined contract stipulations which are evaluated regularly by the Company. The estimates calculated by management for the incentives expected to be earned by providers are recorded as a liability in the period of performance of the providers. The contracts with certain providers also require a monthly review of provider performance to estimate amounts due to providers for changes in membership, changes in the blended per member per month rate and any wrap services provided to unassigned members. These estimates are recorded as a liability in the period of performance of the providers.

(1) Company, operations, and significant accounting policies (continued)

Alternative payment model liability - AHCCCS subjects 1% of funded gross prospective capitation of Acute contractors in Arizona to measurements based on each contractor's performance on selected Quality Management Performance Measures as determined by AHCCCS. The program is an effort to encourage activity for AHCCCS contractors in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings. As of December 31, 2018, the Company accrued approximately $1,841,000 for the alternative payment model liability which represents the portion of the 1% the Company estimates as a potential repayment to AHCCCS based on the results of the performance measures. The change in the accrual is recorded as an offset to capitation premium revenue for the year ended December 31, 2018 and as a long-term liability as of December 31, 2018 based on the expected settlement date with AHCCCS.

Medicaid risk adjustment - AHCCCS at times performs a review of the Medicaid program rates for its enrollees and assessed the appropriateness of rates applied to services for those enrollees. This risk adjustment of capitation payments modifies revenue to contractors based on the health status of the contractors' covered population relative to the average health status of the overall population. To estimate the impact to its capitation rates for contract years 2017 and 2016, the Company performed an analysis of the impact of the published rate change for its enrolled populations based on member months during those years. The Company estimated amounts payable to AHCCCS of approximately $7,233,000 for contract year 2017, which was recorded as a liability at December 31, 2017. In May 2018, the Medicaid risk adjustment for contract year 2017 was settled with AHCCCS, resulting in an additional payment to the Company of approximately $12,148,000, which is included in capitation revenue in the accompanying statement of comprehensive income for the year ended December 31, 2018. The difference between the estimated payable as of December 31, 2017 and the recoupment in August 2018 for contract year 2017 was driven by changes in health status of both the Company's covered and overall population, as well as a process changes made by AHCCCS in determining the applicable rates and calculations to use in assessing the Company's position relative to other managed care organizations for contract year 2017. These changes were implemented in 2018 subsequent to the estimate recorded by the Company as of December 31, 2017. For contract year 2018, the Company received $15,526,000 in August 2018, representing the calculated Medicaid risk adjustment for the period from October 1, 2017 through June 30, 2018. Prospectively from June 30, 2018, all risk adjustments will be incorporated by AHCCCS into the rates paid to the Company on a monthly basis.

Income taxes - The Company accounts for income taxes using FASB ASC 740, *Accounting for Income Taxes*. Under FASB ASC 740, deferred federal and state income taxes are provided on an asset and liability method whereby deferred income tax assets are recognized for deductible temporary differences and operating loss and tax credit carryforwards and deferred income tax liabilities are recognized for taxable temporary differences. Temporary differences are the difference between the reported amounts of assets and liabilities and their tax bases. Valuation allowances are established when necessary to reduce deferred income tax assets to the extent they are not realizable based on the Company's deductible temporary difference reversals, taxable income in its carryback period, its surplus, and the existence of taxable temporary differences. Deferred income tax assets and liabilities are adjusted for the effects of changes in tax laws and rates on the date of enactment.

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the statutory financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled.

(1) Company, operations, and significant accounting policies (continued)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

For the year ended December 31, 2018, the Company files a consolidated federal income tax return with Centene and its other subsidiaries. In accordance with the group's tax allocation agreement, the subsidiaries reimburse or recover from Centene their portion of the income taxes as calculated on a separate company basis.

The Company's policy is to classify income tax penalties and interest as income tax expense in its financial statements. During the year ended December 31, 2018, the Company incurred no penalties or interest.

The Company evaluates its uncertain tax positions, if any, on a continual basis through review of its policies and procedures, review of its regular tax filings, and discussions with outside experts.

Concentrations of credit risk - Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash equivalents and receivables from AHCCCS, primarily including capitation and supplement receivables, health insurer fee receivable, reinsurance receivables and reconciliation receivables. All cash equivalents are managed within established guidelines, which provide diversity among issuers. Concentration of credit risk with respect to the receivables from AHCCCS is high due to the single payer comprising the Company's customer base. However, since the single payer is the state government, the risk is mitigated. The receivables from providers are due from many providers such that a risk of concentration is not considered to be material.

Substantially all of the Company's revenue is earned in Arizona from its contracts with AHCCCS. Failure to renew these contracts would have a significant impact on the Company's operations.

Fair value measurements - FASB ASC 820, *Fair Value Measurements,* establishes a common definition for fair value to be applied to accounting principles generally accepted in the United States of America requiring use of fair value, establishes a framework for measuring fair value, and expands disclosures about such fair value measurements. FASB ASC 820 also establishes a hierarchy for ranking the quality and reliability of the information used to determine fair values.

FASB ASC 820 requires that assets and liabilities carried at fair value be classified and disclosed in one of the following three categories:

Level 1: Unadjusted quoted market prices in active markets for identical assets or liabilities.

Level 2: Unadjusted quoted prices in active markets for similar assets or liabilities, unadjusted quoted prices for identical or similar assets or liabilities in markets that are not active, or inputs other than quoted prices that are observable for the asset or liability.

Level 3: Unobservable inputs for the asset or liability.

(1) Company, operations, and significant accounting policies (continued)

Recent accounting pronouncements - In May 2014, the FASB issued Accounting Standards Update ("ASU") No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), that will supersede most current revenue recognition guidance, including industry-specific guidance. The core principle of the new guidance is that an entity will recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The standard provides a five-step analysis of transactions to determine when and how revenue is recognized. Other major provisions include the capitalization and amortization of certain contract costs, ensuring the time value of money is considered in the transaction price, and allowing estimates of variable consideration to be recognized before contingencies are resolved in certain circumstances. Additionally, the guidance requires disclosures related to the nature, amount, timing, and uncertainty of revenue that is recognized.

In August 2015, the FASB issued FASB ASU No. 2015-14, *Revenue from Contracts with Customers (Topic 606)*, which changed the effective date of the provisions of FASB ASU No. 2014-09. As a result, the new effective dates for public business entities, certain not-for-profit entities, and certain employee benefit plans to apply the guidance in FASB ASU No. 2014-09 is for annual reporting periods beginning after December 15, 2017. All other entities should apply the guidance in FASB ASU No. 2014-09 to annual reporting periods beginning after December 15, 2018. Earlier application is permitted only as of annual reporting periods beginning after December 15, 2016. Transition to the new guidance may be done using either a full or modified retrospective method. Management does not expect the adoption of this standard to have a material impact on the financial statements of the Company.

In February 2018, the FASB issued FASB ASU No. 2018-02, *Income Statement – Reporting Comprehensive Income (Topic 220)*, which allows a reclassification from accumulated other comprehensive income ("OCI") to retained earnings for stranded tax effects resulting from the Tax Cuts and Job Act (TCJA). The Company adopted the new guidance in 2018 and elected to reclassify stranded tax effects as a result of the TCJA. The Company uses the individual security approach to release income tax effects from accumulated OCI. The new guidance did not have a material impact on the Company's financial statements.

Subsequent events - The Company has evaluated subsequent events through September 20, 2019, which is the date the financial statements were available to be issued.

(2) Contract performance bonds

In accordance with the terms of its contracts with AHCCCS, the Company is required to post performance bonds with AHCCCS equal to 100% of the first monthly AHCCCS payment to the Company each contract year based on gross capitation payments, as specified in each contract. The amount of each bond is subject to adjustment as certain conditions change and its method of calculation is specified in the contracts. The actual amount is reset each year upon expiration. The performance bonds must be maintained to guarantee payment of the Company's obligations under the contracts.

(2) Contract performance bonds (continued)

As of December 31, 2017, the Company had a performance bond for the benefit of AHCCCS totaling $22,000,000, covering the period from October 1, 2017 through September 30, 2018. Effective October 1, 2018, the Company secured performance bonds for the Complete Care and RBHA contracts which became effective October 1, 2018. Each performance bond covers the Company through September 30, 2019. The performance bond requirement for the Complete Care contract was met through the purchase of a surety bond in the amount of $71,508,439 and the performance bond requirement for the RBHA contract was met through the purchase of a surety bond in the amount of $37,000,000. The performance bonds cover the minimum coverage requirements for the applicable contracts.

(3) Investments

Investments have been classified as available for sale according to management's intent. The amortized cost of investments and their approximate fair values at December 31, 2018 are as follows:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Asset-backed	$ 4,689,306	$ 1,578	$ (42,474)	$ 4,648,410
Mortgage-backed	3,648,092	-	(72,561)	3,575,531
Corporate bonds	15,045,587	19,478	(280,290)	14,784,775
Municipal bonds	14,347,528	54,904	(170,844)	14,231,588
Total	$ 37,730,513	$ 75,960	$ (566,169)	$ 37,240,304

The following is a summary of maturities of available-for-sale investments as of December 31, 2018:

Amounts maturing in:	Amortized Cost	Fair Value
One year or less	$ 4,053,569	$ 4,029,002
After one year through five years	9,535,947	9,347,781
After five years through ten years	11,312,262	11,208,678
After ten years	12,828,735	12,654,843
Total	$ 37,730,513	$ 37,240,304

(4) Fair value measurements

The Company regularly evaluates its investments for impairment. The Company considers factors affecting the issuer, factors affecting the industry the issuer operates within, and general debt and equity market trends. The Company considers the length of time an investment's fair value has been below carrying value, the severity of the decline, the near term prospects for recovery to cost, and the Company's intent and ability to hold the investment until maturity or market recovery is realized. If and when a determination is made that a decline in fair value below the cost basis is other than temporary, the related investment is written down to its estimated fair value through a charge to realized losses on investments. Of the gross unrealized losses as of December 31, 2018, approximately $380,000 have been in a loss position for longer than 12 months. Management intends to hold these investments for an extended period such that the losses incurred have been classified as temporary. For the year ended December 31, 2018, there were no other than temporary impairments of investments.

(4) Fair value measurements (continued)

The following table summarizes the valuation of the Company's assets subject to recurring fair value measurement by the above FASB ASC 820 categories as of December 31, 2018.

	Total	Level 1	Level 2	Level 3
Asset-backed	$ 4,648,410	$ -	$ 4,648,410	$ -
Mortgage-backed	3,575,531	-	3,575,531	-
Corporate bonds	14,784,775	-	14,784,775	-
Municipal bonds	14,231,588	-	14,231,588	-
Total	$ 37,240,304	$ -	$ 37,240,304	$ -

The fair value of the above investments are measured using quoted market prices multiplied by the quantity held when quoted market prices are observable. If quoted market prices are not available, fair value is determined using one, or a combination, of the following methods (1) matrix pricing for similar instruments, (2) quoted prices for recent trading activity of assets with similar characteristics, or (3) using an income approach valuation technique that considers, among other things, rates currently observed in publicly traded debt markets for debt of similar terms to companies with comparable credit risk and a credit value adjustment to consider the likelihood of counterparty nonperformance, after consideration of the impact of collateralization and netting agreements, if applicable.

The Company has no other assets or liabilities subject to recurring fair value measurement at December 31, 2018.

(5) Income taxes

The Company's federal income tax return is consolidated with Centene and its affiliates. The method of allocation among companies is subject to a written agreement whereby allocation is made primarily on a separate company basis using the percentage method pursuant to provisions of IRC Sections §1502 and §1552 and Treasury Regulations §1.1502 and §1.1552. This percentage method allocates a tax asset (i.e. intercompany receivable) for any benefit derived by the consolidated group for the member's losses or credits that offset consolidated taxable income. In accordance with the tax sharing agreement, each member shall pay to Parent or receive from Parent the amount of tax liability or benefit reported on each member's proforma federal income tax return within 90 days of the date Parent files its consolidated federal income tax return.

Significant components for the income tax provision (benefit) are as follows for the year ended December 31, 2018:

Current provision (benefit):	
Federal	$ 2,382,609
State and local	214,598
Total current provision	2,597,207
Deferred benefit	(236,886)
Total provision for income taxes	$ 2,360,321

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes includes state income taxes, ACA health insurer fee, income tax reform, and other items.

(5) Income taxes (continued)

The tax effects of temporary differences that give rise to deferred tax assets and liabilities include net unrealized gain/(loss) on investments, discounted loss reserves, unearned premiums, allowance for doubtful accounts, loss reserves transition, prepaid insurance, and other items for the year ended December 31, 2018. Gross deferred tax assets totaled $1,237,476 at December 31, 2018, and gross deferred tax liabilities totaled $130,602 at December 31, 2018.

As of December 31, 2018, the Company had no operating loss or tax credit carryforwards available for tax purposes.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowance adjustment to gross deferred tax assets as of December 31, 2018 was $0. The realization of the deferred tax asset is dependent upon the Company's ability to generate sufficient taxable income in future periods. Based on historical results and the prospects for current operations, management anticipates that it is more likely than not that future taxable income will be sufficient for the realization of the remaining deferred tax assets.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. The Company's reserve for uncertain tax positions totaled $800,458 for the year ended December 31, 2018. The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date. Related interest and penalties are treated as income tax expense under the Company's accounting policy. The total amount of interest and penalties, net of related tax benefits, recognized in the statement of comprehensive income for the year ended December 31, 2018 is $0. The total amount of interest and penalties, net of related tax benefits, recognized in the balance sheet as of December 31, 2018 is $0. As of December 31, 2018 the Company is under federal examination for tax years 2011 through its final return in 2016. Additionally, Centene's tax returns for years 2014 through 2017 are subject to federal examination. The tax return for 2018 has not yet been filed.

Presently, the consolidated group is undergoing examination by various state taxing authorities. The Company does not believe that any ongoing examination will have a material impact on its balance sheet and statement of comprehensive income.

On December 22, 2017, the United States enacted tax reform legislation through the Tax Cuts and Jobs Act, which significantly changes the existing U.S. tax laws, including a reduction in the corporate tax rate from 35% to 21%, as well as other changes. As a result of enactment of the legislation, the Company incurred an additional one-time equity decrease during the 4th quarter of 2017, primarily related to the remeasurement of certain deferred tax assets and liabilities.

The Tax Cuts and Jobs Act of 2017 provides for a change in the methodology employed to calculate reserves for tax purposes. Beginning January 1, 2018, a higher interest rate assumption and longer payout patterns will be used to discount these reserves. In addition, companies will no longer be able to elect to use their own experience to discount reserves, but will instead be required to use the industry-based tables published by the IRS annually. The Company updated the discount rate based on available guidance and the transition resulted in an increase to deferred tax assets with a corresponding increase to deferred tax liabilities of $61,089 at January 1, 2018, with no impact on the effective tax rate. The Company has completed its accounting of the effects of the TCJA on current and deferred income taxes.

(6) Related party transactions

The Company relies on affiliate services to conduct its business in order to achieve cost savings. The Company does nevertheless exercise ultimate control over its assets and operations and retains the ultimate authority and responsibility regarding its powers, duties, and responsibilities.

On April 1, 2016, the Company and Centene Management Company ("CMC") entered into a management agreement whereby CMC agrees to manage the general and administrative function of the Company inclusive of payroll, facilities, and other administrative expenses. The management fee is based on the variable degree of management services required to support the differing categories of membership covered by the Company and the size of the Company's operations. The fee can be modified each month to account for net revenue earned in excess or below the specified percentages and to comply with the AHCCCS financial viability standards (see Note 8). The management agreement is in effect for one year with automatic one year extensions unless the agreement is terminated as elected by either party or for matters of default as defined in the management agreement.

The management agreement renews annually unless amended or terminated by either party. The Company recorded management fees per the management agreement of approximately $44,265,000 for the year ended December 31, 2018. This amount is included in administrative expenses in the accompanying statement of comprehensive income. As of December 31, 2018, the Company has overpaid management fees to CMC and was owed approximately $1,046,000, which is included in due from affiliates in the accompanying balance sheet. Balances associated with this service agreement are settled within 30 days in the normal course of business.

The Company is a party to a Claims Administration Service Agreement with Health Net Pharmaceutical Services ("HNPS"), an affiliated company wholly-owned by HNI which is wholly owned by Centene. HNPS provides pharmacy benefit management services to eligible enrollees. The Company incurred expense to HNPS of approximately $68,552,000, net of rebates, for these services for the year ended December 31, 2018, which are included in other medical services in the accompanying statement of comprehensive income. Claims encounters are submitted to AHCCCS to substantiate these payments. HNPS also receives an administration fee from the Company for administering pharmacy claims processing. For the year ended December 31, 2018, these administration fees approximated $545,000 and are included in administrative expenses in the accompanying statement of comprehensive income.

Envolve Vision, Inc., an affiliated company wholly-owned by Envolve Holdings, Inc. which is wholly-owned by Centene, provides a vision network and manages the vision benefits for eligible enrollees pursuant to an agreement with the Company that was established on July 1, 2016. The Company incurred expense to Envolve Vision, Inc. of approximately $912,000 for these services during the year ended December 31, 2018. These amounts are included in other medical services in the accompanying statement of comprehensive income. As of December 31, 2018, the Company has approximately $367,000 due to Envolve Vision, Inc. which are included in medical claims payable in the accompanying balance sheet.

Envolve Dental, Inc., an affiliated company wholly-owned by Envolve Holdings, Inc. which is wholly-owned by Centene, provides dental services for eligible enrollees pursuant to an agreement with the Company that was established on October 1, 2016. The Company incurred expense to Envolve Dental, Inc. of approximately $8,981,000 for these services during the year ended December 31, 2018. These amounts are included in other medical services in the accompanying statement of comprehensive income. As of December 31, 2018, the Company has approximately $282,000 due to Envolve Dental, Inc. which are included in medical claims payable in the accompanying balance sheet.

(6) Related party transactions (continued)

Envolve PeopleCare, Inc., an affiliated company wholly-owned by Envolve Holdings, Inc. which is wholly-owned by Centene, provides disease management, nurse triage, and call center services to eligible enrollees through a contract with HNI that was established July 1, 2016. The Company incurred expense to HNI related to the services provided by Envolve PeopleCare, Inc. of approximately $3,532,000 during the year ended December 31, 2018. These amounts are included in other medical services in the accompanying statement of comprehensive income. As of December 31, 2018, the Company has approximately $488,000 due to HNI related to the services provided by Envolve PeopleCare, Inc. which are included in medical claims payable in the accompanying balance sheet.

(7) Commitments and contingencies

Liability insurance - The Company, through Centene, maintains professional and general liability insurance. The professional liability coverage is written on a claims made basis and insures losses up to $15,000,000 with a self-insured retention of $5,000,000. There is an umbrella policy over the professional liability coverage with a limit of $15,000,000. The general liability insurance is written on an occurrence basis and insures losses up to $1,000,000 per claim and $2,000,000 in the aggregate. There is also an umbrella policy over the general liability insurance with a limit of $25,000,000. Claims reported endorsement (tail coverage) is available if the professional policy is not renewed to cover claims incurred but not reported. The Company anticipates that renewal coverage will be available at the expiration of the current policy. The Company participates in the above policy with its affiliates. Per claim and aggregate limits are applicable to all covered entities as a group.

Litigation - Periodically, the Company may be involved in litigation and claims arising in the normal course of operations. In the opinion of management based on consultation with legal counsel, losses, if any, from these matters are covered by insurance or are immaterial.

Healthcare regulation - The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Company is in compliance with fraud and abuse laws and regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future review and interpretation as well as regulatory actions unknown or unasserted at this time.

Health reform legislation at both the federal and state levels continues to evolve. Changes continue to impact existing and future laws and rules. Such changes may impact the way the Company does business, restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase medical, administration and capital costs, and expose the Company to increased risk of loss or further liabilities. The Company's operating results, financial position and cash flows could be adversely impacted by such changes.

Community reinvestment program - Effective October 1, 2018, the Company approved a Community Reinvestment program, as described in their contract with AHCCCS. Under the program, the Company will place a minimum of 6% of its after tax profits into the program. For the quarter ended December 31, 2018, the Company had met or exceeded that amount. The program funds community projects that enhance the lives of people in the communities in the Company's geographic service areas.

(7) Commitments and contingencies (continued)

For the year ended December 31, 2018, the Company approved amounts that resulted in appropriations of approximately $243,000 to be spent on various community projects. During the year ended December 31, 2018, the Company spent approximately $10,000 of the appropriated funds. At December 31 2018, the Company has recorded a liability for unspent community reinvestment program funds of approximately $233,000, which is included in other current liabilities in the accompanying balance sheet.

(8) Contract requirements

In accordance with its contracts with AHCCCS, the Company is required to maintain certain minimum financial reporting and viability measures. The Company must meet a minimum capitalization requirement based on the number of members enrolled as well as various quarterly financial viability standards and performance guidelines. As of December 31, 2018, the Company was in compliance with the requirements for the Complete Care and RBHA contracts.

The RBHA contract is limited by the terms of its contract with AHCCCS to profit that can be earned under the various programs, generally up to 4%. The Company is subject to a profit risk corridor calculation that calculates a return of premium to the extent certain financial ratios are not met by program types. For the year ended December 31, 2018, the Company did not exceed the profit limits as stipulated in the contracts with AHCCCS.

Under the RHBA contract, the Company is required to meet quarterly and contract year end minimum encounter submission percentages, or be subject to sanction by AHCCCS. Typically, the Company has up to eight months after fiscal year end to submit encounters related to the fiscal year. As of December 31, 2018, the Company anticipates meeting the required encounter threshold for the year ended September 30, 2019. Accordingly, as of December 31, 2018, the Company has not recorded a liability associated with an encounter sanction.

On December 28, 2018, the Company submitted a self-imposed corrective action plan (“CAP”) to AHCCCS. The CAP focused on the Company’s challenges surrounding the implementation of a single provider network database specifically with respect to provider contracts, provider loads, and claims payment. In January 2019, the Company was notified by AHCCCS that the Company was not in compliance with their contract relative to the Company’s failure to successfully implement the provider network database it elected to pursue for its provider network, resulting in non-compliance with certain provisions and safeguards for provider claims payments standards. AHCCCS also noted that the Company’s failure to ensure performance consistent with AHCCCS requirements resulted in adverse impacts to the Company’s relationship with providers, widespread disruption to provider payments, and undue hardship to providers which could have been avoided with adequate planning, management, and oversight. As a result of this non-compliance, AHCCCS imposed a $125,000 monetary sanction. The total sanction amount will be withheld from future capitation payments. The Company is required to submit ongoing detailed updates of its CAP to AHCCCS, outlining the specific activities that are being taken to resolve the issues resulting from implementation of the integrated single provider network database, including but not limited to, data related to number of impacted providers, paid and outstanding claims volume and values, and any claims adjustments made. The Company must demonstrate sustained compliance with contractual claims payment requirements prior to release of the Administrative Action.

(8) Contract requirements (continued)

Should the Company be in default of any material obligations under its contracts with AHCCCS, AHCCCS may, at its discretion, in addition to other remedies, either adjust the amount of future payment or withhold future payment until they have received satisfactory resolution of the default or exception. In addition, although it has not expressed an intention to do so, AHCCCS has the right to terminate the contracts in whole or in part without cause by giving the Company 90 days written notice. Further, if monies are not appropriated by the state or are not otherwise available, the contracts with AHCCCS may be cancelled upon written notice until such monies are so appropriated or available.

For the year ended December 31, 2018, the Company recorded expenses for sanctions from AHCCCS of approximately $1,978,000 which are included in administrative expenses in the statement of comprehensive income. Of the $1,978,000, the Company has received formal sanction of approximately $675,000 for contract year 2016 and has estimated sanctions to be received of approximately $1,303,000 for contract years 2017 and 2018. The sanctions received and expected to be received from AHCCCS relate primarily to noncompliance with certain contract requirements and performance measures for contract years 2016 through 2018. If the Company were to be subject to additional sanctions or its contracts with AHCCCS were terminated or not renewed, this would have a material adverse impact on the Company's business, its reputation, results of operations, cash flows or financial condition.

SUPPLEMENTAL INFORMATION

4722 North 24th Street, Suite 300 ■ Phoenix, AZ 85016
Main: 602.264.6835 ■ Fax: 602.265.7631 ■ www.mhmcpa.com

INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTAL INFORMATION

To the Board of Directors of

HEALTH NET ACCESS, INC. d/b/a ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

Report on Supplemental Information

We have audited the accompanying sub-capitated expenses report ("Supplemental Information") as defined in the AHCCCS Complete Care contract dated October 1, 2018 between ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan*** and AHCCCS, for the year ended December 31, 2018.

Management's Responsibility for the Supplemental Information

Management is responsible for the preparation and fair presentation of the supplemental information in accordance with the AHCCCS Complete Care contract; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of supplemental information that is free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the supplemental information based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the supplemental information is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the supplemental information. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the supplemental information, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the supplemental information in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the supplemental information.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the supplemental information referred to above properly presents the sub-capitated expenses under the AHCCCS contract for the year ended December 31, 2018, as defined in the AHCCCS contract referred to in the first paragraph.

This report is intended solely for the information and use of the Board of Directors, management of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan***, others within the entity and AHCCCS, and is not intended to be used and should not be used by anyone other than these specified parties.

September 20, 2019

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

SUPPLEMENTAL INFORMATION

Schedule 1 - Sub-Capitated Expenses Report

Year Ended December 31, 2018

Account	Account Description	YTD Amount
Sub-Capitated Hospitalization Expenses:		
50105-01	Hospital Inpatient	$ -
50110-01	Hospital Inpatient -Behavioral Health Services	-
50115-01	PPC-Hospital Inpatient	-
	Total Sub-Capitated Hospitalization Expense:	-
Sub-Capitated Medical Compensation Expenses:		
50205-01	Primary Care Physician Services	-
50210-01	Behavioral Health Physician Services	-
50215-01	Referral Physician Services	-
50220-01	PH FQHC/RHC Services	-
50225-01	Other Professional Services	-
50230-01	PPC - Physician Services	-
	Total Sub-Capitated Medical Compensation Expenses:	-
Sub-Capitated Other Medical Expenses:		
50305-01	Emergency Facility Services	-
50310-01	PH Pharmacy	-
50315-01	Laboratory, Radiology and Medical Imaging	-
50320-01	Outpatient Facility	-
50325-01	Durable Medical Equipment	-
50330-01	Dental	8,429,798
50335-01	Transportation	-
50340-00	Nursing Facility, Home Health Care	-
50345-01	Therapies	-
50350-01	Alternative Payment Model Performance Based Payments to Providers	-
50355-01	Behavioral Health Day Program	-
50355-05	Behavioral Health Case Management Services	-
50355-10	Behavioral Health Crisis Intervention Services	-
50355-15	Behavioral Health Rehabilitation Services	-
50355-20	Behavioral Health Residential Services	-
50355-25	All Other Behavioral Health Services	-
50360-01	PPC-Other Medical Expenses	-
50370-01	Other Medical Expenses	4,569,647
	Total Sub-Capitated Other Medical Expenses:	$ 12,999,445
	Total Sub-Capitated Expenses:	$ 12,999,445

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Main: 602.264.6835 ■ Fax: 602.265.7631 ■ www.mhmcpa.com

INDEPENDENT AUDITORS' REPORT ON ADDITIONAL INFORMATION

To the Board of Directors of

HEALTH NET ACCESS, INC. D/B/A ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

We have audited the financial statements of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan*** as of and for the year ended December 31, 2018, and our report thereon dated September 20, 2019, which contained an unmodified opinion on those financial statements, appears on pages 1 and 2. Our audit was performed for the purpose of forming an opinion on the financial statements as a whole. The contract balance sheet and contract statement of comprehensive income (loss) on pages 28 and 29 are presented for purposes of additional analysis and are not a required part of the financial statements. These statements are required in accordance with the AHCCCS contracts. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The additional information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the additional information is fairly stated in all material respects in relation to the financial statements as a whole.

Mayer Hoffman McCann P.C.

September 20, 2019

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

ADDITIONAL INFORMATION

SCHEDULE 2 - CONTRACT BALANCE SHEET

December 31, 2018

A S S E T S

	ACC Contract	RBHA Contract	Total
CURRENT ASSETS			
Cash and cash equivalents	$ 77,819,169	$ 35,690,702	$ 113,509,871
Capitation and supplement receivables	567,126	1,918,316	2,485,442
Health insurer fee receivable	4,739,605	454,483	5,194,088
Reinsurance receivables	4,301,515	-	4,301,515
Provider receivables	9,463,804	4,315,953	13,779,757
Pharmacy receivables	4,175,070	1,291,504	5,466,574
Reconcilliation receivables	1,774,314	-	1,774,314
Income taxes receivable from affiliate	8,711,684	856,509	9,568,193
Short-term investments	4,029,002	-	4,029,002
Prepaid expenses and other current assets	3,632,121	(1,706,887)	1,925,234
Due (to) from affiliates	(335,374)	6,362,935	6,027,561
TOTAL CURRENT ASSETS	118,878,036	49,183,515	168,061,551
LONG-TERM INVESTMENTS	33,211,302	-	33,211,302
RECONCILIATION RECEIVABLES	3,654,035	-	3,654,035
DEFERRED INCOME TAX ASSET (LIABILITY), net	1,129,545	(22,671)	1,106,874
TOAL ASSETS	$ 156,872,918	$ 49,160,844	$ 206,033,762

L I A B I L I T I E S A N D S T O C K H O L D E R ' S E Q U I T Y

	ACC Contract	RBHA Contract	Total
CURRENT LIABILITIES			
Medical claims payable	$ 104,380,066	$ 45,807,722	$ 150,187,788
Reconcilliation payables	1,755,158	-	1,755,158
Payable to providers	2,062,267	4,596,432	6,658,699
Other current liabilities	3,366,320	1,150,363	4,516,683
TOTAL CURRENT LIABILITIES	111,563,811	51,554,517	163,118,328
RECONCILLIATION PAYABLES	9,451,071	-	9,451,071
UNRECOGNIZED TAX BENEFIT LIABILITY	800,458	-	800,458
ALTERNATIVE PAYMENT MODEL LIABILITY	1,841,344	251,919	2,093,263
TOTAL LIABILITIES	123,656,684	51,806,436	175,463,120
TOTAL STOCKHOLDER'S EQUITY (DEFICIT)	33,216,234	(2,645,592)	30,570,642
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$ 156,872,918	$ 49,160,844	$ 206,033,762

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

ADDITIONAL INFORMATION

SCEHDULE 3 - CONTRACT STATEMENT OF COMPREHENSIVE INCOME (LOSS)

December 31, 2018

	ACC Contract	RBHA Contract	Total
REVENUES			
Capitation premiums	$ 379,592,219	$ 106,430,222	$ 486,022,441
Delivery supplement	11,130,733	-	11,130,733
Health insurer fee revenue	5,194,088	-	5,194,088
Investment and other income	1,615,811	-	1,615,811
TOTAL REVENUES	397,532,851	106,430,222	503,963,073
EXPENSES			
Health care services:			
Hospitalization	80,637,243	14,210,472	94,847,715
Medical compensation	89,250,518	9,278,554	98,529,072
Other medical services	174,631,957	73,849,885	248,481,842
Less: reinsurance recoveries	(8,835,534)	-	(8,835,534)
Total health care services, net of reinsurance recoveries	335,684,184	97,338,911	433,023,095
Premium tax	8,046,910	1,890,526	9,937,436
Health insurer fee	4,125,145	-	4,125,145
Administrative	39,285,943	10,664,875	49,950,818
Interest	189,427	20,096	209,523
TOTAL EXPENSES	387,331,609	109,914,408	497,246,017
NET INCOME (LOSS) BEFORE INCOME TAXES	10,201,242	(3,484,186)	6,717,056
INCOME TAX EXPENSE (BENEFIT)	3,198,917	(838,596)	2,360,321
NET INCOME (LOSS)	7,002,325	(2,645,590)	4,356,735
OTHER COMPREHENSIVE LOSS			
Unrealized losses on available-for-sale investments, net of tax	(325,689)	-	(325,689)
TOTAL COMPREHENSIVE INCOME (LOSS)	$ 6,676,636	$ (2,645,590)	$ 4,031,046

UNIFORM GUIDANCE
SUPPLEMENTARY REPORTS

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended December 31, 2018

Federal Grantor / Pass-Through Grantor / Program Cluster or Title	Federal CFDA Number	Contract Number	Pass-through Entity Identifying	Passed Through to Subrecipients	Federal Expenditures
U.S. Department of Health and Human Services					
Passed through Arizona Health Care Cost Containment System					
Substance Abuse and Mental Health Services - Projects of Regional and National Significance					
Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA)	93.243	YH17-0003	11356415170214	$ 94,946	$ 103,203
State Targeted Response to the Opioid Crisis Grants (Opioid STR)	93.788	YH17-0003	11356415170214	741,611	806,098
Passed through Arizona Health Care Cost Containment System					
Block Grants for Community Mental Health Services (MHBG):					
SMI - Non Title XIX	93.958	YH17-0003	11356415170214	272,627	308,521
Children - Non Title XIX	93.958	YH17-0003	11356415170214	388,932	457,375
SMI FEP - Non Title XIX	93.958	YH17-0003	11356415170214	70,540	76,674
Total Mental Health Block Grant (93.958)				732,099	842,570
Passed through Arizona Health Care Cost Containment System					
Block Grants for Prevention and Treatment of Substance Abuse (SABG):					
Substance Abuse/General Mental Health	93.959	YH17-0003	11356415170214	2,242,808	2,471,757
Prevention	93.959	YH17-0003	11356415170214	461,336	522,346
Total Block Grants for Prevention and Treatment of Substance Abuse (93.959)				2,704,144	2,994,103
Total U.S. Department of Health and Human Services				4,272,800	4,745,974
TOTAL EXPENDITURES OF FEDERAL AWARDS				$ 4,272,800	$ 4,745,974

See Independent Auditors' Report
See Notes to Schedule of Expenditures of Federal Awards

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended December 31, 2018

(1) Basis of presentation

The accompanying Schedule of Expenditures of Federal Awards (the "Schedule") includes the federal grant activity of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan*** under programs of the federal government for the year ended December 31, 2018. The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan,*** it is not intended and does not present the financial position, changes in stockholder's equity or cash flows of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan.***

(2) Summary of significant accounting policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan*** has not elected to use the ten percent de minimus indirect cost rate allowable under the Uniform Guidance.

(3) Catalog of federal domestic assistance (CFDA) numbers

The program titles and CFDA numbers were obtained from the 2018 *Catalog of Federal Domestic Assistance*.

4722 North 24th Street, Suite 300 ■ Phoenix, AZ 85016
Main: 602.264.6835 ■ Fax: 602.265.7631 ■ www.mhmcpa.com

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Directors and Stockholder of

HEALTH NET ACCESS, INC. d/b/a ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan***, which comprise the balance sheet as of December 31, 2018, and the related statements of comprehensive income, stockholder's equity and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated September 20, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control. Accordingly, we do not express an opinion on the effectiveness of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Mayer Hoffman McCann P.C.

September 20, 2019

4722 North 24th Street, Suite 300 ■ Phoenix, AZ 85016
Main: 602.264.6835 ■ Fax: 602.265.7631 ■ www.mhmcpa.com

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

To the Board of Directors and Stockholder of

HEALTH NET ACCESS, INC. d/b/a ARIZONA COMPLETE HEALTH – COMPLETE CARE PLAN

Report on Compliance for Each Major Federal Program

We have audited ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** compliance with the types of compliance requirements described in the U.S Office of Management and Budget ("*OMB") Compliance Supplement* that could have a direct and material effect on each of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** major federal programs for the year ended December 31, 2018. ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States; and the requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance"). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** compliance.

Opinion on Each Major Federal Program

In our opinion, ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan*** complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2018.

Report on Internal Control Over Compliance

Management of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan*** is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of ***Health Net Access, Inc. d/b/a Arizona Complete Health – Complete Care Plan's*** internal control over compliance.

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Mayer Hoffman McCann P.C.

September 20, 2019

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended December 31, 2018

Section I – Summary of Auditors' Results

Financial Statements

1. Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP: Unmodified
2. Internal control over financial reporting:
   a. Material weakness(es) identified? No
   b. Significant deficiency(ies) identified? None reported
3. Noncompliance material to financial statements noted? No

Federal Awards

1. Internal control over major federal programs:
   a. Material weakness(es) identified? No
   b. Significant deficiency(ies) identified? None reported
2. Type of Auditors' report issued on compliance for major federal programs: Unmodified
3. Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? No
4. Identification of major federal programs:

CFDA Number	Name of Federal Program or Cluster
93.958	Block Grants for Community Mental Health Services
93.959	Block Grants for Prevention and Treatment of Substance Abuse
93.788	State Targeted Response to the Opioid Crisis Grants (Opioid STR)

5. Dollar threshold used to distinguish between type A and type B programs: $750,000
6. Auditee qualified as a low-risk auditee? No

HEALTH NET ACCESS, INC. d/b/a
ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended December 31, 2018

Section II – Financial Statement Findings

None noted

Section III – Federal Award Findings and Questioned Costs

None noted

Section IV – Schedule of Prior Year Findings

None noted