Molina Healthcare of Arizona

Arizona Health Care Cost Containment System (AHCCCS)
Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled
Solicitation No: YH12-0001

April 1, 2011 **Copy** Binder 1 of 2

MOLINA® HEALTHCARE

Molina Healthcare of Arizona, Inc.

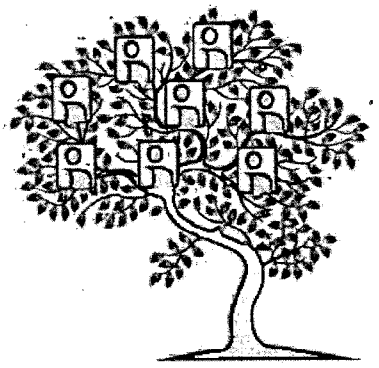
Response to
Arizona Health Care Cost Containment System
(AHCCCS)

Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled

Solicitation No.:
YH12-0001

Copy

April 1, 2011



Binder 1 of 2

MOLINA® HEALTHCARE

Your Extended Family.

OFFEROR'S CHECKLIST

Offerors must submit all items below, unless otherwise noted. In the column titled "Offeror's Page #," the Offeror must enter the appropriate page number(s) from its proposal where the AHCCCS Evaluation Panel may find the Offeror's response to the specified requirement. AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's proposal. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the proposal when reviewing a specific response to an individual submission requirement.

A. General Matters

Subject	Reference	Offeror's Page #
Offeror's signature page	(Front Page)	9
Offeror's Checklist (this attachment)	N/A	10
Completion of all items in Section G of the RFP	Section G	186

B. CAPITATION

Subject	Requirement #	Offeror's Page #
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	15

C. ORGANIZATION

Subject	Requirement #	*Offeror's Page #*
Moral and Religious Objection	2	19
Organization and Staffing	3	20
	4	64
	5	64
Sanctions	6	67
Claims	7	70
	8	73
	9	75
Encounters	10	78
Information Systems	11	85
	12	98
	13	101
	14	101

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Subject	Requirement #	*Offeror's Page #*
Grievance System	15	103
Corporate Compliance	16	109
Finance and Liability Management	17	113
	18	113
	19	113

D. PROGRAM

Subject	Requirement #	*Offeror's Page #*
Case Management	20	115
	21	117
	22	120
	23	123
	24-A	126
	24-B	130
	24-C	133
	24-D	135
Medical Management	25	139
	26	144
	27	144
	28	146
Quality Management	29	150
	30	152
	31-A	154
	31-B	156
	32	159
	33	161
	34	163
Oral Presentation	35	The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. on April 8.

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E. PROVIDER NETWORK

Subject	Requirement #	*Offeror's Page #*
Provider Network	36	169
	37	169
	38	171
	39	173
	40	175
	41	178
	42	179
	43	180
	44	182
Network Summary via EFT/SFTP	45	N/A

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CONTENTS

Binder 1 of 2

Binder 2 of 2

Table of Contents

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Executive Summary

EXECUTIVE SUMMARY

Molina Healthcare of Arizona (Molina*) is the licensed entity that will administer the services proposed in this Request for Proposal response for Arizona Long-term Care System (ALTCS) elderly and physically disabled beneficiaries. This new local subsidiary health plan will leverage the administrative and legal structure of its parent company, Molina Healthcare, Inc. (Molina Healthcare*), to administer a cost-effective combination of local plan operations and shared corporate resources, while maintaining a patient-centered, outcomes-focused approach to managed care services.

About Molina

Molina Healthcare, headquartered in Long Beach, California, began from a single clinic opened by C. David Molina, M.D. as a safety net provider in 1980 under the name Molina Medical Centers. The initial clinic sites served populations who lacked adequate access to primary care services. These populations were commonly characterized by cultural, ethnic and linguistic distinctions that required unique care to address each member's combination of medical needs and social diversities. Molina Healthcare currently operates 21 primary care clinics that serve economically disadvantaged members who have limited access to health care services. Sixteen clinics are located in California, three in Virginia, two in Washington, and Molina Healthcare will open three new clinics in New Mexico in 2011.

At present, as Chief Executive Officer, Dr. Mario Molina provides physician leadership to direct the activities of Molina Healthcare's administration of managed care services for Medicaid (including long-term care), Children's Health Insurance Program (CHIP), Medicare and other government programs. Molina Healthcare serves approximately 1.6 million members in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin. Depending upon the contract, covered services may include preventive and primary care; Early and Periodic Screening, Diagnosis and Treatment (EPSDT); urgent care; emergency care; long-term care; behavioral health; prenatal care; pharmacy; case management; disease management; transplantation; care for Children with Special Health Care Needs (CSHCN); transportation; and other services as required by specific state agencies. Molina Healthcare also offers health information management and business process outsourcing solutions for state Medicaid programs through its subsidiary, Molina Medicaid Solutions, which holds Medicaid Management Information Systems (MMIS) contracts in Idaho, Louisiana, Maine, New Jersey and West Virginia. The combined services of Molina Healthcare's subsidiaries touch approximately 4.3 million Medicaid beneficiaries and 189,000 providers in 15 states, making it one of the largest national Medicaid vendors.

Molina Healthcare's 30-year mission to serve the underserved will also be Molina Healthcare of Arizona's guiding principle. Molina Healthcare's experience and expertise will enable Molina Healthcare of Arizona to implement the services described in this proposal to administer quality nursing home and community-based care for the elderly or physically disabled individuals in the ALTCS program. Molina will coordinate ALTCS Medicaid and Medicare program benefits to help members obtain eligible services regardless of payer. By adapting its programs to meet the needs of the diverse ALTCS population, Molina will help members maintain as much independence and self-determination as possible. This will be accomplished by providing physical and behavioral health preventive and treatment services, case management services, and integrated services to ensure members receive the right care, at the right time, in the right setting.

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Molina's Commitment

For more than a year, Molina has invested considerable resources into building a robust provider network that meets AHCCCS contract requirements. Molina will continue to develop its network and service presence over the coming months while leveraging the strength of its multistate parent company to ensure efficient and effective network operations fully capable of serving all ALTCS member needs. In addition, since late 2010, Molina has engaged its project implementation team to perform substantial work toward building the operational infrastructure that will contribute to a successful new health plan in Arizona. In recognition of the inherent challenges of a short implementation period and the extensive requirements of the ALTCS program, Molina has focused on developing key time-sensitive implementation areas such as operational infrastructure, IT interfaces and system configurations.

Molina Healthcare will pursue NCQA accreditation for Molina Healthcare of Arizona to ensure quality improvement and cost containment is foundational to its operations. Molina Healthcare is dedicated to maintaining the highest quality standards as demonstrated through the enterprise performance goal that all of its health plans achieve NCQA accreditation. Molina Healthcare's eight NCQA accreditations demonstrate its commitment to accountability and achieving improved outcomes. Two of Molina Healthcare's health plans have received Excellent Health Plan Accreditation (New Mexico and Utah), which requires HEDIS results in the highest range of national performance. Three Molina Healthcare health plans have received New Health Plan Accreditation (Ohio, Texas and Florida), and three have a Commendable accreditation (Washington, Michigan and California).

Molina Healthcare actively works with the communities it serves, and Molina Healthcare of Arizona will carry on this proud tradition of community involvement. Molina will solicit input from community stakeholders by establishing an ALTCS Advisory Board that will consist of key representatives from hospitals, regional centers, disability advocates and safety net providers. This ensures local stakeholders will play an active role in supporting innovative and effective programs that prevent or delay the institutionalization of members through the effective use of Medical Home and community-based services. Additionally, Molina employees will be encouraged to provide volunteer services in their communities through the Molina Volunteer Time-off Program. Molina will also actively engage the communities it serves through:

- Dedicating service to specific local charities through active charity board participation;
- Establishing frequent forums for education of specific provider types;
- Conducting routine meetings offering the interchange of ideas between community advocacy groups and specific Molina operating departments, including Provider Services and Case Management; and
- Holding regular joint operating meetings with key provider groups and facilities, with the intent of early identification and effective management of emerging issues.

Molina's executive staff will use their extensive experience in strategic planning, large complex project management, implementation and operations to lead a dedicated team committed to AHCCCS goals and objectives. The organizational structure will include the required Key Personnel and Additional Required Staff tasked to achieve excellent operational performance to ensure responsiveness to member needs and fulfillment of contract requirements. To ensure administrative performance and efficiency, Molina's Chief Executive Officer will focus on the operation of a fully integrated system that supports providing members with the highest level of care in the least restrictive setting. This structure also provides for consistent and timely

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assessments, appropriate utilization of services, and communication with providers about members' service utilization and associated cost of care.

Case Management

Molina's Case Management programs will be tailored to encompass a broad spectrum of services designed to provide ALTCS members with the highest level of care in the least restrictive setting. Case Managers will work closely with Molina staff and Primary Care Physicians (PCPs) in a Medical Home environment to proactively identify members who may be at additional risk based on current health status, chronic disease states, disabilities and the likelihood of hospitalization. The Case Manager will utilize the collective information to work with members and their families to proactively address issues in order to have the greatest impact on the member's health and well-being. Case Managers will promote choice, dignity, independence, individuality, privacy and self-determination. Every ALTCS member will receive Case Management services, including development of individualized care plans. Members will be enrolled in appropriate disease management and other care management services. Members and their families will be encouraged to participate in the member's own health management to maximize health outcomes and encourage independence. Molina will respond to each member's unique healthcare delivery challenges with cultural expertise that provides a better understanding of individuals' social, cultural and linguistic needs.

Central to Molina's success will be well-run managed care programs that produce:

- Comprehensive access to care for its members;
- Reductions in inappropriate Emergency Department and other utilization;
- Appropriate reporting for claims, healthcare costs and financial information;
- Efficient communications between different provider types;
- Effective member outreach programs to increase preventive care; and
- Outstanding case management, disease management, utilization management, and 24-hour access to medical personnel.

Innovation

Recognizing that specific populations have unique challenges beyond their medical needs, Molina will discuss with AHCCCS innovative ideas to address challenges that ALTCS members may face. For example, Molina Healthcare's Neighborhood Shuttle in Fontana, California, travels a 15-mile route from the Molina Medical Clinic to a variety of medical and non-medical locations. Shuttle riders do not need to be Molina members and can use the shuttle to see a doctor, fill prescriptions and/or travel to other locations, such as the library, senior center and grocery store. This useful transportation option provides access to vital community resources that support residents' overall health and well-being.

Molina Healthcare Neighborhood Shuttle

Molina Healthcare is also continuously seeking innovative approaches to maximize health outcomes through the integration of services that address members' full-spectrum of health needs. Molina Healthcare's experience indicates that integrating behavioral and physical health coverage in the medical setting results in better clinical outcomes and may result in reduced total health care costs as demonstrated in the partnership between Molina Healthcare of

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Washington and Compass Health. Compass Health is the primary behavioral healthcare provider in the Washington counties of Snohomish, Skagit, San Juan and Island. Together, Molina Healthcare of Washington and Compass Health opened an innovative clinic called Molina Medical at Compass Health in Everett, Washington. The new clinic gives patients greater access to primary care and coordinated care, and links multiple programs of care through a single setting. By providing enhanced quality of care through the integration of physical health, mental health and substance abuse services, Molina Medical at Compass Health becomes part of a broader solution for supporting improved health outcomes and serves as a patient-centered health care home.

Molina is interested in exploring similar innovative strategies with AHCCCS to assist the state in controlling costs, integrating care, and affecting improved outcomes for ALTCS beneficiaries.

Successful Partnership

The following proposal describes Molina's strategies for building an innovative local health plan to serve the needs of the elderly and physically disabled beneficiaries of the ALTCS program. Molina will leverage Molina Healthcare's shared resources, experience and cost efficiencies to administer acute care and Long-term Care ALTCS benefits to improve member health outcomes and to help AHCCCS control the rising cost of healthcare. Guided by physician leadership, one of Molina's fundamental principles will be to ensure every member has a choice of options and is empowered to achieve or maintain the highest level of self-sufficiency. Molina Healthcare's demonstrated history of meeting and exceeding the standards set for managed care health plans ensures Molina will successfully partner with AHCCCS to fulfill its mission, goals and objectives.

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Amendments

AHCCCS	**SOLICITATION AMENDMENT** Solicitation Number: RFP YH12-0001 Amendment Number 1 (One) Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Contract Management Specialist: Jamey Schultz, CMS E-mail: Jamey.Schultz@azahcccs.gov

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.	This Solicitation Amendment is hereby executed this the 24th day of February, 2011, in Phoenix, Arizona.
D. Lynn Allen 3/23/2011	
Signature / Date	
D. Lynn Allen, President	
Typed Name and Title	Michael Veit
Molina Healthcare of Arizona, Inc	Contracts and Purchasing Administrator
Name of Company	

AHCCCS	**SOLICITATION AMENDMENT** Solicitation Number: RFP YH12-0001 Amendment Number 2 (Two) Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Contract Management Specialist: Jamey Schultz, CMS E-mail: Jamey.Schultz@azahcccs.gov

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11th day of March, 2011, in Phoenix, Arizona.
D. Lynn Allen 3/23/11		
Signature	Date	
D. Lynn Allen, President		
Typed Name and Title		Michael Veit
Molina Healthcare of Arizona, Inc.		Contracts and Purchasing Administrator
Name of Company		

A. General Matters

Table of Contents

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A. GENERAL MATTERS

See the Offeror's Checklist contained in the Bidder's Library for information to be submitted under this section.

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AHCCCS	**Notice of Request for Proposal**		AHCCCS Arizona Health Care Cost Containment System
	SOLICITATION NO.: **YH12-0001**	PAGE 2	701 East Jefferson, MD 5700
		OF 160	Phoenix, Arizona 85034

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and best-and-final offers (if any). Signature also acknowledges receipt of all pages indicated in the Table of Contents.

Arizona Transaction (Sales) Privilege Tax License No.: N/A

For clarification of this offer, contact:

Name: Lynn Allen

Federal Employer Identification No.: 13-4204626

Phone: (800) 377-9594 x180270

E-Mail Address: Lynn.Allen@molinahealthcare.com

Fax: (505) 798-7313

Molina Healthcare of Arizona, Inc.
Company Name

Signature of Person Authorized to Sign Offer

8801 Horizon Blvd.
Address

Lynn Allen
Printed Name

Albuquerque	NM	87113	President
City	State	Zip	Title

CERTIFICATION

By signature in the Offer section above, the bidder certifies:

The submission of the offer did not involve collusion or other anti-competitive practices.

The bidder shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 99-4 or A.R.S. §§ 41-1461 through 1465.

The bidder has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.

The bidder certifies that the above referenced organization ___ is/_X_ is not a small business with less than 100 employees or has gross revenues of $4 million or less.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments and best-and-final offer (if any), contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

This contract shall henceforth be referred to as Contract No. _____YH12-0001-_____.

Awarded this _____ day of _____ 2011

_____

Michael Veit, as AHCCCS Contracting Officer and not personally

B. Capitation

Table of Contents

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B. CAPITATION

Capitation is a fixed (per member) monthly payment to the Contractor for the provision of covered services to members. It is an actuarially sound amount to cover expected utilization and costs in a risk-sharing managed care environment.

AHCCCS will only evaluate the Offeror's full long term care capitation rates. The PPC and Acute Care Only rates will be published by AHCCCS prior to October 1, 2011. To facilitate the preparation of its capitation proposals, AHCCCS will provide Offerors with a Data Supplement located in the Bidder's Library. This data source should not be used as the sole source of information in making decisions concerning the capitation proposal. Information referenced below is located in this Data Supplement. Each Offeror is solely responsible for research, preparation and documentation of its capitation proposal.

Capitation Bid Submission

1. All GSAs in which an Offeror bids will require a capitation rate bid submission. Each bid will encompass three components; a medical component, a case management component and an administrative component. Each component will be scored separately.

Bid component limits:

- **AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates prior to March 1, 2011. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from the minimum to the midpoint.**
- **AHCCCS will not provide a range or a maximum for the case management component.**
- **AHCCCS will limit the administrative component to a maximum of 8%. The administrative component is calculated as: Administration / (Net NF + Net HCBS + Acute Care Prior to Reinsurance offsets + Case Management).**
- **Capitation bids submitted with any component outside of the published range or the administrative maximum will not be accepted.**

AHCCCS reserves the right to request supporting documentation for any component of the capitation rate bids submitted.

If any moral or religious objections are submitted as specified in Section I, Paragraph 14, C. 2, the Offeror must not exclude direct and related costs from the capitation bid(s). If awarded a contract, capitation will be reduced for these costs via a subsequent contract amendment.

AHCCCS will provide, by GSA, the HCBS/NF mix percentages, Share of Cost (SOC) amounts and reinsurance offsets that must be used in the bid submission. The HCBS/NF mix percentages and SOC amounts are currently available in the Data Supplement. The reinsurance offsets will all be at the $20,000/$30,000 deductible levels and will be published prior to March 1, 2011.

AHCCCS is also providing Offerors with a case management model. This model is designed to assist Offerors in establishing the case management component of the capitation rates. The use of this model is optional and is not a required submission with the RFP. For further case management information, the Offerors may also review financial statements and case management component amounts included in the current and historical capitation rates. The case management component amounts included in capitation rates can be found in the ALTCS actuarial certifications which are located on the AHCCCS website at: http://www.azahcccs.gov/commercial/ContractorResources/capitation/capitationrates.aspx#

A template for the capitation rate bid submission is included in the Data Supplement. The template must be completed for each GSA in which the Offeror submits a bid. The template(s) must be submitted to AHCCCS via the EFT/SFTP server by 3 p.m. on the Proposal Due Date in Section A. Instructions for access to the EFT/SFTP are included in Section A of the Data Supplement.

In addition to the electronic submission of the template(s), hard copies of the completed template(s) for each GSA in which the Offeror submits a bid must be included in the RFP submission. A hard copy of an actuarial certification of all rates submitted, signed by a qualified actuary, must also accompany the RFP submission. The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid.

AHCCCS will adjust the awarded capitation rates via contract amendment prior to October 1, 2011 for Contractor specific capitation factors (e.g., Nursing Facility/HCBS mix adjustments) and reserves the right to

adjust awarded capitation rates for program changes, legislative requirements, Contractor experience, and/or actuarial assumptions that were not previously included in the RFP capitation rate ranges published or the awarded capitation rates.

GSA 42 Capitation Rate Bid Submission

Table B1-1 GSA 42 Capitation Rate Bid Submission

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission			
Service Category	**Molina Healthcare of Arizona / GSA 42**		
	Gross	MIX	Net
Nursing Facility	$ 4,701.27	41.20%	$ 1,936.92
Share of Cost			$ (290.22)
Net Nursing Facility			**$ 1,646.70**
HCBS Home and Community	$ 1,112.64	58.80%	$ 654.23
Net HCBS			**$ 654.23**
Acute Care Prior to Reinsurance			$ 677.34
Reinsurance Offset			$ (186.69)
Net Acute Care			**$ 490.65**
Medical Component			**$ 2,791.58**
Case Management			$ 114.92
Administration		6.50%	$ 201.06
Sub-Total of Scored Components			**$ 3,107.56**
Risk/Contingency at 1%			$ 32.94
Net Capitation			**$ 3,140.50**
Premium Tax (98% of Final Cap)			$ 64.09
Net Cap w/ Premium Tax			**$ 3,204.59**

Key
user input
user input using AHCCCS provided numbers
formula

An actuarial certification of all rates submitted, signed by Molina Healthcare's qualified actuary, accompanies this RFP submission in the "Certifications and Other Required Forms" section.

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GSA 44 Capitation Rate Bid Submission

Table B1-2 GSA 44 Capitation Rate Bid Submission

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission			
Service Category	**Molina Healthcare of Arizona / GSA 44**		
	Gross	MIX	Net
Nursing Facility	$ 5,144.17	32.13%	$ 1,652.82
Share of Cost			$ (304.75)
Net Nursing Facility			**$ 1,348.07**
HCBS Home and Community	$ 899.27	67.87%	$ 610.34
Net HCBS			**$ 610.34**
Acute Care Prior to Reinsurance			$ 576.51
Reinsurance Offset			$ (106.81)
Net Acute Care			**$ 469.70**
Medical Component			**$ 2,428.11**
Case Management			$ 136.77
Administration		6.50%	$ 173.66
Sub-Total of Scored Components			**$ 2,738.54**
Risk/Contingency at 1%			$ 28.45
Net Capitation			**$ 2,766.99**
Premium Tax (98% of Final Cap)			$ 56.47
Net Cap w/ Premium Tax			**$ 2,823.46**

Key
user input
user input using AHCCCS provided numbers
formula

An actuarial certification of all rates submitted, signed by Molina Healthcare's qualified actuary, accompanies this RFP submission in the "Certifications and Other Required Forms" section.

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GSA 52 Capitation Rate Bid Submission

Table B1-3 GSA 52 Capitation Rate Bid Submission

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission			
Service Category	**Molina Healthcare of Arizona / GSA 52**		
	Gross	MIX	Net
Nursing Facility	$ 5,507.09	25.82%	$ 1,421.93
Share of Cost			$ (223.08)
Net Nursing Facility			**$ 1,198.85**
HCBS Home and Community	$ 1,393.86	74.18%	$ 1,033.96
Net HCBS			**$ 1,033.96**
Acute Care Prior to Reinsurance			$ 814.72
Reinsurance Offset			$ (229.85)
Net Acute Care			**$ 584.87**
Medical Component			**$ 2,817.68**
Case Management			$ 115.94
Administration		6.50%	$ 205.63
Sub-Total of Scored Components			**$ 3,139.25**
Risk/Contingency at 1%			$ 33.69
Net Capitation			**$ 3,172.94**
Premium Tax (98% of Final Cap)			$ 64.75
Net Cap w/ Premium Tax			**$ 3,237.69**

Key
user input
user input using AHCCCS provided numbers
formula

An actuarial certification of all rates submitted, signed by Molina Healthcare's qualified actuary, accompanies this RFP submission in the "Certifications and Other Required Forms" section.

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C. Organization

Table of Contents

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C. ORGANIZATION

Moral and Religious Objections

Moral and Religious Objection Submission

***2.* Submit a statement of any moral and religious objections to providing any services covered under Section D, Program Requirements of the ALTCS RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc.**

Molina does not have any moral or religious objections to providing any services covered under Section D, Program Requirements of the ALTCS RFP, including the Covered Services listed in Section D, Paragraph 10. Should Molina identify any moral or religious objections to providing any covered services during the term of the contract it shall:

- Notify Arizona Health Care Cost Containment System (AHCCCS);
- Agree and understand that if granted a subsequent release from providing, reimbursing for, or providing coverage of a counseling or referral service, it shall result in a reduction to Molina's applicable capitation rates;
- Provide information to potential members prior to enrollment regarding the health plan's release of provision of such services;
- Notify its members thirty (30) calendar days prior to any change in its policy regarding coverage of a counseling or referral service; and
- Notify its members how and where to obtain the service.

Organization and Staffing

Organization and Staffing Submissions

3. Submit current resumes of key personnel as required in Section D, Paragraph 25, Staff Requirements and Support Services documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included long term care experience. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description is limited to 2 pages.

Molina Healthcare of Arizona will be staffed with experienced personnel dedicated to the ALTCS program. Molina understands that experienced and qualified Key Personnel and Additional Required Staff are critical to successful operations and ensures its staffing plan will comply with all staffing requirements to support ALTCS operations, and fulfill all contract requirements as outlined in Section D, Paragraph 25, Staff Requirements and Support Services.

Molina has already begun recruiting for full-time, permanent management positions to ensure it can quickly respond to the specific staffing requirements described in the RFP. Molina has assigned existing resources to begin work on critical pre-award activities that will lay the foundation of Molina's health plan to enable rapid deployment of operations.

Submitted in this response are resumes for the Chief Executive Officer, Chief Financial Officer, and Claims Administrator who will support operations at Molina Healthcare of Arizona. These individuals are currently employed at Molina Healthcare and all have extensive experience working in managed care with various Medicaid, Medicare and dual eligible populations, including Long-term Care and Aged, Blind and Disabled members. A resume for the Dental Director is also included. Job descriptions are also provided for positions that will be filled and in place by the operational go-live date.

Additionally, Molina will leverage Molina Healthcare's collective managed care experience in Long-term Care and Aged, Blind and Disabled programs from existing staff for the following Key Positions: Medical Director, Medical Management Coordinator, Case Management Administrator and Behavioral Health Coordinator. For these four positions, the following personnel will be available immediately following contract award as an interim solution to provide leadership for each critical area until permanent staff is hired. These individuals will also provide guidance and support to the new hires that will permanently staff these positions to ensure adequate oversight of operations and personnel. The resumes of these individuals are included at the end of this section.

Medical Director
Dr. Eugene Sun, Molina Healthcare of New Mexico, Chief Medical Officer

Medical Management Coordinator
Margret Young, Molina Healthcare, Director Long-term Care

Case Management Administrator
Barbara Johansson, Molina Healthcare Vice President of Care Coordination

Behavioral Health Coordinator
Debra Horowski, Molina Healthcare Director Behavioral Health

Collectively, this staffing plan will ensure Molina will have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements.

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CHIEF EXECUTIVE OFFICER - DONALD LYNN ALLEN

(602) 703-5971 – Lynn.Allen@Molinahealthcare.com

PROFESSIONAL EXPERIENCE:

MOLINA HEALTHCARE OF NEW MEXICO (Albuquerque, New Mexico) June 2006 to Present
Molina Healthcare is a 1.6 million member healthcare company devoted to the administration of governmental health plans. Molina Healthcare of New Mexico (MHNM) operates under a contract with the State of New Mexico to provide health benefits to acute Medicaid beneficiaries in New Mexico; offering Medicare advantage plans and administers the authorization and assessment process for the New Mexico Fee-for-Service Medicaid plan. MHNM offers a statewide network of acute care providers to serve 90,000 managed care members.

President – August 2010. (Chief Operating Officer prior to August 2010)
Responsible for all operational aspects of the New Mexico health plan, including provider/vendor contracting, provider relations, system configuration, member services, medical services, government relations, quality assurance, human resources and physical plant functions in New Mexico; Requires a strong knowledge of health plan operations specific to Medicaid and Medicare plans and direct supervision of CFO, CMO, Compliance Officer, three directors, two managers, and accountability for 158 staff. Requires advanced understanding of Medicaid and Medicare reimbursement methodologies, operations, and governmental program requirements. Function as lead negotiator in all complex and capitated agreements; responsible for development and execution of the MHNM strategic operating plan. The MHNM President is directly responsible for health plan financial, operational, and quality performance.

EVERCARE HEALTH PLAN OF ARIZONA (Phoenix, Arizona) August 2005 to June 2006
Evercare, a business unit of United Health Group, focuses on the healthcare needs of aging, vulnerable, disabled and chronically ill individuals. Offers Medicare special needs plans (SNPs) and Medicaid long-term care plans in select geographic markets. Health plans require development of networks specifically designed to meet the special needs of the target membership. Networks require a specific emphasis on delivery of primary care and institutional care services.

Director of Contracting. Responsible for all contracting and provider relations efforts for the Arizona and New Mexico markets. Required great familiarity with provider types specific to Medicare special needs and Medicaid long-term care plan types. Direct supervision of eight provider relations and contracting team members. Required an advanced understanding of Medicare and Medicaid reimbursement methodologies and long-term care plan operations. Functioned as the lead negotiator in all complex and capitated agreements.

MARICOPA MANAGED CARE SYSTEMS (Phoenix, Arizona) April 2002 to August 2005
Maricopa Managed Care Systems (MMCS) was a large county government operated health system. MMCS administered four health plans serving 56,000 members and a large one hospital, 12-clinic delivery system. MMCS offered a Medicare Advantage plan, a managed Medicaid acute care plan, a Medicaid long-term care plan, and a self-funded employee health plan. MMCS offered health plans in a mixed model environment that featured a core staff model delivery system with an extensive complementary network of health care providers. The Maricopa Integrated Health System (MIHS) staff model delivery system included Maricopa Medical Center, a 500-bed level-one trauma center, Desert Vista psychiatric hospital, the Comprehensive Health Center and 12 family health centers located throughout Maricopa County. In 2004, Maricopa County transitioned management of the MIHS delivery system to the Maricopa Special Healthcare District and ceased direct health plan operations in the fall of 2005.

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Director of Network Development and Contracting. Responsible for all health plan and delivery system contracting and provider services functions for MMCS. Specific responsibility for contracting of long-term care plan providers, hospitals and sub-capitated contractors. Mr. Allen and his team of seven direct reports negotiated all contracts for MMCS health plans, all delivery system contracts. Reported to the MMCS Health Plan CEO.

HERITAGE SOUTHWEST MEDICAL GROUP (Dallas, Texas) April 2000 to January 2002
Heritage Southwest, an Independent Physician Association and full-risk managed care contractor. Held contracts for 80,000 Commercial and Medicare Risk lives in the Dallas/Ft. Worth metroplex. Health plans contracted with Heritage Southwest included: Pacificare/Secure Horizons, Texas Health Choice, Texas Golden Choice, and CIGNA Healthplans of Texas. Offered a comprehensive medical network including PCPs, specialists, hospitals and a full contingent of ancillary providers.
Director of Network Management. Responsible for all managed care contracting functions for Heritage Southwest Medical Group. Fully accountable for development and maintenance of a comprehensive provider network; reported to the General Manager; twelve direct reports.

SUN HEALTH CORPORATION (Sun City, Arizona) October 1999 to April 2000
Sun Health Corporation, a two hospital, five clinic, not-for-profit integrated delivery system serving senior population. Sun Health Corporation serves as administrator for Sun Health Physicians, a 180 member Physician Hospital Organization developed to accept full-risk global capitation contracts. Sun Health hospitals partners with other local physician groups to form risk-bearing entities. Medisun is Sun Health's provider sponsored Medicare Advantage plan.
Director, Managed Care Contracting. Responsible for all managed care contracting functions for Sun Health Corporation. Mr. Allen and his team of five direct reports negotiated payor contracts for the Sun Health integrated delivery system, Sun Health Physicians and Sun Health Medisun Medicare plan. Reported to the Assistant Vice President for Network Development.

LOVELACE HEALTH SYSTEMS, INC. (Albuquerque, New Mexico) – June 1996 to August 1999
(First year with subcontractor, High Desert Management)
Lovelace Health Systems was a wholly owned subsidiary of the CIGNA Corporation. Lovelace is an integrated delivery system with a 200,000 (1999) member health plan. Lovelace Health Plan (LHP) was CIGNA's New Mexico health plan. LHP offers commercial HMO, ASO, Medicare risk, managed Medicaid and PPO plans. Lovelace Health Systems is a large 2,700 employee corporation featuring acute care hospital facilities, a large physician staff model medical group, and a supporting statewide network. CIGNA sold Lovelace Health Systems in 2002.
Director of Provider Network Management. Leader of a department of 14 contracting, provider relations and provider systems professionals. The LHP Provider Network Management Department was CIGNA's New Mexico contracting and provider relations department. As director of the department, Mr. Allen was responsible for all statewide provider contracts for all product lines. This included all provider relations activities and maintenance and development of provider systems. Contracts were established and maintained with IPAs, PHOs, hospitals, physician groups, and ancillary providers. Contracting methodologies ranged from simple "fee-for-service" arrangements to full risk global capitation agreements. The Provider Network Management Department had an annual operating budget of over $950,000. Reported to the Vice President/Medical Director.

EDUCATION:

University Of New Mexico, Albuquerque, New Mexico 1990
Bachelor of Arts, Economics.

City Colleges of Chicago, Garlstadt, Germany 1986
Certification as Emergency Medical Technician, Basic

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MEDICAL DIRECTOR/CHIEF MEDICAL OFFICER – POSITION DESCRIPTION

INCUMBENT NAME		HIRE DATE	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Medical Director/Chief Medical Officer	**JOB CODE** N/A	**EXEMPT STATUS** Exempt	**PAY GRADE** E23
DEPT/LOCATION Healthcare Services/Arizona	**SUPERVISORS TITLE** CEO		

POSITION SUMMARY (Briefly describe the position).

The Chief Medical Officer is responsible for oversight and management of all Healthcare Service departments and shall be an active participant in all major clinical programs, QM and Medical Management. Adheres to the company/department's confidentiality and HIPAA compliance programs. Adheres to the company/department's fraud and abuse prevention/detection policies and program.

QUALIFICATIONS

Education:

- Doctorate degree in Medicine (MD or DO).
- Knowledge of applicable state, federal and third party regulations. Familiarity and experience in the local market desirable.
- Knowledge of Quality Accreditation Standards. Prefer Master's in Business Administration, Public Health, Healthcare Administration, etc.

Experience:

- 5 years clinical practice
- 4 years direct physician supervision
- 4 years HMO/Managed Care with line management responsibility
- 4 years Utilization/Quality Program Management/Pharmacy
- 4 years senior management leadership team membership
- Experience managing department budgets
- Prefer Peer Review, medical policy/procedure development, provider contracting experience

Licensure/Certification:

- Valid Arizona Medical License (free of any sanctions).
- Board Certification in recognized medical specialty, primary care preferred.
- Must be free of sanctions from Medicaid or any other government program and without restrictions that would affect job performance.

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INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Computer literacy
- Interpersonal communication skills
- Excellent verbal and written communication skills
- Organizational and management skills
- Problem solving and analytical ability

ESSENTIAL JOB FUNCTIONS

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Ensures timely medical decisions, including after-hours consultation as needed
- Responsible for day-to-day oversight and management of the Health Care Service Depts.
- Supports each department's strategic planning and operational improvements with emphasis on improved department performance
- Provides overall support to the Quality Improvement department in areas of Health Care Management, Delegation Oversight and HEDIS.
- Chairs the Quality Improvement Committee.
- Participates in the process to obtain/maintain NCQA accreditation.
- Provides the daily support to the Pharmacy Director and the decision making needed for the Prior Auth process for medications.
- Participates in the process for formulary management.
- Provides support to the Provider Services department related to individual physician and group activities that improve the network, assist with contracting and solidify relationships.
- Reviews service appeals when received.
- Participates in the Utilization Management Committee and report analysis.
- Supports the credentialing processes and participates in the Peer Review Committee and communicates Committee decisions both verbally and in writing to providers across the state.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.

CHIEF FINANCIAL OFFICER – JOSEPH W. WHITE, CPA

E-mail: joseph.white@molinahealthcare.com

EXECUTIVE EXPERIENCE IN FINANCE AND ACCOUNTING:
Comprehensive experience in Accounting, Financial Management, Investor Relations, Financial Analytics and Financial & Regulatory reporting. Extensive experience in developing flexible and creative solutions to financial and operational challenges and in applying strong technical and analytical skills to problem solving and decision making. Expertise includes:

Finance and Accounting	Budget and Cash Management
Financial Planning and Analysis	Investor Relations
Regulatory Reporting	Internal, External and Statutory Audits
Strategic Planning	Month-End Closing

Experience:
Molina Healthcare, Inc., Long Beach, California (June 2003 to Present)
Chief Accounting Officer
Responsible for all accounting, financial reporting, treasury and financial analysis functions of a Health Maintenance Organization holding company with over 1.6 million members and $4 billion in annual revenue.

PPONext, Inc., Long Beach, California (August 2002 to June 2003)
Vice President, Finance
Responsible for all accounting, financial reporting, treasury and financial analysis functions of a medical provider network access company with approximately $20 million in annual revenue.

Maxicare Health Plans, Inc., Los Angeles, California (March 1987 to August 2002)
Chief Financial Officer and Director
Joined organization as Manager of Financial Budgeting. Served in a number of financial and accounting positions for over 15 years. Named CFO in January 2001 and a Director in March 2002. As CFO, responsible for all accounting, financial reporting and financial analysis functions of a Health Maintenance Organization holding company with over 500,000 members and $2.0 billion in annual revenue.

American Medical International, Inc. Beverly Hills, California (February 1986 to March 1987)
Senior Accountant

Coopers & Lybrand LLP, Washington, D.C. (July 1981 to August 1983)
Staff Accountant

Education:
Master of Business Administration, University of Virginia May 1985. Major: Finance

Bachelor of Science, University of Virginia May 1981. Major: Accounting

References: Available upon request.

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PHARMACY COORDINATOR/DIRECTOR POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Director, Pharmacy Services	**JOB CODE** N/A	**EXEMPT STATUS** Exempt	**PAY GRADE** E18
DEPT/LOCATION Pharmacy/Arizona	**SUPERVISOR'S TITLE** Chief Medical Officer		

POSITION SUMMARY (Briefly describe the position).

Responsible for clinical, administrative, financial and regulatory management of pharmacy service. Handles Pharmacy cost, utilization and contracting for all accounts. Oversees and administers the prescription drug and pharmacy benefit.

QUALIFICATIONS

Education:
Required: Doctor of Pharmacy degree

Experience:
- 2-4 plus years progressive experience in Pharmacy management position(s)
- Previous NCQA experience working with NCQA standards
- Previous managed healthcare experience; preferably with Medicaid products
- Previous supervisory experience

Licensure/Certification:
- Arizona Certified licensed Pharmacist
- Must be free of sanctions from Medicaid or any other government program and without restrictions that would affect job performance

Additional Skills and Knowledge:
- Comprehensive knowledge of applicable state, federal and third party regulations.
- Experience with NCQA.
- Computer Literacy (Microsoft Office Products).
- Interpersonal Communication Skills.
- Excellent Verbal and Written communication skills; organization skills.
- Problem Solving; Analytical Ability.
- Ability to maintain confidential information as needed.
- Ability to develop, organize, analyze, and implement procedures.

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INCUMBENT NAME	**HIRE DATE**

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Oversee and administer the prescription drug and pharmacy benefit.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.

DENTAL DIRECTOR – JAMES E. THOMMES, DDS
Doral Dental USA, LLC
12121 N. Corporate Parkway
Mequon, WI 53092
262-241-7140, Extension 3287

EDUCATION: **Loyola University Dental School** — **Chicago, Illinois**
Doctor of Dental Surgery (DDS) — 1983

EXPERIENCE:

James E. Thommes, DDS, PC — **Vernon Hills, IL**
General Dentist and Business Owner — 1987 to Current

Doral Dental USA, LLC — **Mequon, Wisconsin**
Senior Dental Director — 1999 to Current

Independent Dental Consultants, Ltd. — **Vernon Hills, Illinois**
President — 1990 to Current

First Commonwealth Dental HMO — **Chicago, Illinois**
Dental Consultant 1992 to 2002

MetLife — **Aurora, Illinois**
Dental Consultant 1998 to 2000

Zion-Benton Children's Service — **Zion, Illinois**
General Dentist — 1989 to 1994

PROFESSIONAL ORGANIZATIONS:
American Dental Association
Chicago Dental Society
Hispanic Dental Association
Academy of General Dentistry
Illinois State Dental Society
American Association of Dental Consultants – Certified Dental Consultant

DENTAL LICENSES:

Arizona	California
Illinois	New Mexico
Michigan	Connecticut
New Jersey	Missouri
New York	Wisconsin

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COMPLIANCE OFFICER – POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Director, Compliance (Compliance Officer)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Compliance / Arizona	**SUPERVISOR'S TITLE** CEO / Board of Directors		

POSITION SUMMARY (Briefly describe the position).

Responsible for the oversight of all ongoing activities related to the development, implementation, maintenance of, and adherence to policies and procedures and functions associated with ensuring compliance with state contracts and federal and state law. Responsible for development and oversight of the health plan compliance plan. The Director of Compliance shall be available to all health plan employees, for the purpose of direct communication of perceived compliance issues. The Director of Compliance shall have direct authority to access records and make independent referrals to State Medicaid agencies and the Office of the Inspector General.

Reporting Relationship:
The Compliance Director shall report regularly, but not less than quarterly, to the Board of Directors. For administrative and day-to-day operating responsibilities, the Compliance Director takes direction from the Plan CEO. For purposes of performance assessments and compliance related activity, the Compliance Director will report to the Molina Healthcare Vice President of Compliance. Performance evaluations will reflect the combined input of the Plan CEO and the Vice President of Compliance. The Plan CEO shall consider input from the Board of Directors and key management personnel in assessing and reviewing the Compliance Director's performance.

QUALIFICATIONS

Education:

- Required: Bachelor's degree in Business Administration, Healthcare, or related field (or equivalent combination of education and experience).
- Preferred: Master's degree preferred.

Experience:

- 5-plus years experience in managed health care and/or compliance related field.
- 3-plus years experience working in a managed care environment. Preferably in a Medicaid environment.
- 1-plus year supervisory experience.

Licensure/Certification:

- None Required

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INCUMBENT NAME	HIRE DATE

Additional Skills and Knowledge:

- Knowledge of State Health Department mandated laws and rulings including Federal False Claims Act provisions; whistleblower protection laws; federal requirements for reporting fraud and abuse (42 CFR 445 & 42 CFR 438)
- Comprehensive knowledge of state Medicaid policies and programs including A.R.S. Sections 36-2918.01 and 13-2310 and AHCCCS Contractor Operation Manual (ACOM), Chapter 100
- Effective written and oral communication skills.
- Ability to maintain confidential information as needed.
- Ability to develop, organize, analyze, and implement procedures.

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include:

- On-site Management official, with designated and recognized authority.
- Provides leadership for the compliance functions including regular reports to management on compliance related activities.
- Budgets and adheres to budget parameters for activities related to Compliance Plan.
- Coordinates development of written policies and procedures regarding compliance with local, state and federal requirements.
- Facilitates delivery of specialized education and training concerning compliance.
- Selects and directs the Compliance Committee. Regularly, but not less than quarterly, informs the Board of Directors of the status of and activities pertaining to compliance.
- Responds to inquiries and reports concerning compliance and/or non-compliance.
- Investigates instances of suspected non-compliance and suspected fraud.
- Assists management with enforcement and discipline in instances of non-compliance.
- Establishes active relationships with third parties who conduct fraud investigations.
- Establishes audit controls and measurements to ensure correct processes are established.
- Develops and implements a compliance assessment, auditing and monitoring program.
- Oversees Plan's compliance with HIPAA. Works collaboratively with the HIPAA Privacy & Security officials; active participation in HIPAA related workgroups.
- Reports upon discovery (within 24 hours) incidents and issues of non-compliance related to HIPAA to the Privacy Official.
- Responsible for training new hires on HIPAA and other compliance laws and regulations.
- Lead and coordinates external government audits and responses, as well as any follow-up or corrective action that may be necessary.
- Initiates, as necessary development of department corrective action plans, processes and procedures to meet contract requirements.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- Ensures that all new employees are trained on compliance procedures and applicable company policies.

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DISPUTE AND APPEAL MANAGER – POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Grievance Manager (Manager Appeals & Grievances)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Network Operations/Arizona	**SUPERVISOR'S TITLE** Director, Network Management and Operations		

POSITION SUMMARY (Briefly describe the position).

Supervision over staff who resolves member/provider appeals and grievances and requests for hearing relative to quality of care, access to care, provider claims disputes and benefits through research and analysis and by meeting established quality and productivity standards in all areas set by state and federal regulatory agencies. Must be willing to work after hours/weekends as needed to meet state and federal regulatory time frames.

QUALIFICATIONS

Education:

- Associate's degree or equivalent related experience
- Bachelor's degree in related discipline is preferred

Experience:

- 2-plus years supervisory experience or 2 years lead/training experience will be considered in lieu of actual supervisory experience.
- 2-plus years of appeals and grievance experience, preferably in a Medicaid environment
- 1-plus years experience in a healthcare or managed care setting; preferably with the Arizona Medicaid and/or Medicare Program.

Licensure/Certification:
N/A

Additional Skills and Knowledge:

- Computer literacy (Microsoft Office products); interpersonal communication skills; excellent verbal and written communication skills; organization skills; problem solving; analytical ability; communication skills; interpersonal skills; and previous project management experience.
- Knowledge of applicable state, federal and third party regulations. Experience with NCQA.

Supervisory Responsibilities:
Yes

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INCUMBENT NAME	**HIRE DATE**

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include:

- Manage and adjudicate member and provider disputes under the grievance system including member grievances, appeals/requests for hearing and provider claim disputes.
- Directs, monitors and evaluates activities of staff to ensure inquiries and appeals and grievances from members and providers are resolved within specified turnaround timeframes in accordance with state guidelines and departmental policy and procedures and timeframe goals.
- Ensure that the investigation of inquiries and appeals and grievances regarding quality of care, service or liability issues are worked in an expeditious manner with complete research documentation.
- Participate as the principal liaison.
- Reviews daily/monthly/quarterly reports on production. Follow-up on concerns and departmental activities specific to workflow and case closure processes.
- Participates in the establishment of departmental goals, implementation of procedures and performance standards to achieve these goals.
- Participates in AHCCCS, CMS, NCQA and Health Plan audits as needed.
- Responsible education and training for new hires as well as other related departments.
- Prepares and submits operational reports as needed. Prepare and submit required appeals and grievance reports in accordance with regulatory agreements and requirements.
- Prioritizes and analyzes complex member issues, recognizing potential clinical care problems and seeks Medical Director and/or Clinical support involvement as needed.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Assists in the development and implementation of compliance assessment, auditing and monitoring program.
- Assists in the development and implementation of the Compliance Plan.
- Implements audit controls and measurements to ensure correct processes are adhered to.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.

BUSINESS CONTINUITY PLANNING & RECOVERY COORDINATOR – POSITION DESCRIPTION

INCUMBENT NAME		HIRE DATE	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Business Continuity Coordinator	**JOB CODE**	**EXEMPT STATUS**	**PAY GRADE**
DEPT/LOCATION Compliance/Arizona	**SUPERVISOR'S TITLE** Director, Compliance		

POSITION SUMMARY (Briefly describe the position).

Coordinate the development of plans and procedures to ensure Molina can respond to a disaster so that the critical business functions are resumed within a defined time frame. Responsibilities include coordinating the design, development, maintenance and testing of the business continuity plans for each operational and functional area of the health plan. Document plans, operating procedures, and test results to meet internal and external review, and audit requirements. Required to meet state Disaster Recovery and Business Continuity requirements and adhere to local policies and procedures.

Note: The information in this position description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

QUALIFICATIONS

Education:

- Bachelor's degree in Business, Information Management, or a related field; or the equivalent in education and work experience.

Experience:

- Required: 4-6 years of related work experience.
- Preferred: Certified Business Continuity Planner (CBCP) or Associated Disaster Recovery Planner accreditation preferred.

Licensure/Certification:

- None Required

Additional Skills and Knowledge:

- Comprehensive knowledge of Disaster Recovery and Business Continuity concepts including the Federal Emergency Management Agency (FEMA).
- Excellent verbal and written communication skills.
- Effective leadership, customer service, organization, planning and decision making skills
- Ability to travel, as necessary.

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INCUMBENT NAME	**HIRE DATE**
Essential Job Functions: • Implement, coordinate and maintain Disaster Recovery and Business Continuity program. • Disaster Recovery and Business Continuity recovery plan documentation development and maintenance reviewed no less than annually. • Disaster Recovery and Business Continuity recovery plan testing and outcomes documentation. • Disaster Recovery and Business Continuity recovery plan update and maintenance. • Disaster Recovery and Business Continuity recovery training plan. • Coordination with operational units. • Development of standing and emergency plans to ensure member safety and welfare in the event of the loss of any of the following facilities: Nursing Center; Assisted Living Center; Assisted Living Home; Adult Care Home.	

CONTRACT COMPLIANCE – OFFICER POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Director, Government Contracts and Advocacy (Contract Compliance Officer)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Government Contracts and Advocacy / Arizona	**SUPERVISOR'S TITLE** CEO		

POSITION SUMMARY (Briefly describe the position).

Primary point of contact for all operational issues. Responsible for the coordination and execution of all ongoing activities related to the development, implementation, maintenance of, and adherence to policies and procedures and functions associated with ensuring compliance with state contracts and federal and state law. Constant interface with state Medicaid agency.

Reporting Relationship:

The Director, Government Contracts and Advocacy shall report to the health plan CEO. The Director of Government Contracts and Advocacy will work closely with the Molina Healthcare, Inc. department of Government Advocacy and the assigned lead for Arizona.

Note: The information in this position description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job.

QUALIFICATIONS

Education:

- Associate's degree in Business Administration, Healthcare, or related field (or equivalent combination of education and experience).
- Bachelor's degree preferred.

Experience:

- 3-plus years experience in managed health care and/or compliance related field.
- 2-plus years experience working in a managed care environment. Preferably in a Medicaid environment.
- 2-plus years experience working directly with the state Medicaid agency related to this position.

Licensure/Certification:

- None Required

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INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Knowledge of State Health Department mandated laws and rulings.
- Comprehensive knowledge of state and federal mandates policies and programs.
- Effective interpersonal human relations skills.
- Effective written and oral communication skills.
- Computer literacy.
- Ability to maintain confidential information as needed.
- Ability to develop, organize, analyze and implement procedures.

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Serve as primary liaison with state Medicaid agency.
- Interface with Finance department regarding required reports and tracks timeliness of said reports.
- Tracks, coordinates and implements (in cooperation with operational units), any changes to benefits and any changes to state contract.
- Leads health plan Benefits Review Committee.
- Primary liaison with assigned Molina Healthcare Government Advocacy representative.
- Primary liaison with assigned health plan lobbyist.
- Coordination, tracking and submission of all contract deliverables.
- Field and coordinate responses to Medicaid agency inquiries.
- Coordinate the preparation and execution of contract requirements such as OFRS, random and periodic audits and ad hoc visits.
- Ensures that operational units have developed and updated policies and procedures in support of state contract requirements.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.

QUALITY MANAGEMENT COORDINATOR – POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Director, Quality Improvement (Quality Management Coordinator)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Quality Improvement/Arizona	SUPERVISOR'S TITLE Chief Medical Officer or Medical Director		

POSITION SUMMARY (Briefly describe the position).

Under the general supervision of the Chief Medical Officer, this position is responsible for implementing process improvements; resolves, track and trends quality of care grievances and integrating quality throughout the organization.

Note: The information in this position description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

QUALIFICATIONS

Education:

- Bachelor's degree in Business Administration, Healthcare, or related field (or equivalent combination of education and experience).
- Master's degree preferred.

Experience:

- 3-plus years experience in managed health care and quality management/improvement.
- 5-plus years experience working in a managed care environment. Preferably in a Medicaid environment.
- 1-plus year in supervisory role.

Licensure:

- Registered Nurse (RN); Physician or Physician's Assistant (PA) (licensed in Arizona) or Certified Professional in Healthcare Quality (CPHQ)
- Preferred: Case Mgr. (CCM), UM (CPUM) or other certification.

INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Working knowledge in performance improvement methodology (focus PDCA).
- Comprehensive knowledge of state Medicaid policies and programs.
- Knowledge of applicable federal and third party requirements including NCQA.
- Effective written and oral communication skills.
- Computer literacy.
- Ability to maintain confidential information as needed.
- Ability to develop, organize, analyze and implement procedures.

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Responsible for ensuring individual and systemic quality of care.
- Responsible for ensuring a credentialed provider network.
- Assists CMO, QM Director and others with NCQA and HEDIS compliance and External Quality Review (EQR).
- Assists in the data analysis to identify significant &/or problematic issues and concerns and reports appropriately.
- Tracks and trends provider practice patterns, performs ongoing report analysis to identify potential quality of care issues, readmissions, unexpected deaths, centennial events and assists in the implementation of corrective action plans, as appropriate.
- Integrates quality throughout the organization and implements process improvements.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.

PERFORMANCE/QUALITY IMPROVEMENT COORDINATOR – POSITION DESCRIPTION

INCUMBENT NAME		HIRE DATE	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Quality Improvement Analyst (Quality Improvement Coordinator)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Quality Improvement/Arizona	**SUPERVISOR'S TITLE** Director, Quality Improvement		

POSITION SUMMARY (Briefly describe the position).

Under the general supervision of the Director of Quality Improvement this position is responsible for developing, organizing, collecting, coordinating, preparing and presenting results of quality improvement review activities of the plan providers to achieve the objective of monitoring, evaluating and continuously improving the quality of healthcare services to plan members.

Note: The information in this position description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

QUALIFICATIONS

Education:

- Associate's degree in Business Administration, Healthcare, or related field (or equivalent combination of education and experience).
- Bachelor's degree preferred.

Experience:

- 2-plus years experience in managed health care and quality management/improvement.
- 3-plus years experience working in a managed care environment, preferably in a Medicaid environment.
- 1-plus year in data and outcomes measurement.

Licensure/Certification:

- Certified Professional in Healthcare Quality (CPHQ) required

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INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Working knowledge in performance improvement methodology (focus PDCA).
- Comprehensive knowledge of state Medicaid policies and programs.
- Knowledge of applicable federal and third party requirements, including NCQA.
- Effective written and oral communication skills.
- Computer literacy.
- Ability to maintain confidential information as needed.
- Ability to develop, organize, analyze and implement procedures.

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Focuses organizational efforts on improving clinical quality performance measures.
- Develops and implements performance improvement projects.
- Provides oversight and supervision of the QI information system data entry and QI Committee activities.
- Provides feedback by reporting, communicating and coordination of quality review data and performance outcomes.
- Preparation of narratives, graphs, charts flowcharts, etc. for use in committee presentations and as required by regulatory guidelines.
- Utilizes data to develop intervention strategies to improve outcomes.
- Reports quality improvement/performance outcomes.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.

MATERNAL HEALTH/EPSDT COORDINATOR – POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Health Education Coordinator (Maternal Health / EPSDT (child health Coordinator)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Quality Improvement /Arizona	**SUPERVISOR'S TITLE** Director, Quality Improvement		

POSITION SUMMARY (Briefly describe the position).

Under the general supervision of the Director of Quality Improvement this position is responsible for oversight of identification and coordination assistance for identified member needs; promoting family planning and preventive health strategies; ensuring receipt of EPSDT services; ensuring receipt of maternal and postpartum care and is an interface with community partners.

Note: The information in this position description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

QUALIFICATIONS

Education:

- Master's degree in Health Care Administration, public health, health services or related field.

Experience:

- 3-plus years experience in managed health care and quality management/improvement.
- 5-plus years experience working in a managed care environment, preferably in a Medicaid environment.
- 1-plus year in supervisory role.

Licensure:

- Registered Nurse (RN); Physician or Physician's Assistant (PA) (licensed in Arizona) &/or Certified Professional in Healthcare Quality (CPHQ).

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INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Comprehensive knowledge of state Medicaid policies and programs.
- Knowledge of applicable federal and state EPSDT requirements.
- Effective written and oral communication skills.
- Computer literacy. (Microsoft Office products; database experience is preferred.)
- Ability to maintain confidential information as needed.
- Effective interpersonal human relations skills.
- Ability to develop, organize, analyze and implement policies and procedures.

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Ensures receipt of EPSDT services.
- Ensures receipt of maternal and postpartum care.
- Promotes family planning services.
- Promotes preventive health strategies.
- Interfaces with community partners.
- Functions as a liaison to internal departments, community based organizations and public health departments.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.

MEDICAL MANAGEMENT COORDINATOR – POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Manager, Utilization Management (Medical Management Coordinator)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Medical Management / Arizona	**SUPERVISOR'S TITLE** Director, Health Care Services		

POSITION SUMMARY (Briefly describe the position).

Responsible for adopting and ensuring compliance and consistency with medical necessity criteria; concurrent, prospective and retrospective review; and discharge planning. Develop, implement and monitor the provision of care coordination, disease management and case management functions. Interacts with Medical Directors, Utilization Management department staff, various other Molina staff and providers to deliver cost effective, quality of care services to Molina members, in accordance with Molina policies, procedures and processes. Provide administrative and leadership support to staff.

Note: The information in this position description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job.

QUALIFICATIONS

Education:

- Required: Master's degree in health services, health care administration or business administration or related field required for non medical necessity determinations.
- Bachelor's degree in Nursing or related field preferred.

Experience:

- Required: 3-plus years clinical nursing experience, with 3-5 years in Medical Management.
- Required: Minimum 2 years management experience.

Licensure/Certification:

- Required: Current Arizona Registered Nurse (RN); Physician or Physician's Assistant (PA) (licensed in Arizona) with no restrictions for medical necessity determinations

INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Comprehensive knowledge of Arizona Medicaid policies and programs.
- Comprehensive knowledge of federal and state guidelines.
- Effective interpersonal human relations skills.
- Effective written and oral communication skills.
- Ability to travel as needed.
- Computer literacy. (Microsoft Office products; QNXT experience is preferred.)
- Ability to maintain confidential information as needed.
- Ability to develop, organize and implement procedures.

Supervisory Responsibilities:

Yes

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Monitors, analyzes and implements appropriate interventions based on the utilization data, including identifying and correcting over- and under-utilization of services.
- Adopts and implements consistent application of appropriate inpatient and outpatient medical necessity criteria.
- Adopts and implements appropriate concurrent review, prospective review and discharge planning of inpatient stays guidelines and ensure they are conducted.
- Develops, implements and monitors the provision of care coordination, disease management and case management functions.
- Oversees, coordinates and monitors all department activities to facilitate proactive coordination.
- Oversees and evaluates team members including referral management, pre-service review, admission review, concurrent review, discharge planning, case management and appeals management
- Ensures adequate staffing and service levels and maintains customer satisfaction by implementing and monitoring staff productivity and performance indicators.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.

BEHAVIORAL HEALTH COORDINATOR – POSITION DESCRIPTION

INCUMBENT NAME		**HIRE DATE**	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Director, Behavioral Health (Behavioral Health Coordinator)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Health Care Services / Arizona	**SUPERVISOR'S TITLE** Director, Health Care Services		

POSITION SUMMARY (Briefly describe the position).

Responsible for coordinating the assessment, planning, implementation, monitoring and evaluation of behavioral health and care coordination services for members identified with primary complex mental health, and/or chemical dependency and social services support issues and potentially overlapping medical issues. Responsible for coordinating effectively with Primary Care Providers and the RBHA system and oversight of behavioral health referral and coordination activities to ensure compliance with AHCCCS requirements.

QUALIFICATIONS

Education:

- Required: Behavioral health medical practitioner licensed and authorized by law to use and prescribe medication with at least one full year of full-time behavioral health work experience.

Experience:

- Required: Minimum 2 years experience in a setting that includes managing behavioral health, chemical dependency and medical care services
- Preferred: Experience in social services, chemical dependency services &/or mental healthcare
- Preferred: Experience in discharge planning, home health or transitional care

Licensure/Certification:

- Required: Current Arizona licensed professional in at least one of the following;
  - Psychiatrist
  - Behavioral health medical practitioner
  - Psychologist
  - Social Worker
  - Counselor
  - Marriage and family therapist
  - Substance abuse counselor
  - Registered Nurse (RN) with at least 1 full year of full-time behavioral health work experience

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INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Comprehensive knowledge of Arizona Medicaid policies and programs.
- Comprehensive knowledge of state, federal and third party regulations and standards (CHAMPUS, Labor & Industry, SSI Program, etc.).
- Knowledge of social support systems and resources available.
- Effective interpersonal human relations skills.
- Effective written and oral communication skills.
- Computer literacy. (Microsoft Office products; QNXT experience is preferred.)
- Ability to maintain confidential information as needed.
- Ability to develop, organize and implement procedures.

Supervisory Responsibilities:

Yes

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Coordinates member behavioral health care needs with the RBHA system.
- Develops processes to coordinate behavioral health care between PCPs and the RBHA system.
- Participates in the identification of best practices for behavioral health in a primary care setting.
- Coordinates behavioral care with medically necessary services.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.

PROVIDER SERVICES MANAGER – POSITION DESCRIPTION

INCUMBENT NAME		HIRE DATE	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Provider Services Manager	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Network Operations / Arizona	**SUPERVISOR'S TITLE** Director Network Management & Operations		

POSITION SUMMARY (Briefly describe the position).

Responsible for managing the day to day operations of the Provider Services Department including staff recruiting, training and evaluating. Develop and maintain departmental policies and procedures. Manage provider education program including orientations, training seminars, provider meetings and individual sessions. ePortal management and project management. Arizona provider network management activities and assisting with internal department when warranted. Adheres to the company/department's confidentiality and HIPAA compliance programs. Adheres to the company/department's fraud and abuse prevention/detection policies and programs.

QUALIFICATIONS

Education:
- Required: Bachelor's degree in Business or related discipline
- Preferred: Master's degree preferred

Experience:
- 5-plus years experience in health care or managed care setting, preferably with Medicaid product;
- 3-plus years experience working in a Provider Service related role;
- 3-plus years in a supervisory role,
- 3-plus years experience working in a Customer Service related role; and
- 3-plus years claims or billing related experiences.

Licensure/Certification:
- None Required

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INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Strong analytical and reasoning abilities;
- Managed care culture and philosophy;
- Computer literacy. (Microsoft Office products; QNXT experience is preferred.)
- Perform independently and handle multiple projects simultaneously;
- Strong presentation/communication skills (verbal and written);
- Knowledge of applicable state, federal and third party regulations; and
- Experience with NCQA accreditation requirements;
- Excellent understanding of AHCCCS/ALTCS program requirements.

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Provide excellent customer service.
- Coordinates communications between the plan, its subcontractors, IHS and tribally operated health programs under P.L. 93-638 (Indian Self Determination and Education Assistance Act).
- Develop and implement annual and adhoc training plans for providers.
- Provide assistance to providers in resolving problems.
- Respond to provider inquiries timely and efficiently.
- Educate providers and their staff about participation in AHCCCS program.
- Maintain a sufficient provider network and ensures provider needs are met.
- Establish proper management of relationships and promotes efficiency in delivery of service to providers.
- Responsible to ensure accuracy of provider information in system, Web site and provider directories.
- Acts as a liaison to the state regulatory agency regarding inquiries or reporting needs related to network and provider claims.
- Ensure advocacy of providers in review of NCQA standards and state regulatory agencies.
- Comply with required workplace safety standards.
- Adhere to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adhere to the company and/or departmental fraud and abuse prevention/detection policies and programs.

CLAIMS ADMINISTRATOR – ANTOINETTE SMITH JONES

Over 15 years' managerial experience in medical claims processing and customer service. Proven abilities in meeting and exceeding goals while adhering to state regulations, compliance standards and health plan audit specifications. Expertise in developing and maintaining departmental budgets, developing and implementing process improvements and policies and procedures, conducting bi-weekly staff meetings, as well as preparing yearly performance reviews for unit comprised of 25 claims examiners. Proficient in various Microsoft applications to include Word, Excel, Power Point and Visio.

PROFESSIONAL EXPERIENCE

MOLINA HEALTHCARE, Long Beach, CA April 2006 – present
Claims Manager
Manage the process of examining Medicaid claims while complying within state regulations. This includes managing the process for multiple states including Florida, Missouri, Ohio, New Mexico and Michigan Medicaid programs.

- Develop training guidelines and workflows; mentoring staff to next level.
- Staff capacity forecasting.
- Assist implementation of claims workflow process.
- Facilitate executive meetings; interact daily with executive management.
- Assist with budget forecasting.

MOLINA HEALTHCARE, Long Beach, CA July 2001 – April 2006
Claims Supervisor
Supervised the process of examining claims within 10 calendar days with a staff of 25 claims examiners. Developed and monitored results against assigned targets while maintaining the accuracy of payments within company guidelines.

- Motivated and enriched lives.
- Managed the day to day process.
- Directed resources appropriately to ensure timely and accurate processing of claims.
- Interacted with staff to build teamwork.
- Counseled, trained and assisted staff daily.
- Tested new implementation of contracts.
- Tested system for implementation of new business.

MedPartners/KPC Medical Management, Cerritos, CA September 1998 – February 2001
Claims Manager
Managed the process of examining senior, Medi-Cal and commercial claims while complying with HCFA and DOC regulations with a staff of 30 people. Established liaison between claims department and contracting department. Instrumental in increasing compliance from 40% to 99% in four months. Provided a positive workflow between the claims department and support units. Managed a claims membership of over 500,000 members. Hired, trained and motivated staff.

- Developed policies and procedures to enhance claims processing.
- Worked with programmers interpreting claims adjudication requirements for the implementation of online claims processing.
- Directly responsible for all operational activities.
- Worked with programmers for implementation of Web page for claims status.

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MedPartners, City of Industry, CA March 1998 – September 1998
Commercial Claims Supervisor
Supervised the process of examining commercial claims within 30 to 45 working days with a staff of 21 claims examiners. Developed and monitored results against assigned targets while maintaining the accuracy of payments within company guidelines. Unit awarded "Most Claims Processed" during recent production drives, consistently outperformed other units.

- Managed a claims membership of over 250,000 members.
- Increased moral of unit by coaching, feedback and rewarding positive results.
- Managed the largest claims unit with the highest production quota.
- Received several awards and expressions of gratitude from members, co-workers, etc.

American Healthsystems Inc. Long Beach, CA October 1995 – February 1998
Assistant Supervisor
Supervised 12 claim processors with strict adherence on processing claims accurately and timely. Conducted weekly staff meetings with training focus to include such topics as: effective time management, adherence to HCFA regulations and comprehending provider contracts.

- Wrote unit guidelines for claims examiners to refer to as a quick reference throughout work day.
- Awarded "Outstanding Results" for exceeding production quotas, 1997.

American Healthsystems Inc. Long Beach, CA July 1995 – October 1995
Claims Processing Trainer
Conducted training seminars for new hires. Training topics included basic knowledge of gathering information from the 1500 or UB92 claim forms, inputting appropriate data, and finalizing claim via adjudication.

- Created and developed claims reference materials for claims processing.
- Provided seminars for the AS 400 claims processing systems.
- Provided audit and progress reports of trainees to management as needed.

American Healthsystems Inc. Long Beach, CA January 1995 – June 1995
Claims Examiner
Responsibilities included processing commercial and senior claims accurately against assigned quotas. Surpassed production goal of 100 claims per day; audited and voided provider checks. Assisted in training new claim examiners.

- Highest producer of simple and complex medical claims: Avg. 275 per day
- Processed special project claims distributed by Senior Processor

EDUCATION:
Complete Claims Services: Brea, CA – Claims Certificate
Basic Supervision Certificate – 1996

AWARDS:
International Who's Who of Professionals – 1996
Outstanding Supervisor of the Year – 1996

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PROVIDER CLAIMS EDUCATOR – POSITION DESCRIPTION

INCUMBENT NAME		HIRE DATE	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Claims Liaison / Provider Service Rep II (Provider Claims Educator)	**JOB CODE**	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Provider Services / Arizona	**SUPERVISOR'S TITLE** Provider Services Manager		

POSITION SUMMARY (Briefly describe the position).

Responsible for the oversight, coordination and education of provider office staff as it relates to claim issues and provider grievance. This position will identify trends and guides the development and implementation of strategies to improve provider satisfaction.

Note: The information in this position description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

QUALIFICATIONS

Education:

- Required: Bachelor's degree in health care related field (relevant experience will be considered in lieu of a degree)

Experience:

- Required: Minimum 3 years of relevant health care provider experience.
- Required: 2-3 years experience in a claims environment; preferably with a Managed Care Organization

Licensure/Certification:

- Valid Arizona driver's license with a good driving record

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INCUMBENT NAME	**HIRE DATE**

Additional Skills and Knowledge:

- Comprehensive knowledge of Arizona Medicaid policies and programs.
- Comprehensive knowledge of state, federal and third party regulations and standards (CHAMPUS, Labor & Industry, SSI Program, etc.).
- Knowledge of claims processing systems (QNXT preferred).
- Effective interpersonal human relations skills.
- Effective written and oral communication skills.
- Computer literacy. (Microsoft Office products; QNXT experience is preferred.)
- Ability to maintain confidential information as needed.
- Ability to develop, organize and implement procedures.

Supervisory Responsibilities:

No

Essential Job Functions:

In addition to the previously listed Position Summary, the Essential Job Functions include the following:

- Educates contracted and non-contracted providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, compliance standards, electronic claims transactions and electronic fund transfer (EFT), and available resources such as provider manuals, Web site, fee schedules, etc.
- Interfaces with the call center to compile, analyze and disseminate information from provider calls.
- Identifies trends and guides the development and implementation of strategies to improve provider satisfaction.
- Frequently communicates (telephonic and on-site) with providers and their office staff to ensure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.
- Acts as a liaison between provider network and internal departments.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.

CASE MANAGEMENT ADMINISTRATOR/MANAGER – POSITION DESCRIPTION

INCUMBENT NAME		HIRE DATE	
PURPOSE OF REVIEW		**EVALUATION DUE DATE**	
POSITION TITLE Director Health Care Services (Case Management Administrator)	**JOB CODE** N/A	**EXEMPT STATUS** Exempt	**PAY GRADE**
DEPT/LOCATION Health Care Services	**SUPERVISOR'S TITLE** Molina Healthcare of Arizona Plan President		

POSITION SUMMARY (Briefly describe the position).

Provides program development, strategic direction and oversight for administration of the Case Management department at Molina Healthcare of Arizona. Ensure program compliance with State Health Department contract and external accreditation entities when applicable. Direct managers, supervisors and staff in the department(s) working on the ALTCS Case Management program. Represents Molina Healthcare and these special programs in meetings and communications with community representatives, member groups, providers, and regulatory agencies.

QUALIFICATIONS

Education and Experience:

- Bachelor's Degree required. Advanced degree in Nursing, Business, or Healthcare Related Field preferred.
- AZ Registered Nursing License required. Bachelor's Degree in Nursing preferred. Case Management Certificate preferred.
- Minimum 5 years management or supervisory experience in healthcare required.
- Minimum 5 year experience working with ABD/SSI, mentally ill and chemically dependent populations.
- Minimum 3 years Medicaid/Medicare Managed Care with solid understanding of Managed Care budgets and finances, e.g. capitation, case rates, contract administration.
- Minimum 2 years case management experience.

Additional Skills and Knowledge:

- Knowledge of a variety of clinical areas, as well as, in-depth knowledge of community resources for long-term case management; Experience with Aged, Blind and Disabled (ABD)/SSI population preferred;
- Knowledge of a variety of state and/or government funded services for the ABD/SSI population;
- Knowledge of Home and Community Based Services (HCBS) programs;
- Knowledge of health care facilities, current practices, procedures, acceptable medical treatment and diagnoses.
- Skill to learn company policies and procedures as they relate to case management as well as authorization/denials, physician review, appeals, fair hearings, etc.
- Skill to successfully apply established guidelines and regulation to specific and individual situations.

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- Skill in both oral and written communications to ensure the accurate transfer of information, to build rapport that will ensure the trust, confidence and cooperation of others in a work situation.
- Skill in establishing and maintaining a variety of records necessary to provide complete information and documentation for relevant and appropriate medical determination.
- Skill to establish and maintain effective work relationships with those contacted in the performance of required duties. Proficiency with PC-based computer systems, ability to learn new information systems and software.
- Excellent organizational skills.
- Knowledge of applicable state, federal and third party regulations and standards (Medicaid, SSI).
- Background in discharge planning, transitions of care and home health.
- Public Health experience.
- Demonstrated experience and success in design and build up of new healthcare service programs.

Essential Job Functions:

In addition to the previously listed Position Summary, Essential Job Functions include following:

- Provide strategic direction and leadership for the Case Management program development and implementation. Direct the Long-term Care authorization, concurrent review, discharge planning, and case management processes according to contracted benefits to meet the needs of Molina members.
- Point of contact for state regulators and participate regulatory meetings and communications.
- Ensure choice, dignity, independence, individuality, privacy and self-determination is promoted.
- Establish and maintain open communication and interface between key departments within the Health plan such as Government Programs and Compliance, Member Services, Provider Relations, Claims and other internal Healthcare Services departments
- Establish and maintain open communication and professional working relationships with regulatory and accreditation bodies to ensure compliance with all applicable standards.
- Mentors manager and line staff on leadership, teamwork and program development.
- Advise senior staff at Molina Healthcare of Arizona, Inc. of strategic planning activities related to the Long-term Care program.
- Recommend changes and improvements where appropriate.
- Accurately analyzes program reports relative to productivity, quality of care, quality of service, cost of care and utilization.
- Develops strategic plans to improve outcomes.
- Maintains responsibility of implementing processes to improve outcomes, streamline workflows and impact cost of care.
- Participate in state budget process and establish budget for the Long-term Care program.
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.
- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to company and/or department fraud/abuse prevention/detection policies & programs.

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Following are the resumes of the existing Molina Healthcare employees that will provide expertise in support of the four Key Positions: Medical Director, Medical Management Coordinator, Case Management Administrator and Behavioral Health Coordinator, until permanent full-time employees are hired.

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Medical Director
Dr. Eugene Sun, Molina Healthcare of New Mexico, Chief Medical Officer

CHIEF MEDICAL OFFICER – EUGENE F. SUN, M.D., M.B.A.
Molina Healthcare of New Mexico, Molina Healthcare of Arizona (ACTING)

Physician executive with demonstrated success in progressively responsible leadership positions; with broad experience in primary care, biotechnology, pharmaceuticals, and managed care. In depth knowledge of all facets of medical management for Commercial, Medicare, and Medicaid lines of business including preauthorization, concurrent review, case and disease management, and quality improvement including experience with both URAC and NCQA accreditation.

EXPERIENCE:

Chief Medical Officer (February 2008 – present)
Molina Healthcare of New Mexico, Albuquerque, NM; a Medicaid managed care plan with approximately 93,000 insured and 110,000 ASO members

- Implemented Maternity Management program to identify and manage pregnancies as early as possible, and to utilize 17-alphahydroxyprogesterone as appropriate to decrease preterm deliveries. Neonatal ICU days decreased 21% from an average of 37 days/1,000 in 2008 to 29 days/1,000 in early 2010.
- Managed pharmacy benefits with increase in generic fill rate from 80% to 87% and 25% decrease in spend (approximately $9 per member per month) from 2008 to early 2011.
- Managed a seamless transition from previous Pharmacy Benefits Management vendor to RxAmerica/Caremark in mid 2009.
- Implemented medical claims review of non-emergent Emergency department claims, resulting in savings of $1.8 million in first year.
- Maintained Excellent NCQA Accreditation.
- Developed and maintaining positive, collaborative, working relationships with key New Mexico State Human Services and Medical Assistance staff.

Vice President, Medical Affairs (January 2005 – February 2008)
Health America, Pittsburgh, PA, a managed care plan with approximately 650,000 members including Commercial and Medicare Advantage

- Consolidated two separate medical management teams in Harrisburg and Pittsburgh into one cross-functional team with unified statewide approach, with overall responsibility for nine medical directors.
- Achieved low single digit medical utilization trend over the last two years.
- Developed and maintained strong relationships with key physicians and hospitals.

Vice President, Medical Affairs (May 2004 – January 2005)
Qualis Health, Seattle, WA

- Reorganized the department to improve medical director support for all lines of business, including utilization management for state Medicaid, private contracts including ASO and Taft-Hartley trusts, and independent external review.
- Responsible for ensuring compliance with requirements of contract with Centers for Medicare and Medicaid Services (CMS) Quality Improvement Organization (QIO) program for Idaho, Alaska and Washington.

Associate Regional Medical Director (April 2001 – May 2004)
Merck US Human Health, Kirkland, WA

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- Acted as liaison between Medical and Scientific Affairs department/key regional customers.
- Maintained full compliance with all FDA regulatory requirements.

Regional Medical Director (July 1998 – April 2001)
PacifiCare of Washington and Oregon, Seattle, WA
- Worked with contracted groups, including PHO, IPA, and Multispecialty Group models to improve their capabilities to perform medical management.
- Managed and grew the Utilization Management department during the transition period during which capitated, delegated medical groups shifted risk and UM back to Pacificare.

Medical Director (May 1997 – July 1998)
United HealthCare of the Mid-Atlantic, Baltimore, MD
- Provided clinical support to Quality Improvement program, including study design for NCQA accreditation and coordination of HEDIS 3.0 reporting.
- Designed and implemented medical management initiatives such as disease management to improve quality and cost effectiveness of care delivered to 90,000 HMO and 135,000 POS/PPO members.

Associate Medical Director (July 1995 – May 1997)
Regence Washington Health, (formerly King County Medical Blue Shield), Seattle, WA
- Co-managed team providing Medical Management services for Indemnity products (POS, PPO, PAR), with approximately 500,000 covered lives.

Clinical Research Medical Associate (March 1993 – February 1995)
Cytran Incorporated, Kirkland, WA
- Participated in the development of Phase I/II Clinical Plan and drafted Clinical Protocols for an experimental human therapeutic agent.

University of Washington Graduate School of Business (September 1991 – March 1993)
Attended MBA program full time.

Staff Physician, Internal Medicine (August 1989 – September 1991)
Kaiser Permanente, Portland, OR
- Evaluated and treated thirty or more outpatients daily.

Intern and Resident, Internal Medicine (June 1986 – July 1989)
University of Pittsburgh Medical Center, Pittsburgh, PA

EDUCATION:
M.B.A., General Management (1993) University of Washington, Seattle, WA
M.D. (1986) University of New Mexico, Albuquerque, NM
B.A., Biochemistry (1982) Pomona College, Claremont, CA

PROFESSIONAL CERTIFICATION AND LICENSURE:
Diplomat, National Board of Medical Examiners (1987)
Diplomat, American Board of Internal Medicine (1989)
Currently licensed to practice medicine in New Mexico, Washington

PROFESSIONAL MEMBERSHIPS:
Alpha Omega Alpha Medical Honor Society American College of Physicians
New Mexico Medical Society Beta Gamma Sigma Business Honor Society

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Medical Management Coordinator
Margret Young, Molina Healthcare, Director Long-term Care

Medical Management Coordinator – Margret Young
Molina Healthcare, Inc., Molina Healthcare of Arizona (ACTING)
Margaret.Young@molinahealthcare.com

Education
1980 - 1985 UTHSC Nursing School, San Antonio, TX
BSN / Nursing

1995 - 1999 Webster University, San Antonio, TX
MBA with emphasis in Health Service Management

Professional Experience
Corporate Director Long-term Care
2008 - present Molina Healthcare, Inc., San Antonio, TX
- Participate in planning and preparation of potential new Long-term Care plans
- Participate in Request For Proposal process
- Provide onsite implementation of Long-term Care program
- Developed policies and procedures related to Long-term Care

Director Special Programs
2006 - present Molina Healthcare, Inc., San Antonio, TX
- Provide on-going program development, strategic direction, implementation and oversight for administration of the STAR+PLUS program, an Aged Blind and Disabled 1915c Waiver Medicaid program focusing on disabled and frail elderly population and their acute and long-term care community needs.
- Established and maintain open effective communication and professional working relationships with state officials and regulatory and accreditation bodies to ensure compliance with all applicable standards.
- Effectively managed and maintained membership surge from 3,250 to 16,000.

Consultant
2000 - 2006 MYoung Consulting, San Antonio, TX
Sole proprietor of consulting firm offering:
- Assistance to executive leadership to identify and develop new service lines focusing on cost and reimbursement strategies;
- Identification of superfluous costs, research root cause(s) and develop strategies to decrease loss;
- Business development and compliance in Medicare and Texas Medicaid Programs, including waiver programs; and

Key contracts include:
- Molina Health Care (Managed Care)
  - Providing presentations to home health agencies involved with SSI eligible population for STAR+PLUS program expansion in Texas.
  - Developing provider network for Medicaid STAR+PLUS expansion project focusing on significant traditional providers and long-term care community providers.

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- Community First Health Plan (Managed Care)
  - Wrote Care Coordination and CBA sections of RFP for Medicaid STAR+PLUS expansion project – selected as 1 of 3 HMOs by HHSC Medicaid panel
  - Prepared and presented to executive leadership information regarding proposed Medicaid STAR+PLUS expansion project and waivered programs.
- Elder Health, Inc. (Managed Care)
  - Actively participated in the preparation of the application submission to TDI to obtain HMO license; Certificate of Authority issued.
  - Developed corporate policy and procedures in compliance with CMS regulations
- CHRISTUS Santa Rosa – Project Management Case Management Project
- Directed the development of Case Management policy and procedures
- Directed the preparation of the application submitted to TDH to obtain provider status for Medicaid Case Management for Children and Pregnant Women – provider status obtained without deficiencies
- Texas Department of Human Services – Regulatory Agency
- Program Nurse for Special Needs Waiver Programs: Medically Dependent Children's Program
- Reviewed policy/process changes with waiver programs such as MDCP and CWP.

President/Chief Executive Officer
1999 - 2003 ACCESS, Inc., San Antonio, TX
Founder and owner of case management organization providing services to pregnant women and children through Medicaid program

- Worked closely with Medicaid (Managed Care and Traditional) members and providers for PCCM, STAR, CHIP and STAR+PLUS programs
- Developed and maintained excellent business relationships with community leaders, advisory group members, board members of highly visible organizations and State/Regional TDH regulatory staff

Compliance Officer – Medicaid and Medicare Services
1995 - 1999 Concepts of Care, Inc., South Texas

- Interpreted federal and state regulations as they applied to services, processes, practices and procedures
- Audited claims to fiscal intermediaries for compliance – ensuring proper and appropriate documentation to justify claim

1979 - 1995 St Luke's Lutheran Hospital, San Antonio, TX
1979 - 1988 Staff Nurse
1988 - 1995 Director of Critical Care Units

Professional and Community Activities
Bexar County Case Management Coalition
Regional Advisory Counsel (RAC) – Member 2000 – 2004
Community Resource Coordination Group – Member 2000 – 2003
UTHSCSA Nursing School Alumni – Board Member
Project Better Future Coalition – Member 2000 – 2003

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Case Management Administrator
Barbara Johansson, Molina Healthcare Vice President of Care Coordination

Case Management Administrator – Barbara Johansson
Molina Healthcare, Inc., Molina Healthcare of Arizona (ACTING)
Barbara.Johansson@molinahealthcare.com

EDUCATION:

UNIVERSITY OF WASHINGTON
Seattle, WA
Bachelor of Science, 1984
Nursing

UNIVERSITY OF WASHINGTON
Seattle, WA
Bachelor of Arts, 1985
Communication/Public Relations

LICENSURE AND CERTIFICATIONS:

RN Washington State-Current and Unrestricted
Certified Case Manager (CCM)
Certified Professional Utilization Manager (CPUM)

WORK EXPERIENCE:

MOLINA HEALTHCARE, INC. (7/2006 - present)
Vice President, Care Coordination Strategies (9/2008 - present)
Accountable for the corporate oversight of Care Coordination including the provision of Long-term Care and Behavioral Health programs to ensure that the integrated model meets regulatory requirements. Works with state agencies, local Molina health plans to ensure implementation and ongoing operations achieve program goals. Corporate development of new markets focused on chronic populations.

Director, Healthcare Strategy (4/2007 - 8/2008)
Responsible for development of multiple programs including aged, blind and disabled, behavioral health, long-term care and rural populations. Accountable for operational responsibilities of planning and implementation of new programs including hiring, staff training and policies and procedure development. Managed vendor selection activities for outsourcing of specific operations. Participated in business development activities including presentations to state agencies and due diligence analysis of potential business opportunities. Other duties included research, development and implementation of new technologies and services to promote health.

Director of Aged, Blind and Disabled Programs (7/2006 - 4/2007)
Responsible for the implementation of care coordination integrated model (medical, long-term care and behavioral health) for new state programs including Molina Healthcare of Texas and Molina Healthcare of Ohio. Duties included participation in RFP process and representing Molina Healthcare at state meetings. Operational responsibilities included hiring of management team, training new staff, development of policies and procedures, designated representative for state readiness reviews and follow-up audits as needed.

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MOLINA HEALTHCARE OF WASHINGTON (11/2004 - 7/2006)
Director of Special Programs
Responsibilities included implementation and management of care coordination services within an integrated care model (medical, behavioral health and long-term care) for the Washington Medicaid Integration Partnership (WMIP). Participated in Center for Health Care Strategies (CHCS) and Robert Wood Johnson Foundation (RWJF) grant focused on chronic populations. Other responsibilities included development and 2006 implementation of the Medicare Special Needs Plans program. Responsible for a team of 20 staff and $1.5 M budget. Served as the liaison for state and community agencies regarding the program.

QUALIS HEALTH (11/1992 - 11/2004)
Director of Private Services (12/2003 - 11/2004)
Responsible for $2 million budget as manager of Case Management Services, Utilization Management, and Medical Consultation Products. Directed a team of up to 22 staff. Key contributor on special projects, including RFPs, Alaska Medicaid's annual report, and performing cost analysis to increase the ROI for case management contracts. Implemented new program model to promote holistic care management for specific population of individuals.

Lead Case Manager (11/2001 - 11/2003)
Responsible for supervision of up to 8 case managers while maintaining an active caseload. Played a key role in the implementation of numerous programs Medicaid programs. Involved extensively in Qualis Health's initial URAC accreditation and key contact for URAC Auditor onsite during the recent re-accreditation application.

Case Manager (5/1995 - 10/2001)
Responsible for managing a caseload of patients with complex medical issues. Performed assessments, onsite visits, and coordinated care including inpatient and outpatient services. Responsible for cost-effectiveness and return on investment. Performed rate negotiations with providers.

Health Care Reviewer (11/1992 - 4/1995)
Performed retrospective medical record audits to determine appropriateness and quality of health care treatment for government and privately funded health care plans.

CLINICAL EXPERIENCE

WESTCHESTER MEDICAL CENTER-Westchester, NY
Float Nurse (1990 - 1991)

UNIVERSITY OF WASHINGTON MEDICAL CENTER-Seattle WA
Oncology/Bone Marrow Transplant Nurse (1985 - 1986)

Board Member

Commission for Case Manager Certification CCMC (June 2008-present)

Publications

Johansson, B. C., Home-Based Long-term Care: Providing Services, Preparing for Challenges. Caring Magazine, February 2010, pp. 26-31.

Johansson, B. C., Case Management Stress: Strategies to Lessen the Load. Care Management Journal 2002, Vol. 8, No. 5, pp. 16-18.

Johansson, B. C., A Pilot Project: The Impact of Case Manager Performing Inpatient Rehabilitation Reviews. Lippincott's Case Management 2004, Vol. 9, No. 3, pp. 157-159.

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Behavioral Health Coordinator
Debra Horowski, Molina Healthcare Director Behavioral Health

Director, Behavioral Health - DEBRA HOROWSKI, Ph.D.
Molina Healthcare, Inc., Molina Healthcare of Arizona (ACTING)
debra.horowski@molinahealthcare.com

EDUCATION:
CORNELL UNIVERSITY Ithaca, New York
Doctorate in Philosophy, 1983
Psychology (Personality & Experimental Psychopathology)

THE OHIO STATE UNIVERSITY Columbus, Ohio
Bachelor of Arts, 1977
Psychology

LICENSURE:
Washington (03/04 – present)
Previous licensure in Massachusetts and North Carolina

CLINICAL TRAINING:
DARTMOUTH MEDICAL SCHOOL
Department of Psychiatry
Child and Adolescent Postdoctoral Fellowship in Psychology
Hanover, New Hampshire (7/84 - 6/86)
Postdoctoral training in clinical psychology with responsibilities including evaluation, assessment, and treatment. Provided supervision to medical students and was consultation liaison to the Pediatrics Dept

TUFTS-NEW ENGLAND MEDICAL CENTER
Psychology Internship
Boston, Massachusetts (7/83 - 6/84)
Clinical training in diagnostic evaluation, assessment, and treatment of children and families with specialized training in sexual abuse evaluations and school consultation.

WORK EXPERIENCE:
MOLINA HEALTHCARE, INC.
Kirkland, Washington (10/08 – present)
Corporate Behavioral Health (BH) Director with oversight of BH service management across states including the integration and care coordination of BH services with medical, long-term care or other services. Responsibilities include corporate management of BH service authorization and utilization, quality improvement, disease management, delegate oversight of BH management vendors and development of new business or in-sourcing of BH management in additional states.

MOLINA HEALTHCARE, INC.
Kirkland, Washington (6/07 – 10/08)
Corporate behavioral healthcare service delivery and management consultant

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MOLINA HEALTHCARE OF WASHINGTON
Bothell, Washington (4/05 – 6/07)
Director of Behavioral Health with responsibility for implementation and management of BH services within an integrated care model (medical, BH and long-term care) for the aged, blind and disabled. Also directed management of the general Medicaid BH benefit.

MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP (VALUEOPTIONS)
Boston, Massachusetts (3/98 – 8/01)
Oversaw statewide review and approval of all Medicaid psychological and neuropsychological testing. Other duties included quality assurance special project coordinator, participation in NCQA review, professional credentialing, site visits and chart review, and statistical analysis of utilization.

PEMBROKE HOSPITAL & PSYCHIATRIC ASSOCIATES OF NORFOLK COUNTY
Pembroke, Massachusetts (11/89 – 3/98)
Clinical Director of Adolescent/Child Services, 1994-98, (inpatient, acute residential and partial hospital programs), providing program/staff development, program administration and clinical care (including general, chemical dependency and sexual abuse group therapies; liaison to schools/agencies; and individual/family treatment and case management). Director of the Women's Trauma Treatment Program, 1992-94, providing program design, administration, staff development/supervision and direct treatment. Provided full/partial battery psychological assessments to all hospital populations (child, adolescent and adult).

PRIVATE PRACTICE
Morehead City, North Carolina (1/88 - 8/89)
Provided individual, couple's and family therapy to a varied community population. Served on the Community Literacy Council. Conducted learning disability evaluations and led parenting classes for the public school system.

NEUSE CENTER FOR MH/MR/SAS
Morehead City, North Carolina (7/86 - 4/88)
Served upon the Area Management Team. Provided individual, couples and family therapy. Conducted group therapy for adolescent chemical dependency and adult anxiety disorders.

NEW YORK STATE DIVISION FOR YOUTH
Brooktondale, New York (11/81 - 6/83)
Served as a psychologist at facilities for criminal (male) and delinquent (females) youth, providing diagnostic evaluation, assessment, individual and group treatment. Also attended youth parole hearings, served on the Committee on the Handicapped, provided training and supervision of division aides, and contributed to program development and administration.

TEACHING:
DARTMOUTH MEDICAL SCHOOL
Hanover, New Hampshire (7/84 – 6/86)
Supervised and instructed medical students on rotation in child /adolescent psychiatry (diagnostics, assessment and treatment).

CORNELL UNIVERSITY DEPARTMENT OF PSYCHOLOGY
Ithaca, New York (9/77-9/81)
Teaching Assistant (various courses).
Supervisor to psychology practicum students and coordinator of related field placement sites.

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4. For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s).

The Molina Compliance Officer will work 80% of the time or at least 1,664 hours per year to implement and oversee the compliance program. The Compliance Officer will be available to all employees, with designated and recognized authority to access records and make independent referrals to AHCCCS, Office for the Inspector General and the Molina Healthcare of Arizona Board of Directors. The Compliance Officer will also serve as the Business Continuity Planning and Recovery Coordinator for 20% of the time or at least 416 hours per year to develop a Business Continuity and Recovery Plan that meets the requirements specified in ACOM Policy 104 – Business Continuity and Recovery Plan. The plan will be reviewed at least annually and updated as needed. These two positions lend themselves to be shared by a single individual with compliance and business continuity planning experience as each position has varying time demands to perform job duties. If the demands of either position exceed the projected allocation of hours, Molina will add appropriate staff.

Molina will hire a single new individual to serve as both the Quality Management Coordinator (90% of the time or at least 1,872 hours per year) and the Maternal Health/EPSDT Coordinator (10% of the time or at least 208 hours per year) who will be an Arizona Licensed Registered Nurse, Physician or Physician's Assistant or is a certified professional in health care quality by the National Association for Healthcare Quality and/or certified in health care quality and management by the American Board of Quality Assurance and Utilization Review Providers. Molina will initially staff these two positions by a single qualified individual until such time that it is deemed necessary to staff the two positions separately. If the demands of either position exceed the projected allocation of hours, Molina will add appropriate staff.

5. Submit a functional organizational chart of the key program areas, responsibilities and areas that report to that position for the following functional areas: Case Management, Quality Management, Medical Management, Prior Authorization, Grievance System (Member Grievances and Appeals and Provider Claim Disputes) Provider Services, Finance, Claims, Encounters and Information Systems.

The chart must identify the functions that will be subcontracted in a Delegated Agreement, Management Service Agreement and or Service Level Agreement.

Molina's core values include creating an organization that is efficient and provides quality service to its members and providers. Molina will employ sufficient staff and utilize appropriate resources to achieve contractual compliance as outlined in Section D, Paragraph 25, Staff Requirements and Support Services and Paragraph 33, Subcontracts. The following organizational chart reflects the staffing that will form the foundation to begin operations in Arizona. Staffing represented in these organizational charts is based on certain enrollment assumptions. Depending on the variance between actual and projected enrollment, staffing will be modified accordingly.

Molina Healthcare will supply Shared Services to Molina Healthcare of Arizona under a Service Level Agreement as indicated in Chart 5-2 - Molina Healthcare of Arizona – Service Level Agreement Shared Services.

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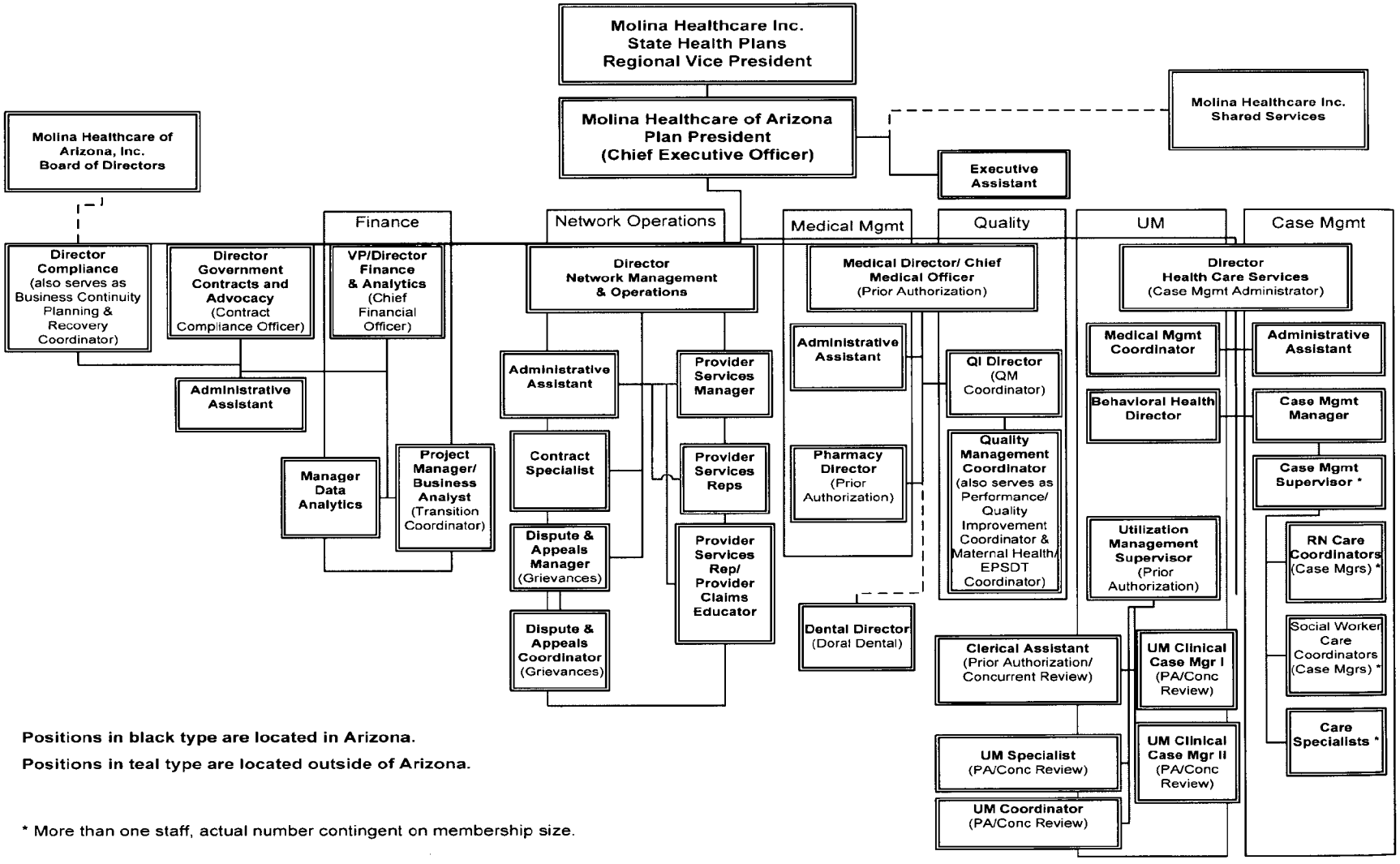
Chart 5-1 – Molina Healthcare of Arizona, Inc. Planned Organizational Chart



Positions in black type are located in Arizona.

Positions in teal type are located outside of Arizona.

* More than one staff, actual number contingent on membership size.

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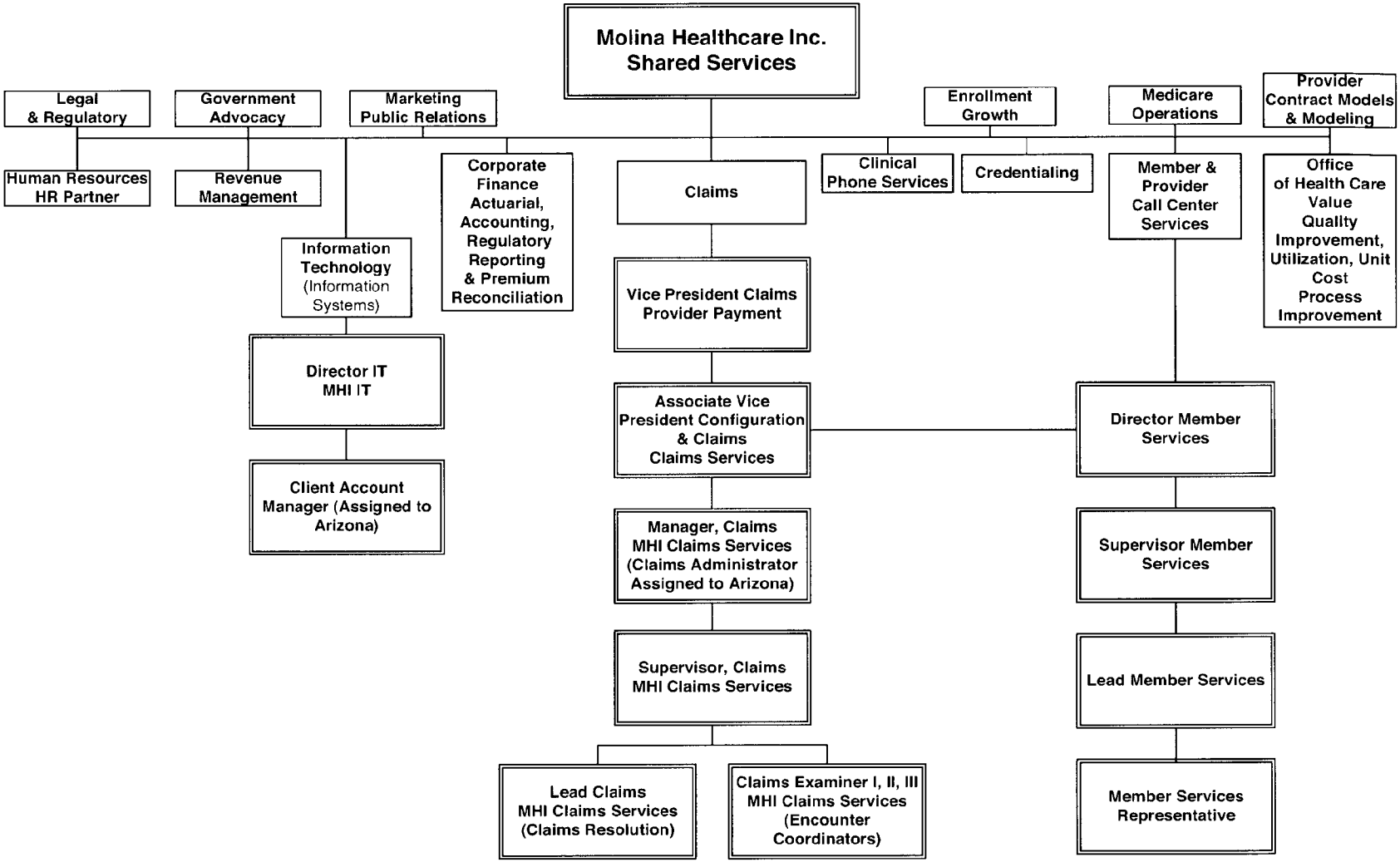
Chart 5-2 – Molina Healthcare of Arizona – Service Level Agreement Shared Services



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Sanctions

Sanctions Submission

6. Describe any sanctions levied against the Offeror, its parent corporation or any legally related corporate entity since January 1, 2008 that have been imposed by AHCCCS, Medicaid programs in other states, Medicare or any state insurance regulatory body. Include the description of the sanction, the specific reason for the sanction and the timeline to resolve or correct the deficiency. Indicate any sanctions that are currently in dispute. Sanctions are defined as any monetary and non-monetary punitive actions taken by regulatory bodies.

No sanctions of any kind have been levied against Molina Healthcare of Arizona, since January 1, 2008, by AHCCCS, by any state insurance regulatory body, or by Centers for Medicare and Medicaid Services (CMS).

No sanctions of any kind have been levied against Molina Healthcare, Inc., the parent corporation to Molina Healthcare of Arizona, since January 1, 2008, including any sanctions by AHCCCS, by Medicaid programs in other states, by any state insurance regulatory body, or by CMS.

In addition to being the parent corporation of Molina Healthcare of Arizona, Molina Healthcare, is the parent corporation of ten other licensed health plans operating in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin. Each health plan is in good standing in its relevant state, and the Medicaid contract of each health plan remains in full force and effect and is not subject to early termination for any reason.

Since January 1, 2008, no sanctions of any kind have been levied against the six Molina Healthcare plans operating in the states of Michigan, Missouri, New Mexico, Utah, Washington and Wisconsin, including any sanctions by the relevant state Medicaid or insurance regulatory body or by CMS.

Since January 1, 2008, the Molina Healthcare plans operating in the states of California, Ohio, Texas and Florida have been subject to various immaterial sanctions or penalty payments. In each such instance, the health plan took corrective action to address the matter at issue.

The following summarizes the sanctions received since January 1, 2008 with respect to four of Molina Healthcare's ten affiliated health plans.

Molina Healthcare of California. There has been one sanction levied against Molina Healthcare of California since January 1, 2008 in the amount of $250,000. The sanction related to claims and provider dispute resolution deficiencies found during a 2007 audit performed by the California Department of Managed Health Care. Molina Healthcare of California is required to submit monthly reports to California Department of Managed Health Care pertaining to Molina Healthcare of California's Corrective Action Plan, and is currently engaged in a problem determination and remediation project as part of a Stipulation Agreement between Molina Healthcare of California and the California Department of Managed Health Care as result of the audit. It is anticipated that the remaining audit matters will be resolved during 2011.

Molina Healthcare of Ohio, Inc. Since January 1, 2008, the Ohio Department of Job and Family Services have imposed certain minor sanctions against Molina Healthcare of Ohio, Inc. as summarized below. During the time period from 2008 to 2010, Molina Healthcare of Ohio's member enrollment increased by 36%.

In 2008, Ohio Department of Job and Family Services imposed fines of approximately $82,000 against Molina Healthcare of Ohio. Deficiencies assessed against Molina Healthcare of Ohio

related to provider network requirements, provider services and utilization management. Molina Healthcare of Ohio has paid the fines and corrected the deficiencies.

In 2009, Ohio Department of Job and Family Services imposed fines of approximately $41,000 against Molina Healthcare of Ohio. Deficiencies assessed against Molina Healthcare of Ohio related to provider network requirements, reinsurance matters, member grievances reporting, and Molina Healthcare of Ohio's online drug listing. Molina Healthcare of Ohio has paid the fines and corrected the deficiencies.

In 2010, Ohio Department of Job and Family Services imposed fines of approximately $36,000 against Molina Healthcare of Ohio. Deficiencies assessed against Molina Healthcare of Ohio related to appeals and grievances reporting and failure to verify that all information on Ohio Department of Job and Family Services Abortion, Sterilization, and Hysterectomy consent forms was provided and legible. Molina Healthcare of Ohio has paid the fines and corrected the deficiencies.

Molina Healthcare of Texas, Inc. The Texas Department of Health and Human Services (HHSC) and CMS have imposed certain minor sanctions against Molina Healthcare of Texas as summarized below.

In 2008, HHSC imposed fines of approximately $28,575 against Molina Healthcare of Texas. Deficiencies assessed against Molina Healthcare of Texas related to provider network adequacy, provider directory, member services call center, file submission errors, member grievances resolution, inaccurate reporting and claims payment timeliness. Molina Healthcare of Texas has paid the fines and corrected the deficiencies.

In 2009, HHSC imposed fines of approximately $33,150 against Molina Healthcare of Texas. Deficiencies assessed against Molina Healthcare of Texas related to claims payment timeliness, member grievances resolution, file submission errors, provider network accessibility and audit responsiveness. Molina Healthcare of Texas has paid the fines and corrected the deficiencies.

In 2009, CMS assessed a civil money penalty against Molina Healthcare of Texas and three affiliated plans in the amount of $11,200 relating to a failure to issue Medicare annual notices of change and evidences of coverage in a timely manner. Molina Healthcare of Texas has paid the fine and corrected the deficiency.

In 2010, HHSC imposed fines of approximately $23,575 against Molina Healthcare of Texas. Deficiencies assessed against Molina Healthcare of Texas related to inaccurate reporting, member services call center and encounter data rejection rates. Molina Healthcare of Texas has paid the fines and corrected the deficiencies.

Molina Healthcare of Florida, Inc. The Florida Agency for Health Care Administration and the Florida Officer of Insurance Regulation have imposed certain sanctions against Molina Healthcare of Florida as summarized below. Molina Healthcare of Florida enrolled its first members effective the fourth quarter of 2008.

- In 2009, Florida Agency for Health Care Administration imposed fines of approximately $4,200 against Molina Healthcare of Florida. Deficiencies assessed against Molina Healthcare of Florida related to late filing of reports and a marketing violation. Molina Healthcare of Florida has paid the fines and corrected the deficiencies.

- In 2010, Florida Agency for Health Care Administration imposed a corrective action, but no financial penalty, against Molina Healthcare of Florida relating to a delegated provider's denial of emergency admissions. Molina Healthcare of Florida has corrected the deficiency.
- In addition, in 2010 Florida Officer of Insurance Regulation imposed a corrective action, but no financial penalty, against Molina Healthcare of Florida relating to failure to file a report describing a special investigations unit. Molina Healthcare of Florida has corrected the deficiency.

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Claims

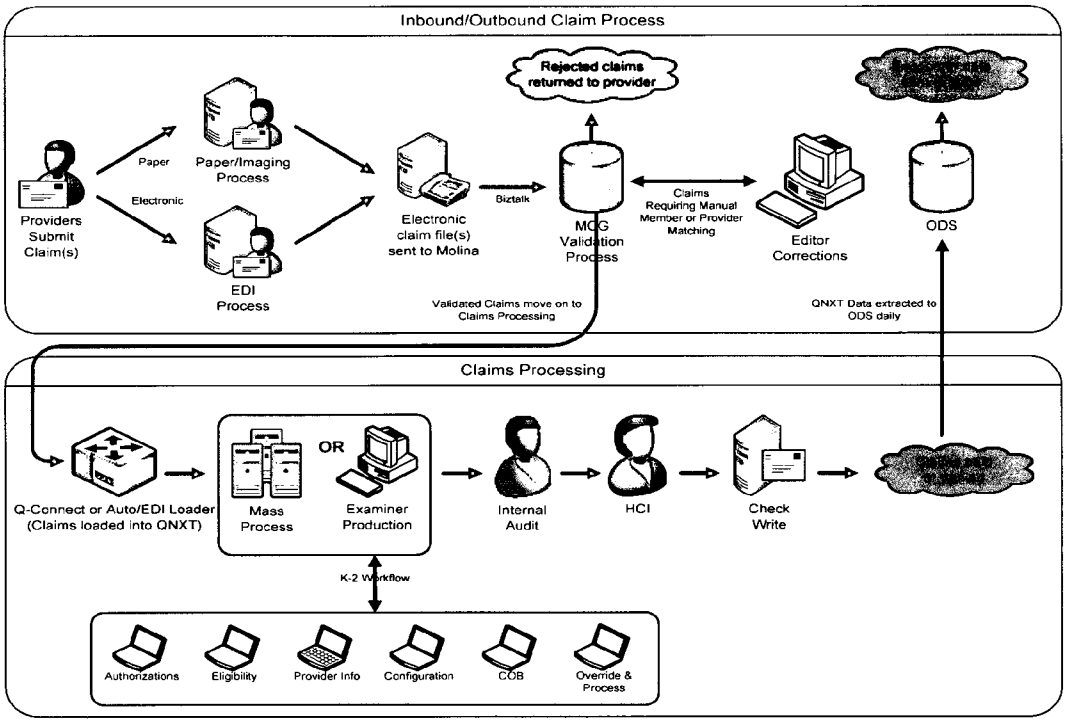
Claims Submissions

7. Provide a detailed flowchart and narrative description of the claims adjudication process, addressing both paper and electronic claims submissions. Include in the description the following: monitoring process for accurate and timely claim adjudication; how deficiencies are identified and resolved; timeliness standards and cost avoidance/TPL activities; and how claim inquiries are handled. Include an actual sample of the remittance advice (front and back) or a written narrative of the remittance advice. The submission requirement will be a maximum of four pages of narrative and an additional five pages of flowcharts.

Molina will ensure that all paper and electronic claims received are adjudicated in a timely and accurate manner in accordance with AHCCCS Program Requirements and standards in Section D, Paragraph 44, Claims Payment/Health Information System and Paragraph 63, Coordination of Benefits/Third Party Liability, using QNXT, its comprehensive claims payment/health information adjudication system. QNXT collects, analyzes, integrates and reports data and provides information on areas including service utilization and claim disputes and appeals.

Following is a detailed flowchart and narrative description of the claims adjudication process for paper and electronic claims submissions.

Figure 7-1: Flowchart of Claims Adjudication Process



QNXT integrates member demographic data, case management information, provider information, service provisions, claims submission and reimbursement, and has modules that collect, store and produce information for the purposes of financial, medical and operational management.

QNXT, a HIPAA compliant claims processing and payment system, is capable of processing, cost avoiding and paying claims in accordance with ARS 36-2903, 2904 and AHCCCS Rules

R9-28 Article 7 and is adaptable to updates in order to support future AHCCCS claims related policy requirements as needed.

Organization-wide, Molina Healthcare currently receives 85.6% of all claims electronically. Molina ensures that it will meet AHCCCS program goals to receive and pay electronic claims in a timely manner. The Molina claims processing and payment system is HIPAA compliant and will be modified, as necessary initially and on an ongoing basis, in accordance with AHCCCS rules and requirements.

Claims Adjudication Process

Molina's claims adjudication process for both paper and electronic submissions ensures claims that pass the validation processes of Molina's electronic data interchange system are loaded into its claims adjudication and processing system QNXT. All claims are processed in receipt date order. Processes are established to ensure a prompt and accurate turnaround meeting all regulatory compliance standards.

Claims are received at the corporate office either as a hardcopy via mail (very small volume), via centralized post office boxes in Long Beach, California, or through electronic submission, electronic data interchange. Electronic data interchange claims are received daily from clearinghouses that format electronic data into standard 837 I or P file formats and uploaded into the claims processing system. The claim is routed through a preprocessor and then through Molina Claims Gateway. An image of the claim is also generated and can be retrieved through a claim viewer.

As claims are loaded into QNXT, the system assigns each claim entered a unique claim reference number. The claim reference number is an eleven-digit number that contains the receipt date information in the form of two digits for the year, three digits for the Julian date and six digits indicating the claims submission type (Electronic Data Interchange, Future Vision, ePortal or paper). The last five digits of the claim reference number are usually assigned in sequential order. For audit purposes, the system stores the username for the user that created the claim, the create date, the last user update and update date. The status of the claim is a key element in the inventory management process. As a result of the pre-load process, which verifies the member ID, pay-to, rendering physician, and service location, a claim is either uploaded to QNXT or if it fails, it will be rejected to the Editor for correction.

The Claims Management team monitors inventory via the claims workflow application and assigns examiners to specific claims queues for processing. As an examiner processes a claim, the claim may take several courses. The claim status and system assigned edit denotes what course the claim has taken and at what stage of the life cycle the claim is in. This is monitored in real-time through the claims workflow application.

The examiner may require assistance from other departments such as Provider Services, Configuration, Eligibility and Utilization Management to investigate a pended claim. If the exception noted requires assistance from another department, the examiner routes the claim to the appropriate queue assigned to the other department. These work queues are also utilized and worked by other departments such as Configuration and Utilization Management. Pended claims which are routed to other departments for processing are monitored in real-time through claims workflow reporting. The Claims Management team utilizes the claims workflow application to generate reports that provide the age of the claim and to ensure that other departments or the examiner are reviewing or processing those claims approaching internally established time frames.

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Monitoring Process for Accurate and Timely Claims Adjudication
Molina's Claims Management team has processes and procedures in place to ensure that all claims are adjudicated in an accurate and timely manner. Molina utilizes a number of key reports and applications to monitor and manage the claims inventory effectively.

In addition to the claims workflow reports previously described, the Claims Management team utilizes various other reporting which provides information regarding claims statistics, history of a claim, etc. These reports are published via Microsoft SSIS/SSRS self service model and offer the flexibility to denote parameters for specific date ranges, line of business, types of claims or a variety of other filters which creates the ability to have customized reports that will meet AHCCCS business needs. Molina will develop and implement, or modify existing reports as necessary, to meet AHCCCS requirements and reporting needs. This includes the development and implementation of the Claims Dashboard report as specified in the AHCCCS *Claims Dashboard Reporting Guide.*

Molina uses multiple system availability and performance monitoring tools to monitor its systems 24 hours a day, 365 days a year. Molina has its own Network Operation Center and Network Operation Engineers which are alerted when system resources reach critical thresholds or experience problems. These alerts received are detailed messages providing critical detailed information about the issue and directing network administrators to the root cause of the problem, thus reducing resolution time. Molina will provide AHCCCS staff information about the system events, status updates and resolutions on an hourly basis via e-mail and telephone.

Identification and Resolution of Deficiencies
Reports are used to identify deficiencies or issues with individual claims or across the claims processing and payment system. Molina's claims management team assesses deficiencies and develops a corrective action plan to research; resolve and report back to team leadership on the resolution of identified deficiencies. Additionally, a cross functional Provider Payment Initiative team has been formed to identify root causes and mitigate under/over payments. This team consists of individuals who have end-to-end work experience and will focus on identifying and implementing more efficient claims processes. This operational team will work closely with other functional teams such as the centralized Provider Telephonic, and the ePortal teams to understand the common payment inquiries and concerns expressed by the provider network.

Timeliness Standards
Molina's performance standard requires the adjudication of 95% of clean claims within 30 days of receipt and 99% within 60 days. Molina Healthcare is proud of its timeliness achievements across all contracts; Molina Healthcare's average turnaround time for clean claims is 99.7% within 30 days. Molina will meet AHCCCS timeliness performance requirements that 90% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

Internal and Independent Audits
Molina conducts regular internal audits of its claims adjudication processes. This audit verifies that the claims process is meeting all performance requirements and standards. Key elements of the internal audit are verification of the accuracy of payments against provider contract terms and adherence to regulatory and Molina Healthcare guidelines and policies. Additionally, the audit ensures that all reimbursement requirements are implemented as specified in the contract. This will be developed and implemented as part of Molina's internal audit function under the AHCCCS contract as well as in accordance with AHCCCS requirements.

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Molina performs daily, focal and process audits to ensure that contracts, processes and system changes are implemented correctly. Testing is also performed by Molina Healthcare's Claims Operations Projects and Initiatives team prior to implementation of complex contracts, contract changes and/or system enhancements or modifications. System changes cannot be implemented in QNXT until testing is completed and sign-off has been received.

Currently, Molina utilizes the services of Ernest & Young for regular internal control audits as well as its annual Sarbanes-Oxley Audit, which includes but is not limited to reviewing payment processing and the QNXT Claims Payment module. Auditors also conduct a comprehensive review of Molina's Claims Standard Operation Procedures to ensure that all control requirements are in place.

Cost Avoidance/TPL Activities

Molina will process and coordinate claims utilizing state-provided eligibility data and data from other insurance coverage. QNXT supports full coordination of benefits (COB) functionality including Medicare as primary coverage. Molina contracts with Health Management Systems (HMS) to verify other insurance coverage of its members. This service also provides cost avoidance and recovery mechanism by providing current information captured on Health Management System platform from various health plans. Health Management Systems verifies the member's eligibility monthly and adds data regarding other insurance coverage to each member's record, if identified. QNXT coordinates other health insurance at the claim line or at the claim header level, allowing for appropriate calculation of payment due for services rendered ensuring appropriate and accurate cost avoidance. For services where Molina is determined to be secondary, payment will be made in accordance with federal and state regulations allowing for payment up to the established allowable levels.

Molina pays covered services and makes reasonable efforts to recover payments for such services whenever it is determined that other health insurance was in effect at the time services were rendered. Recovered funds are posted in QNXT and applied against each applicable claim. Molina will bill the primary insurance carrier to alleviate provider abrasion and any billing issues for the provider of service. If Molina requests a refund from the provider of service and if the provider of service does not submit a refund, QNXT supports off-setting claims payments against monies to be recovered. Any individual recoupment in excess of $50,000 per provider will be submitted in advance to AHCCCS for approval.

Claims Inquiries

Molina utilizes multiple avenues for providers to inquire about claims status. Providers can call Molina's provider services telephone line, use Molina's Web-based ePortal gateway or research claims status via Emdeon's secure Web site. Molina sends daily status files to Emdeon to upload the data to its secure Web site for access by providers. Information available to providers include, but is not limited to, receipt date of claim through to finalization (paid/denied), including reason for denials, if applicable. Providers receive a remittance advice with each payment providing them payment details, reasons for denials, carrier information, including the address, if Molina is not primary and with claims dispute notification.

8. Describe what the Offeror will be doing to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.

To promote and advance electronic claims submission, Molina will participate in state sponsored Health Information Exchange sites intended to mobilize health care information electronically across organizations within a certain geography or community. Molina's appointed

Chief Executive Officer currently sits on the board of the New Mexico designated Health Information Exchange and will pursue similar engagement in Arizona.

Molina will work with AHCCCS to allow widespread adoption of electronic claim submission and acceptance of electronic funds transfer by providers. Molina understands that providers face significant challenges managing multiple systems and applications in a multi-payer environment and Molina technology framework has been developed to enable single sign-on of Molina's network providers to access its secure and robust self-service ePortal. ePortal is Molina's provider Web site that supports member and provider transactions via the Internet. ePortal is built on industry standards and highly scalable architecture with a framework that supports security standards such as SAML2.0, WS-Fed, and facilitates exchange of authentication tokens in a secure and reliable manner. The design of ePortal is flexible and can support variations across Health Information Exchange partners.

Molina promotes best practices with its provider network through education and reminders both in writing and in person. In addition, Molina has developed Pay-for-Performance initiatives which partially involve providers' usage of electronic services. Providers will be financially incentivized for the following:

- PCP office has an EMR in place and is actively using;
- PCP submits at least 97% of claims and/or encounters electronically; and
- PCP uses e-prescribing for at least 50% of all prescriptions.

Molina allows providers to submit claims electronically and encourages providers to accept electronic funds transfers. Providers that submit electronic claims and receive electronic funds transfers have given positive responses to the way both processes function. Molina encourages providers to enroll in the electronic funds transfer program during new provider training and through the course of normal communications. To assist providers to accept electronic funds transfers, Molina provides electronic funds transfer forms, which are available on Molina's Web site and on the provider ePortal.

Molina has entered into a partnership agreement with Emdeon to serve as its single source Electronic Data Interchange (EDI) clearinghouse for Molina's claims and encounter submissions. The partnership, referred to as Managed Gateway Agreement, is a single-vendor solution for Molina and helps manage its entire claim life cycle, thereby simplifying processes for its vendors and contracted providers. Emdeon accepts all electronic claims submitted from any direct provider, practice management system vendor, clearinghouse, or any other third party on Molina's behalf. Emdeon's claim edits are applied consistently to all inbound electronic claims. Emdeon also provides comprehensive claim tracking for both providers and payers' service representatives throughout the claim delivery cycle. Molina provider community benefits include:

- EDI Utilization – Emdeon has the ability to influence higher EDI utilization among Molina's provider community by helping them identify and overcome barriers to EDI (Growth Program) adoption, resulting in greater savings to Molina in the form of reduced EDI "churn," often experienced when competing EDI vendors convince providers to switch clearinghouses.
- Improved auto-adjudication rates/few pended claims through consistent editing and pre-adjudication claim scrubbing.
- Improved provider service with complete visibility and accountability in claim delivery.

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Molina currently exceeds AHCCCS Electronic Transactions receipt requirements of 60% for all Molina Geographic Service Areas (GSAs), and receives an average of 78.3% of all UB and HCFA claims electronically. This is based on volume of actual claims processed excluding claims processed by Pharmacy Benefit Managers (PBMs) submitted through Emdeon or Molina's Internet portal.

For rural GSAs, Molina exceeds AHCCCS Electronic Transactions claims receipt requirements and for comparable rural markets receives 70-80% of claims electronically depending on the market. This includes comparable long term care rural markets. This is based on volume of actual claims processed excluding claims processed by Pharmacy Benefit Manager (PBMs) submitted through Emdeon or Molina's Internet portal. Based on this, Molina is confident that AHCCCS claims Electronic Transaction receipt requirements can be met.

In 2010, Molina Healthcare processed over 13,800,000 claims; 84.4 percent submitted electronically, and 15.6 percent by paper. Claims received via EDI totaled 11,636,740; with 9,116,940 or 78.5 percent 1500 forms and 2,519,800 or 21.5 percent UB claim forms. Paper claims received totaled 2,177,830 with 1,896,946 or 87.1 percent 1500 claim forms and 280,884 or 12.9 percent UB claim forms.

Molina will strive to pay 60% of all claims electronically by 2012 in urban locations based on volume of paid claims excluding claims processed by Pharmacy Benefit Managers (PBMs). Molina currently partners with rural providers to increase adoption of electronic fund transfer (EFT) and is investing in technology to ease adoption of EFT by any provider for all Molina health plans.

Molina will submit a report to the ALTCS Operations staff on December 15th of each contract year if either electronic claims submission or payment volume is below 60%.

9. Provide a description of the clinical edits and data related edits included in the claims adjudication process.

Molina ensures that clinical edits and data related edits in the claims adjudication process are in accordance with AHCCCS Program Requirements and standards in Section D, Paragraph 29, Network Management; Paragraph 44, Claims Payment/Health Information System; and Paragraph 63, Coordination of Benefits/Third Party Liability.

QNXT utilizes a sophisticated array of clinical edits and data related edits that are used to adjudicate claims accurately and ensure data integrity. There are over 900 configurable edits within the QNXT system; some edits are inherent to the system and validate completeness and appropriateness of data entry. These edits are driven by the system integration of other key modules. Clinical edits and data related edits included in the claims adjudication process include validation for:

- Benefit Package Variations (benefits covered, including non-covered benefits);
- Adherence to Timeliness Standards;
- Data Accuracy (including service codes, such as ICD9, CPT, HCPC, bill types and revenue codes);
- Adherence to AHCCCS Policy;
- Provider Qualifications (active providers and contract status);
- Member Eligibility and Enrollment;
- Over-Utilization Standards; and
- Validation of services that are not part of contract terms.

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These validations generally provide header-level warnings/indicators to the claims examiner. Additionally, these trigger hard-coded edits that may not be overridden by an examiner to pay a claim and must be cleared or claim is denied.

System Edits
The Carrier Module contains the edits that guide claims payment. There are over 150 edits that can be configured by line of business to meet different requirements. The Configuration Analyst manages the edits and system security ensures that only this authorized role has access to configure edits. The edits may be configured and will trigger at the appropriate adjudication level. The edit may be set up to send a warning, which does not require that the edit be overridden to continue processing of the claim. The edit may also be set to pend or deny the claim. If the edit does not apply to the business needs, in some cases the edit may be turned off. Additional configuration includes identifying roles that can override specific edits. Edits for capitated encounters are used to ensure data integrity.

Billing Edits
Some of the edits are designed towards statistical and financial validation of provider billing and/or data entry errors. The following are some examples of these edits:

- Attending physician required for inpatient claims;
- Claim total mismatch;
- Primary ICD9 code required;
- Claim does not have service lines;
- CPT code not valid on date of service;
- Duplicate claim submission;
- Claim submission window exceeded;
- No COB entered with a secondary enrollment;
- Claim re-admission, previous claim detected;
- Prior authorized services do not match claim; and
- Review of claim required for indicated dollar amounts.

Configuration Edits
Edits for identifying system configuration requirements needed to process a claim are also available. Examples of these edits include:

- No active provider contract;
- Provider incomplete; and
- No enrollment exists.

Benefit and Contract Edits
The most complex edits link configuration logic from other modules to the Claims Module, such as a gender-specific benefit. In this case, data values from the Member, Benefit and Claims Modules would determine if an edit would trigger. Through this set-up, edits notifying the examiner of delegation of claims fiscal responsibility to another entity is also accomplished. Additional examples of these edits include:

- No benefit for service;
- Benefit has age restriction;
- Benefit requires prior authorization;
- Contract term requires documentation;
- Location-specific term does not match claim;
- IPA is responsible for payment; and

- No contract term found for service.

A claim triggering an edit requires that the examiner investigating the issue undergo a decision-making process. Part of that decision-making process includes determining if the claim should be referred to another department for expert review, if the claim should be denied, or if the root issue causing the edit has been resolved to allow payment of the claim. A claim may trigger multiple edits simultaneously or in a hierarchy fashion. Each edit requires a decision before the examiner can continue processing activities.

Molina Healthcare also contracts with Health Care Insight to provide an additional clinical edit review based upon Arizona AHCCCS approved Fee-for-Service edits, Medicare edits, including but not limited to National Correct Coding Initiative, etc. Prior day's claims in a pay/deny status are extracted nightly and sent to Health Care Insight for processing with 95% of the claims returned within less than 24 hours with no edits triggered. The remaining claims are reviewed by certified clinical nurse coders to ensure appropriate billing. The remaining claims are returned to Molina Healthcare within one business day with a recommendation as to the outcome of the entire claim or claim lines, with the edit being applied accordingly. The provider is informed of the denial reason via a remit code attached to the claim or claim line.

Recoveries

Molina identifies the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 800 through 999.9 (excluding code 994.6) external causes of injury codes E000 through E999 and other procedures. Molina will not pursue recovery in the following circumstances unless the case has been referred to Molina by AHCCCS or AHCCCS' authorized representative:

- Uninsured/underinsured motorist insurance;
- First-and third-party liability insurance;
- Tortfeasors, including casualty;
- Special Treatment Trust Recovery;
- Estate Recovery;
- Worker's Compensation; and
- Restitution Recovery.

Molina will report any case involving the above circumstances according to established AHCCCS protocol for determination of a "total plan" case. Upon determination of "total plan case status" Molina will utilize AHCCCS approved correspondence and appropriate mechanisms to recoup related costs in accordance with A.R.S. 36-2915 and A.R.S. 36-2916.

Encounters

Encounters Submission

10. Submit a description of the Offeror's encounter submissions process including, but not limited to, how accuracy, timeliness and completeness are ensured, how data is extracted from the system and the remediation process when AHCCCS standards are not met. The description should include the tracking, trending, reporting, process improvement, and monitoring submissions of encounters and encounter revisions. Include any feedback mechanisms to the encounter process that improves encounter accuracy, timeliness and completeness. The submission requirement will be a maximum of four pages and four pages of flowcharts.

Molina Healthcare has extensive experience in submitting encounter data to government agencies and private payers. Molina Healthcare currently offers Medicaid and Medicare services in ten states and is responsible for submitting encounter data to the appropriate government agencies adhering to the encounter submission and processing guidelines as outlined by the state's Medicaid/Medicare contract. For Encounter Data submission, Molina Healthcare follows national industry standards and code sets as published by HIPAA X12N supporting Medical (837P), Institutional (837I) and Dental (837D) form types, National Council for Prescription Drug Programs (NCPDP), and other data standard maintenance organizations. Molina Healthcare has established systems and processes to ensure accurate, timely and complete submission of encounter data for the ALTCS program services with or without financial liability. Molina Healthcare will ensure that all AHCCCS Program Requirements and standards are met in Section D, Paragraph 73, Data Exchange Requirements; Paragraph 74, Encounter Data Reporting; the AHCCCS Encounter Manual; and the AHCCCS Data Validation Technical Document related to encounter submissions. Molina Healthcare fully understands the importance of Encounter data and will participate in all activities, including encounter validation studies, undertaken by AHCCCS.

In order to ensure that the encounter data quality continues to be on the same level as fee-for-service claims, Molina has highly extensible validation engines that ensures the same stringent rules and edits. Molina will provide intelligent feedback mechanisms to its submitters ranging from dashboards to detailed reports via Molina's Web portal to help submitters understand and address any issues with the data received, thereby, improving encounter accuracy, timeliness and completeness. Molina Healthcare uses business intelligence tools, such as ProClarity, to understand trends and address issues that may not be visible by single dimensional reports. Molina Healthcare also utilizes analytic tools to understand and remediate any issues related to encounter submissions, including but not limited to inappropriate provider claim coding, completeness of claim data, inappropriate claim coding specific to provider service type, etc.

Upon contract award, Molina Healthcare will implement the encounter submission process described below in Claims/Encounter Submission Process. This encounter submission process will promote end-to-end data quality to achieve timely, accurate and complete submission of encounter data to AHCCCS. Molina will prepare, review, verify, certify and submit encounters for consideration to AHCCCS and certify that services were provided in accordance with AHCCCS format and other requirements, specifically requirements outlined in the *HIPAA Transaction Companion Documents and Trading Partner Agreements* and *AHCCCS Encounter Reporting User Manual.* Molina Healthcare will ensure that all submissions are received by AHCCCS well before, but no later than, 240 days after the end of the month in which the service was rendered. All processes related to Molina Healthcare's encounter submission process will be appropriately maintained and available to AHCCCS upon request.

Encounter Submission Process (Completeness Checks)
Molina Healthcare's robust state-of-the-art technologies ensure a comprehensive business process will be implemented to support the quality of AHCCCS claims and encounter data submitted to Molina.

Molina will implement quality checks to ensure accuracy, timeliness and completeness throughout the claims and encounter submissions process. These measures include:

- Acceptance and verification of claims and encounter data submitted to Molina via Molina's ePortal Web site. Providers, provider groups, IPAs, MSOs and vendors can log into Molina's ePortal Web site to submit their claims and encounter data files through secured SSL. Submissions are automatically logged and tracked through the Web site. Users can then view a log of all their submissions, including errors, to enable resubmission of any failed submissions.
- Acceptance and verification of claims and encounter data submitted to Molina via paper (e.g., scanning/imaging). All paper HCFA encounters, HCFA and UB claims, including those with claim attachments, will be picked-up on a daily basis by Molina's scanning and imaging vendor, Future Vision a subsidiary of Emdeon, to be scanned, Optical Character Recognition (OCR), and imaged. The claims will be scanned using batch count verification and high-level quality control processes within 24 to 48 hours of claims receipt. These files will be sent daily to Molina to load into the QNXT claims system for processing.
- Enforcement of timely claims submission and encounter data from providers and subcontractors by monitoring submission patterns and claims/encounter inventory including inventory totals, claims aging, and staff productivity.
- Timely claims processing and encounter data processing, as well as diligent enforcement of system edits to ensure AHCCCS data submission requirements are met.

Molina Healthcare has developed and will implement its enterprise-wide Encounter Operational Data Store, a comprehensive and fully automated encounter management system that will support data validation and business intelligence to meet all AHCCCS specific requirements relating to encounter submissions. The Operational Data Store is the repository for all Molina Healthcare's finalized claims and encounters and contains business critical subject areas including membership and provider information necessary for encounter submission. These business critical subject areas are exposed to Molina Healthcare's data warehouse/business intelligence platforms for ad-hoc analysis.

Claims Encounter Management System
Molina Healthcare's Claims Encounter Management System, a custom developed web-based application offers a 360 degree view of claims and encounters to Molina's staff, allowing data to be collected from all systems beginning at the gateway entry through submission to the state agency. The Claims Encounter Management System utilizes the Silver Light application which offers a variety of reports and metrics to provide enterprise-wide trends across claims and encounter data that are processed within different stages and environments. It also provides a detailed life cycle of a claim or an encounter, empowering users to know exactly how a claim/encounter progressed across the different QNXT environments. As part of the life cycle within the Claims Encounter Management System, Molina Healthcare staff can view a rejected encounter down to the claim detail level. Encounters pended and not submitted by Molina based upon Molina's validation edits or AHCCCS rejected encounters can be reviewed to determine

where the error occurred and why. Remediation is immediate as the Claims Encounter Management System contains the encounter rejection reason(s) and allows Molina the ability to review and resolve the issue accordingly and resubmit data in a timely manner to AHCCCS.

Figure 10-1 – Claims Encounter Management System
Claims File Life Cycle Flow Chart

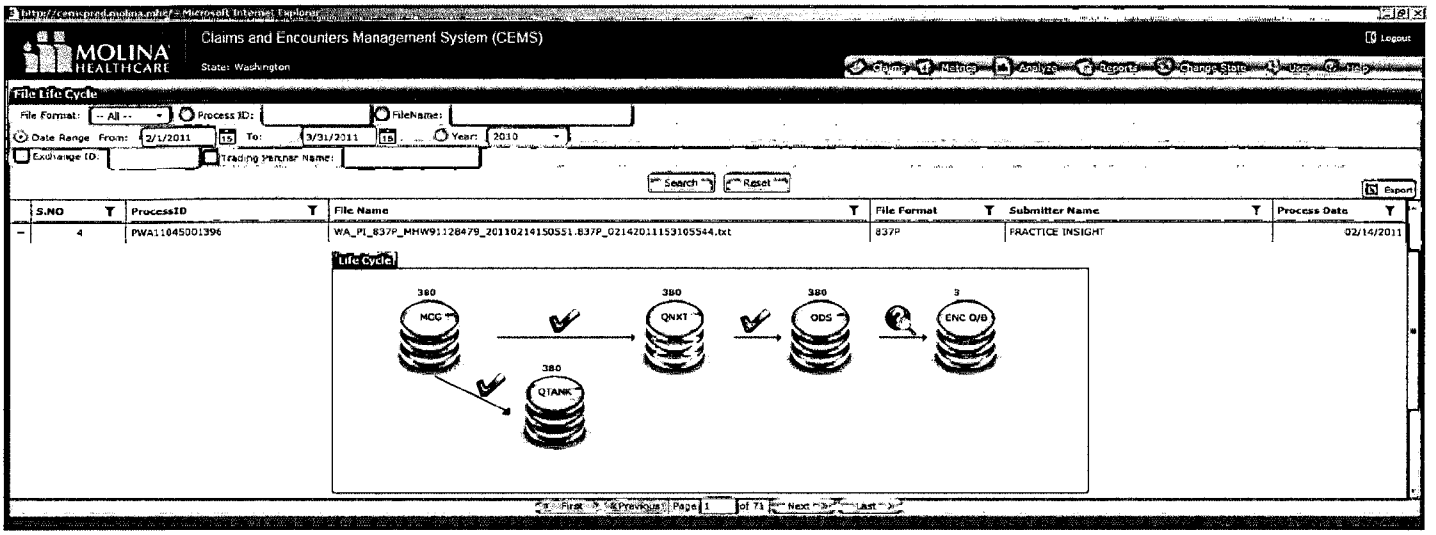
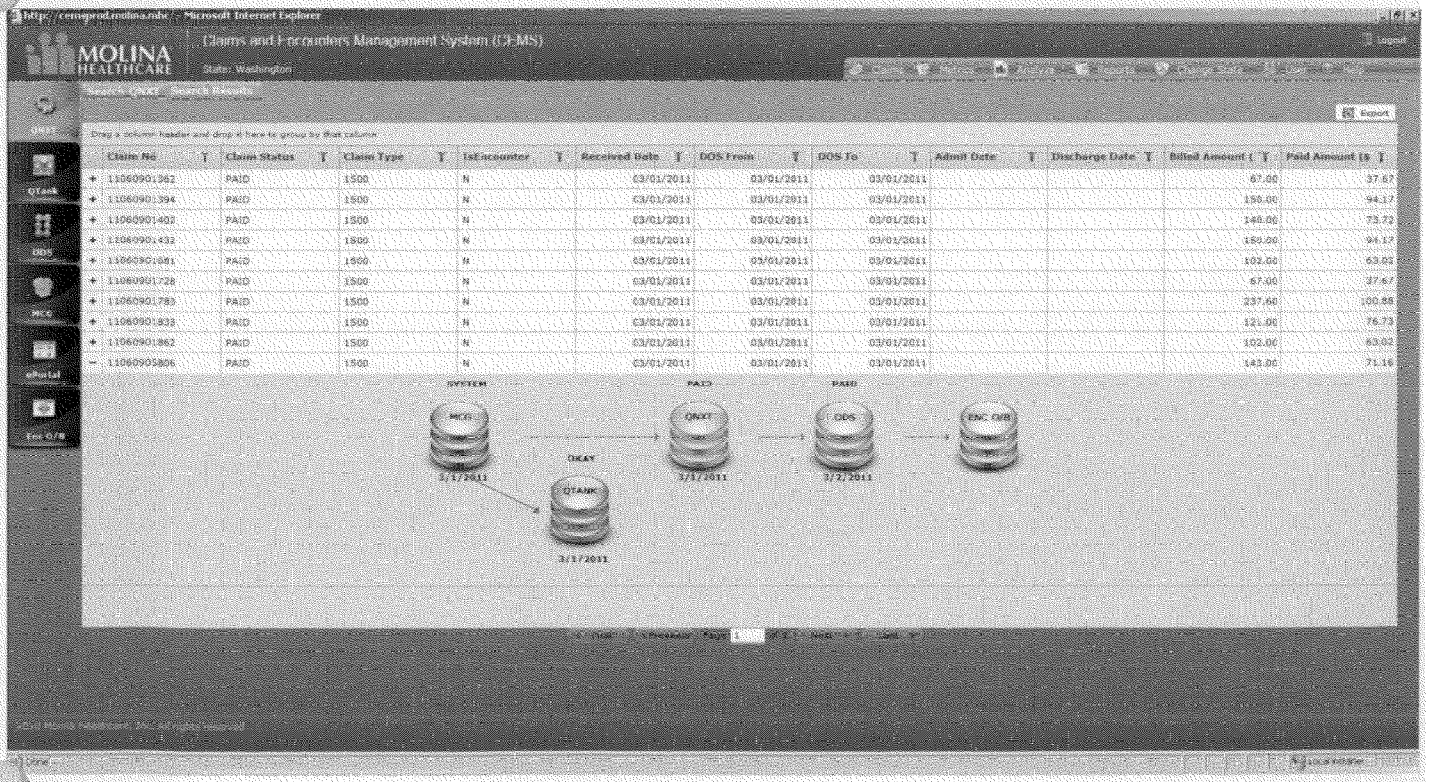


Figure 10-2 – Individual Claim Life Cycle Flow Chart



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Molina Healthcare is in the process of enhancing its encounter processes and improving its Claims Encounter Management System by utilizing additional validation measures to ensure the quality of the inbound and outbound encounter data. These measures include:

- Current tracking mechanisms are being enhanced to monitor resubmitted encounters more efficiently;
- The provider outreach program is being enhanced to include training providers on appropriate coding, submission and resubmission of encounters;
- Edits are being re-evaluated to recommend and implement changes, if applicable;
- Reports are being updated to ensure proper data is being provided for measuring and trending key indicators; and
- An enhanced vendor oversight process is being implemented to ensure providers, provider groups; IPAs, MSOs and vendors are submitting complete and appropriately coded encounter files.

Provider Network File Submission
Molina Healthcare has successfully submitted provider network files to several state health plans in support of encounter processing, and will implement the provider network file submission for the ALTCS program. Molina Healthcare's internal procedures and custom-written software will be updated to ensure all providers are correctly categorized and reported in accordance with the specifications and requirements defined by AHCCCS. The Provider Network File program sweeps through the data records of the QNXT Provider Module to extract the data elements required to populate the required format. The Provider Network File program also supports error reporting to allow operational units to correct information if necessary and include in re-submission or next submission to the state. This process can be modified to accommodate requirements in addition to provider network reports submitted to AHCCCS.

Encounter Reporting
Molina will submit encounter data to AHCCCS as frequently as necessary to comply with AHCCCS encounter submission requirements. These state files will include data for all fee-for-service claims (paid by Molina) as well as subcontractor paid claims from any period of time as specified by AHCCCS. The process to create the encounter file begins with claim identification and extraction. All finalized claims (claims in "Paid" status in QNXT including adjustments) will undergo internal validation to ensure completeness of member and provider data for reporting. The internal validation also includes application of state specific logic/edits to ensure data is accurate and complete. Submission of duplicate encounters ("duplicate" = same CRN) is eliminated by virtue of the selection logic that controls the process of preparing encounters for submission. Any errors flagged by the pre-submission validation process are reviewed by a health plan specific encounter workgroup facilitated by Molina Healthcare's Claims Operations staff meets on a regular basis to identify and coordinate resolutions as well as prepare the claims for submission to the state. All submitted claims are logged into the QNXT system for reconciliation and tracking purposes. Molina Healthcare's encounter submission process includes identification of adjustments. Therefore, Molina Healthcare can, if necessary generate a file for reporting of voids and replacements.

Claims that pass internal validation are then extracted into appropriate form specific files for reporting to the state. Encounters files follow state specified naming conventions and will be securely transmitted to the state in accordance to state established file transfer protocols.

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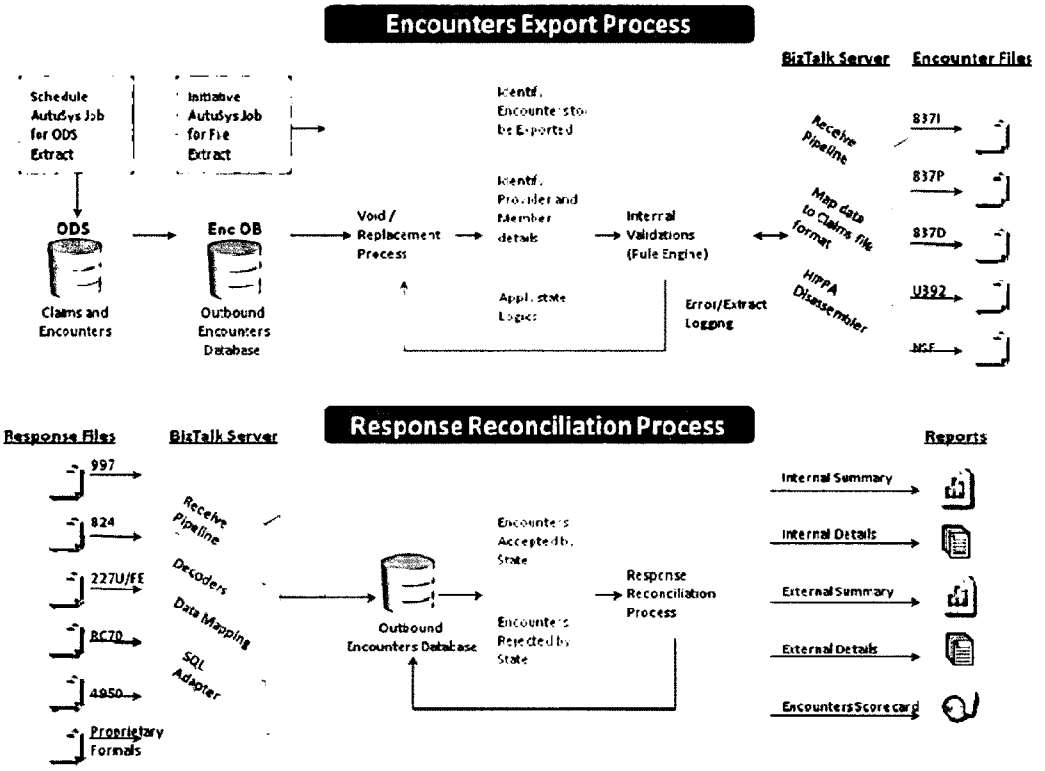
Encounter Remediation Process (Pended or Corrected Encounters)
Molina will meet AHCCCS requirements to resolve all pended encounters within 120 days of the original processing date. Molina will submit replacement or voided encounters, including recoupment that result in reduced or increased claim values, in accordance with AHCCCS requirements.

Molina Healthcare has established health plan specific cross-functional encounter workgroups facilitated by Molina Healthcare's Claims Operations where encounter related issues are reported, reviewed and corrected for resubmission. Molina Healthcare will establish a Molina Healthcare of Arizona cross-functional encounter workgroup tasked with ensuring the quality, timeliness and completeness of encounter submissions to AHCCCS in accordance with submission standards. Molina's remediation process when encounter submissions fail to meet AHCCCS standards will include a comprehensive review of the encounter process, including encounter submission, reconciliation and remediation. The cross-functional workgroup will work with its assigned AHCCCS encounter representative to research specific encounter issues. Upon completion of the remediation process, encounters will be resubmitted to AHCCCS to be processed. Key Molina encounter staff will participate in quarterly encounter meetings with AHCCCS and attend encounter training sessions to ensure complete, accurate, and timely encounter submissions to AHCCCS.

Encounter Process Improvement
The encounter reconciliation process also includes distributing retrospective data analysis to the specific state health plan encounter workgroup to support continued improvement of the encounter process. This state health plan encounter workgroup represents the end-to-end encounter process from claims/encounter, system configuration, information technology, provider information management, and health plan data/business analysis. The state health plan encounter workgroup is charged with the evaluation of retrospective data and coordination across departments to address submission errors/rejections and ensure data correction and resubmission. The encounter workgroup will also initiate and manage projects to coordinate any remediation efforts required to support the encounter resubmission process.

Figure 10-3 – Encounter Outbound – Data Flow Process



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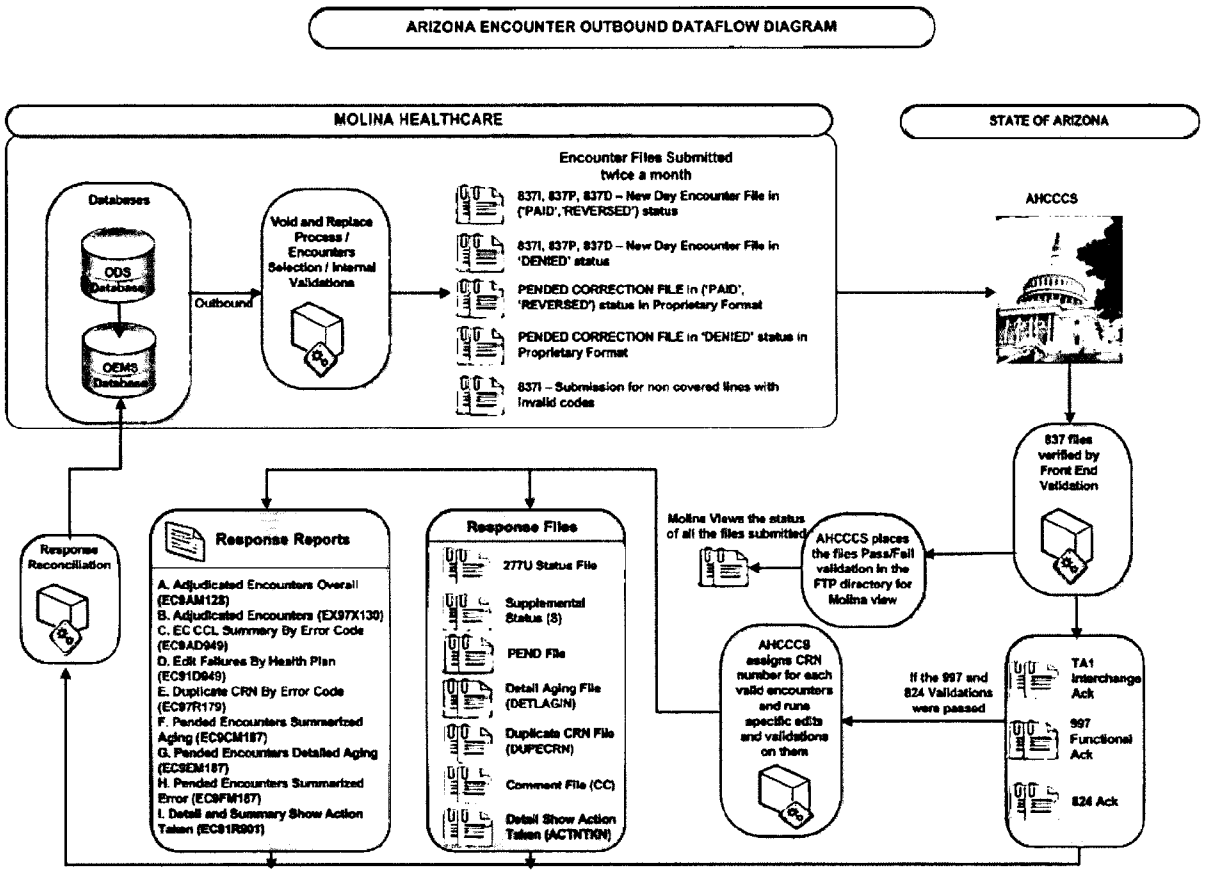

Encounter Tracking Reports

Molina will submit reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions of encounter and encounter revisions to AHCCCS as frequently as necessary and as required by the AHCCCS Encounter Manual requirements. Molina has the ability to produce encounter reports on request by leveraging its Encounter Operational Data Store and associated analytic tools. Specifically, Molina will maintain and make available to AHCCCS encounter data and reports in accordance with AHCCCS encounter reporting requirements. For example, Molina will develop and make available the required Encounter Submission Tracking Report, as well as a report to reconcile financial fields of a claim to the financial fields of an adjudicated encounter. Both reports will facilitate the linkage of claims to encounters.

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Information Services

Information Services Submissions

11. Describe the structure (internal and external) of the Offeror's information system and the hardware and software that supports or will support the ALTCS line of business, including a diagram of the information system and data processing flow with all existing or planned interfaces. If not a current ALTCS Contractor, the Offeror must include a detailed plan for ensuring that all IS requirements will be met prior to the contract start date. The submission requirement will be a maximum of ten pages, plus flowcharts.

Molina Healthcare Information Services is a centralized corporate department that supports its managed care programs information system architecture for application management, development, Electronic Data Interchange, database administration, network management, server/storage administration, data center management, monitoring, communication systems and disaster recovery. The structure of Molina Healthcare's information system is designed with state-of-the-art technology to support care coordination for its Long-term Care, Aged, Blind and Disabled, and Medicare members by focusing on quality, compliance and growth, data, and systems management.

All Molina Healthcare health plans operate on a consolidated set of applications in QNXT™, its core claims processing system. Similarly, all Molina Healthcare health plans utilize the CareAdvance application for case management and disease management. Molina Healthcare's information systems technology infrastructure is designed to allow operational cost savings for its health plans as it expands into new states or lines of business. In addition, Molina Healthcare's Information Services is able to quickly apply reusable technology components to state partners from its library of proven solutions. Molina Healthcare's technology platform has a demonstrated track record to scale and take on new opportunities and future growth. Some key metrics in the existing technology environment include:

- 3 million annual phone calls handled via the Cisco VoIP System;
- 12 million annual claims adjudicated in QNXT;
- 2 million annual inbound encounters processed through Molina Information Technology systems;
- 20 million annual Medicaid eligibility transactions processed by BizTalk-based EDI framework;
- Over 700 physical and virtual servers managed in the primary and secondary data centers; 50% of current server base is supported on the most current VMware technology;
- Over 55 office sites managed across a unified MPLS-based network for voice and data;
- 400,000 annual authorizations/referrals managed by Molina Information Technology's Paperless Utilization Management System;
- 600,000 annual Self-Service Interactive Voice Response Transactions which service both members and providers; and
- 3 million annual transactions executed via the member and provider self-service portals.

Claims Payment/Health Information Systems

QNXT has fully integrated modules for members (enrollee/eligibility), providers, encounters and other claims, finance, utilization management/quality improvement, authorizations, benefits, contracts, credentialing and reporting. These modules are fully integrated and relational to each other as all data resides in a single database repository. Utilizing QNXT, Molina Healthcare currently supports over 1.6 million lives across ten Medicaid plans as well as its Medicare lines of business in several states.

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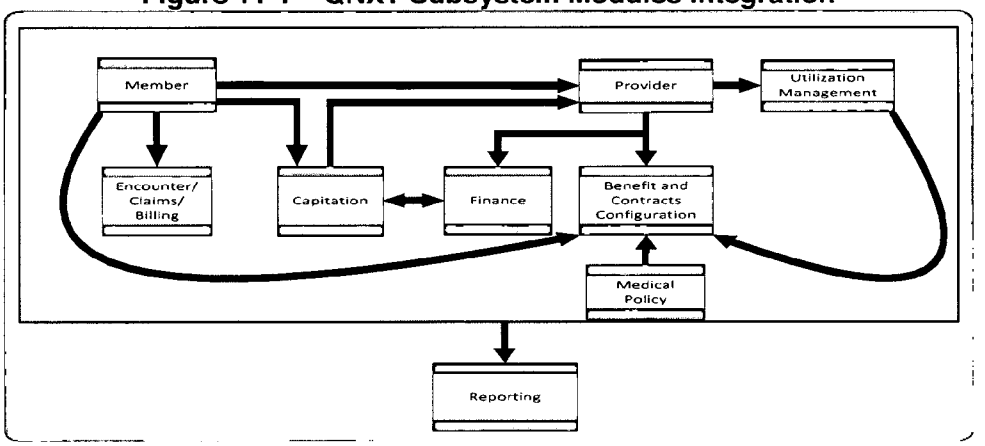
QNXT is an integrated application system designed specifically for health plans specializing in Medicaid programs to achieve high performance, availability and scalability. QNXT is a fully configurable system that enables Molina to customize system requirements to the extent that it meets or exceeds the Model Medicaid Management Information System requirements. Its extensibility and scalability allows it to also support capacity changes, growth and increase in claims or member enrollments. Designed to encompass an "n-tier" environment and service-oriented architecture, QNXT offers the flexibility and functionality that allows Molina to achieve optimal growth and efficiency. Key features of QNXT include simplified data retrieval from centralized databases; synchronized data in one central location; flexible, powerful and user-friendly Web interface; and integrated comprehensive modules.

Molina Healthcare's single core managed care system provides significant advantages to state regulatory agencies, members and providers, including expedited eligibility verification, streamlined claims process/database management, and instant access to complete information for Utilization Management and Quality Improvement review. By utilizing a centralized relational database, QNXT supports a single source of data updates, which in turn promotes the efficient use of data and consistent information. The figure below illustrates the integration of modules and use of data in QNXT.

Figure 11-1 – QNXT Subsystem Modules Integration



The following QNXT Subsystem Modules Summary table provides a brief description of the functions and capabilities of each QNXT module.

QNXT Subsystem Modules Summary

Module	Description
Member	Creates and maintains member demographic data; enrolls members in benefit plans and assign members to primary care physicians; stores and tracks calls from members.
Provider	Manages all aspects of provider records including demographic data, information about which providers participate in different lines of business and networks, relationships between providers, contractual and payment agreements a provider has, and a provider's membership assignments.
Encounter/Claim Processing	Enables Molina to quickly and accurately record, process and pay for healthcare services rendered by providers and other organizations.
Finance / Capitation	Supports claims payment, capitation payment and premium billing functionality and allows Molina to create customized reports about the financial performance of its health plans and lines of business.
Premium Billing	Enables premium bill generation, pending invoices, final bill and void invoices. It also enables consolidated billing, subscriber billing, and arrears billing (non-monthly billing cycles).

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Module	Description
Utilization Management	Enables effective and accurate authorization generation, user and monitoring of service requests and rendered services from providers.
Benefits and Contract Configuration	A centralized repository of information used by many other QNXT modules including the Member, Provider, Claims, Credentialing, Call Tracking, and Member modules.
Reporting	This primary reporting tool for QNXT is used to simplify and enhance the cataloging, viewing and printing of reports, forms and letters by business users for operational, administrative, and regulatory reporting to the state agencies.
Medical Management	Provides flexibility to setup and configure specific business drivers to avoid unnecessary overpayments/underpayments.

Key Software Applications Integrated with QNXT

Molina Healthcare has developed and implemented a robust information system application footprint covering all of its managed care processes. These applications are comprised of custom developed and other key third party applications that interface with QNXT. These integrated applications provide additional functionality and meet all compliance requirements. Following are examples of selected custom developed and third party applications that are integrated with QNXT.

Application	Description
Claims Workflow	Claims Workflow is a custom developed application that supports the distribution of work throughout the various departments that process claims for Molina Healthcare health plans. The application is capable of displaying specific claims image for quick disposition. Built-in extensive reporting and dashboard provides a clear view of operational activities, transaction details, progress, aging and many other measurements at any point in time for managers and supervisors to plan and execute tasks efficiently.
Clinical CareAdvance System	Clinical CareAdvance System, a web-based integrated platform for performing Case and Disease Management. It enables a member centric view for clinical users by aggregating data from variety of sources such as claims, pharmacy, lab, etc. Clinical users can leverage sophisticated criterion to identify and stratify 'at risk' members, generate guidelines based care plans, perform health risk assessments, and track and document member interaction. Clinical CareAdvance is highly configurable and can be customized easily to add new assessments, forms, letters etc. using the content editor.
Utilization Management System	The Utilization Management System is a comprehensive web-based workflow application that automates the entire life cycle of prior authorization, concurrent review and case management faxes from receipt to delivery and back to the provider. The application has built-in features to enforce turnaround time as faxes move electronically between clerks, coordinators, nurses and the medical director. It has an extensive set of fax editing features that allows Molina Healthcare to annotate/stamp electronically on faxes, and stitch separate faxes and electronic documentation into a single file. The application is integrated with Interqual to help Molina Healthcare assess medical necessity. The Utilization Management System keeps track of the Interqual reviews and associates it with the case in UM/K2. Robust security enforces role based privileges and ensures members' protected health information is not compromised. An integrated search feature provides the ability to track a case or pull up historical information with the click of a button. Reporting dashboard provides the ability to manage day to day operational needs. The application is integrated with Molina Healthcare's core claims system QNXT to obtain claims, eligibility and demographic information. This allows users to progress through the workflow without disruption or accessing other applications for reference information. Prior Authorizations are automatically selected by QNXT claims process during adjudication based on Authorization settings and match criteria. If QNXT does not find a

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Application	Description
	matching Prior Authorization, claim adjudication will continue to process the claim. If the benefit or contract configuration requires a Prior Authorization for the claim line, the appropriate edit will trigger if configured. The system provides a completely paperless solution that reduces administrative hours, increases staff productivity and allows more time to interact with providers and members.
Appeals and Grievances System	The Appeals and Grievances System is a Web-based application that enables the management of appeals and grievances process. It interfaces with QNXT to initiate or follow up on appeals or grievances logged into the QNXT call tracking module. Rules can be configured within the system to determine the types of appeals and grievances to be managed and pulled from QNXT. The application is also integrated with sophisticated document generation software that allows the generation of letters for providers or members. A configurable reporting dashboard allows the generation of reports for managing day to day operations. The application also assigns appeals and grievances to the appeals coordinators based on configurable criterion. If required, extracts can be generated from the application to address needs mandated by the state.
Visual Cactus System	Visual Cactus is a third party credentialing management application, fully configurable to allow business users to define and store custom provider attributes. Ad-hoc queries can be designed and run through a user friendly wizard in addition to leveraging standard reports. It has a robust security module to protect confidential information.
WebStrat	WebStrat third party coding, compliance and reimbursement management system is a browser-based application that delivers the necessary tools for payers to efficiently reimburse providers using PPS. Molina Healthcare has developed a custom interface for this application to seamlessly integrate pricing and grouping data between QNXT and WebStrat. WebStrat is HIPAA-compliant and offers support for more than 30 state- or payer-specific payment systems and is browser-based; therefore, it can be easily deployed to multiple users throughout the enterprise. It effectively manages risk using prospective payment, calculates reimbursement for inpatient out-of-network claims using DRGs, and calculates reimbursement for outpatient out-of-network claims using APCs.
Interactive Voice Response (IVR)	Molina Healthcare robust telephony infrastructure is supported via leading edge VoIP Cisco technology. Services provided include: ID card request, PCP change request, authorization status, claim status, and eligibility verification. The Interactive Voice Response system is integrated with live QNXT data, and retrieves real time information for providers and members on a 24/7 basis. Currently Molina Healthcare's Interactive Voice Response handles 80,000 to 85,000 calls per month.
Molina Healthcare ePortal	Molina Healthcare has deployed a secure electronic portal (ePortal) comprised of a provider portal, a member portal and a File Management System. ePortal gives providers 24/7 access to member eligibility information, allows claim submission (HFCA 1500) and inquiry on status of claims submitted. Providers can submit authorization requests directly into the main system. Other features of ePortal for Providers include verification of member eligibility/benefits, submission of National Provider Identifier, obtaining patient roster and downloading their affiliation lists, service forms, and nurse advice line reports. Members have similar functionality including ID card request, PCP change request, benefit verification and ability to reference health and wellness materials.
Operational Data Store (ODS)	Operational Data Store is a single 'source of truth' for all claims and encounter inbound data submitted by various sources including providers, IPAs, and also via the Molina Healthcare ePortal. Operational Data Store aggregates information from multiple systems, processes, and repositories to provide a seamless view of Claims and Encounters life cycles. Data Marts and Data Cubes are built upon this system for data aggregation and reporting purposes. Analysts and managers have full access to generate reports, perform complex analysis, create compliance related submissions/reports and slice and dice the historical data for various purposes. This tool also provides high-level dashboards where executives can look at key performance indicators at a glance and drill-down from high-level totals to detailed data and based on security privileges. Operational

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Application	Description
	Data Store and Data Mart are supported by a dedicated group of analysts and database administrators that define processes and standards to ensure data quality and integrity. The Operational Data Store infrastructure is designed for 24/7 operations and is designated as a critical application continuously monitored by the Molina Healthcare Network Operations Center.

Information Systems Hardware and Software
Molina Healthcare's Information Systems hardware and software infrastructure is capable of performing all required Information Technology functions to support AHCCCS requirements for the ALTCS program. Molina Healthcare has invested in the latest technologies and most reliable support systems to provide timely, accurate information and services to State and Federal government agencies and its members and providers. These information systems technologies include:

- Voice Over Internet Protocol (VoIP) telephony systems from Cisco Systems;
- Interactive Voice Response (IVR) with provider and member self-service also based on Cisco Technology;
- RecoverPoint Disaster Recovery technology (used by the Federal Reserve Bank) that enables a 30 minute recovery of Molina core systems to its data "hot" site;
- Symantec's NetBackup Technology for fully automated remote backup and off-site storage;
- Virtual Machine server technology (VMware) with sophisticated server clustering technology; and
- State-of-the-art Data Center and Network Operations Center that provides 24/7/365 support for all systems and network infrastructure. Molina has implemented industry standard safeguards to include physical security measures such as card access systems, locked storage to secure equipment, 24/7 surveillance, and enforcement of policies and procedures for Data Center visitors e.g., full-time escort.

Hardware Architecture
Molina Healthcare's hardware architecture includes:

- Server and Storage Systems:
  - Unisys ES7000 server platform to host the QNXT core claims processing application and the Business Intelligence application;
  - EMC Clarion Series Storage Area Network to house non-production QNXT SQL Databases;
  - EMC Symmetrix vMAX system is a high-end storage array to support high-capacity 750GB SATA II disk drives alongside high-performance 4 Gb/s Fiber Channel disk drives;
  - HP Blade Technology that provides highly manageable, scalable, fault tolerant systems to more efficiently manage the data center rack and floor space;
  - Quantum Scalar i500 LTO-4 Tape Library to backup all corporate-wide information including SQL databases, cubes, files, Exchange mails and claims imaging; and
  - HP Proliant Series Server (Proliant DL500 and DL300 Series) to host the production Microsoft SQL databases.
- Network Infrastructure Systems – At its core network, Molina Healthcare deploys enterprise class hardware Cisco 7200 series routers for MPLS connectivity and Cisco's Nexus 7000/5000/2000; a flexible, versatile and tested platform of Catalyst 6500 switches known

for its high performance, availability and scalability. At the edges of its network, Molina Healthcare deploys Cisco's 3800/2800 and 1700 routers, and catalyst 4000/3500 switches that are feature-rich, secure and easy to manage.

Software Architecture
Molina Healthcare's software architecture includes:

- Windows 2003/2008 infrastructure to run business critical applications;
- Windows Terminal Services to deliver Windows-based applications to virtually any application or computing device;
- Microsoft SQL Server 2005/2008 to support its mission critical applications;
- Windows Exchange Server 2007 designed for large enterprise corporations, allows multiple storage groups and multiple databases to be created;
- Cisco's Voice over Internet Protocol Communication System for enterprise telephony needs;
- Cisco Call Manager Phone System, an integral component of the Cisco Over Internet Protocol Communications system, the software-based call-processing component of the Cisco enterprise Internet Protocol telephony solution; and
- BizTalk 2009, a Microsoft enterprise application that enables automation of business processes.

System Management Tools and Utilities
The System Management Tools and Utilities include:

- Altiris, an integrated Information Technology life cycle management suite of products that allows for seamless management for desktops, notebooks, handhelds and servers;
- Autosys, a job scheduling tool that provides operational advantages to manage dependency, provide file watcher, status monitoring and combine various jobs for easy operation;
- Citrix an application virtualization solution for providing any user with secure access to client/server applications from anywhere, using any device or connection;
- Symantec Netbackup software to schedule and perform daily backups of its data onto tape media;
- System Center Operations Manager solution that reduces the complexity associated with managing today's Information Technology infrastructure environment and lowering the cost of operations;
- IronPort's secure email server enables Molina to automatically secure online communications with its providers and partners by redirecting email to a secure, encrypted message channel based on policies that identify protected health information;
- MoveITDMZ a secure managed file transfer system optimized for mission critical encrypted file and data transfers with trading partners;
- Team Foundation Server that allows for source control, data collection, reporting and project tracking intended for collaborative software development, and
- Test Director, a software test management tool used to automate and organize the testing process.

Figure 11-2 displays a diagram of Molina Healthcare's information system and Figure 11-3 displays a diagram of the data processing flow with all existing or planned interfaces that will support the ALTCS program.

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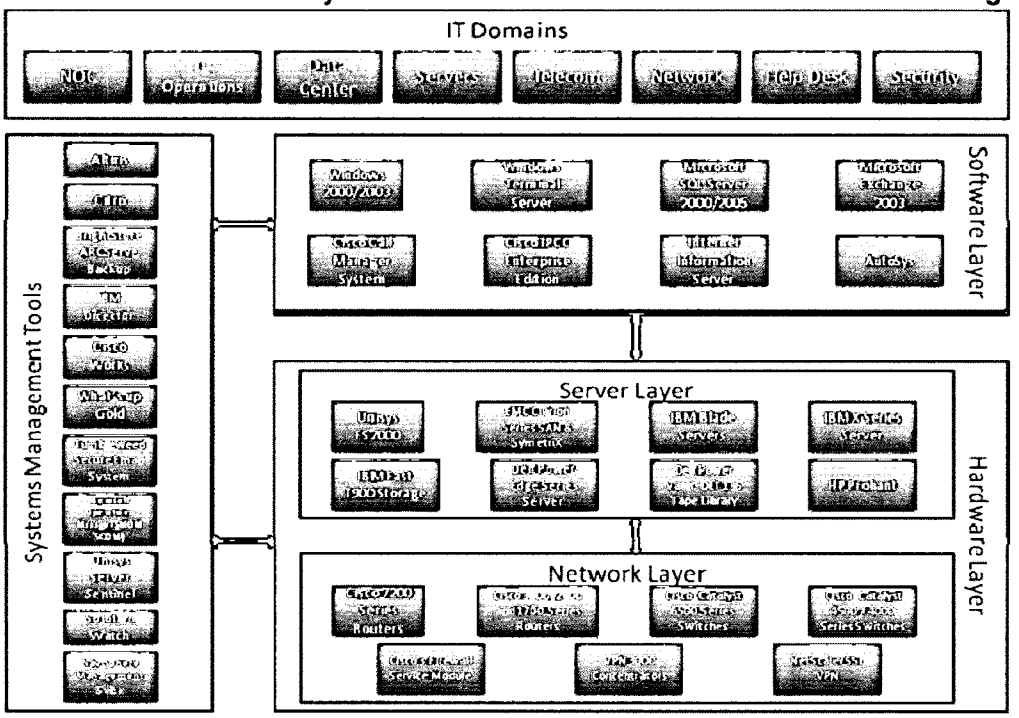
Figure 11-2 – Information Systems Hardware and Software Infrastructure Diagram



Molina Healthcare's competitive advantage is that it has invested in vital infrastructure enhancements to its network and supporting systems to provide a robust centralized framework that supports its membership growth, strategic direction and priorities. Molina Healthcare's Information Systems hardware and software is specifically designed for government claims and administrative data processing. This is a cost-effective model for integrating new business lines and maintaining ongoing transactions. Molina Healthcare utilizes best practices in employing system components, infrastructure and computer systems that are robust, scalable, high performance, and industry standards.

Trading Partner Interface

Molina Healthcare uses various combinations of network technologies to provide secure and reliable access to its data resources. Molina Healthcare's Trading Partner Services team establishes and maintains communication links with the various state agencies and exchanges data files with trading partners either via secure file transfer protocols, secure login to the Trading Partner Services Web sites to post and retrieve files utilizing Virtual Private Network secure connection via the internet.

Molina Healthcare has developed and implemented the following electronic healthcare transactions covered under HIPAA:

- Claims/Encounter Data – ASC 837 Professional, Institutional and Dental claims;
- Eligibility – ASC 270/271 Eligibility Inquiry and Response and ASC 834 Benefit enrollment and maintenance transaction;
- Referral Certificate and Authorization – ASC 278 health care services request for review and response;
- Claim Status – ASC 276/277 Healthcare claim status request and response;

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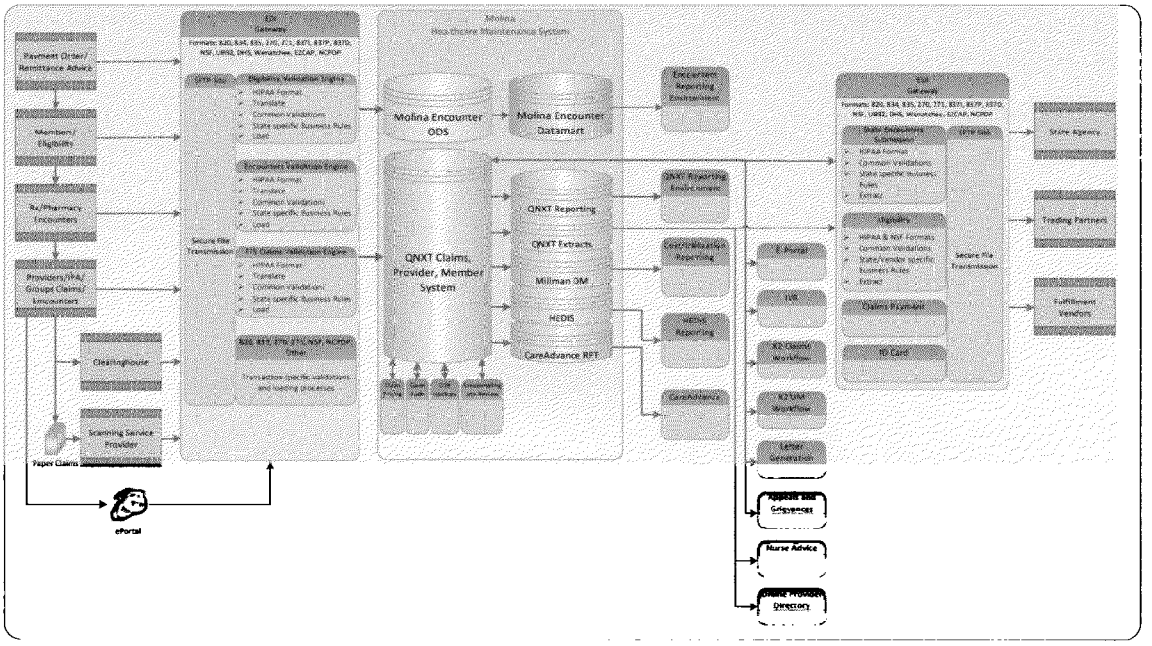
- Payment and Remittance Advice – ASC 835 Health care claim payment/advice; and
- Functional acknowledgements – ASC 997's, 824's and TA1 transaction sets.

Data Processing Flow and Interfaces

Figure 11-3 Data Processing Flow and Interfaces diagram provides a high-level progression of inbound and outbound data and process flows for all key business processes as well as the interfaces with major Information Systems applications supporting these processes.

Figure 11-3 – Data Processing Flow and Interfaces Diagram



These major functions include Membership, Provider/Service Coordination and Encounter/Claims. The following data flow descriptions are the highlights of each function.

Eligibility/Enrollment File Processing

Molina's eligibility/enrollment process is completely automated including PCP auto assignment and ID card generation, by downloading a raw data file or 834 file to the core administration system (see Figure 11-4 Eligibility Inbound Process). The 834 process reports generated provide detailed status information about the enrollment process. The enrollment process is also monitored by Molina Healthcare's state-of-the-art Network Operation Center through completion.

Molina Healthcare's inbound eligibility/enrollment process leverages a custom-developed, highly-integrated technology solution utilizing .NET and Microsoft BizTalk to provide extensibility and scalability for managing and processing inbound eligibility data before it is loaded into QNXT. Processes are also "re-startable" from the point of interruption or at any point throughout the process.

File Download – The enrollment process will begin when Molina receives the Benefit Enrollment and Maintenance Transaction File from AHCCCS. The file is downloaded from the secured trading partner location and runs through initial validation procedures that confirm the file layout, record counts and HIPAA compliance. Any anomalies in initial validations will immediately be reported to AHCCCS.

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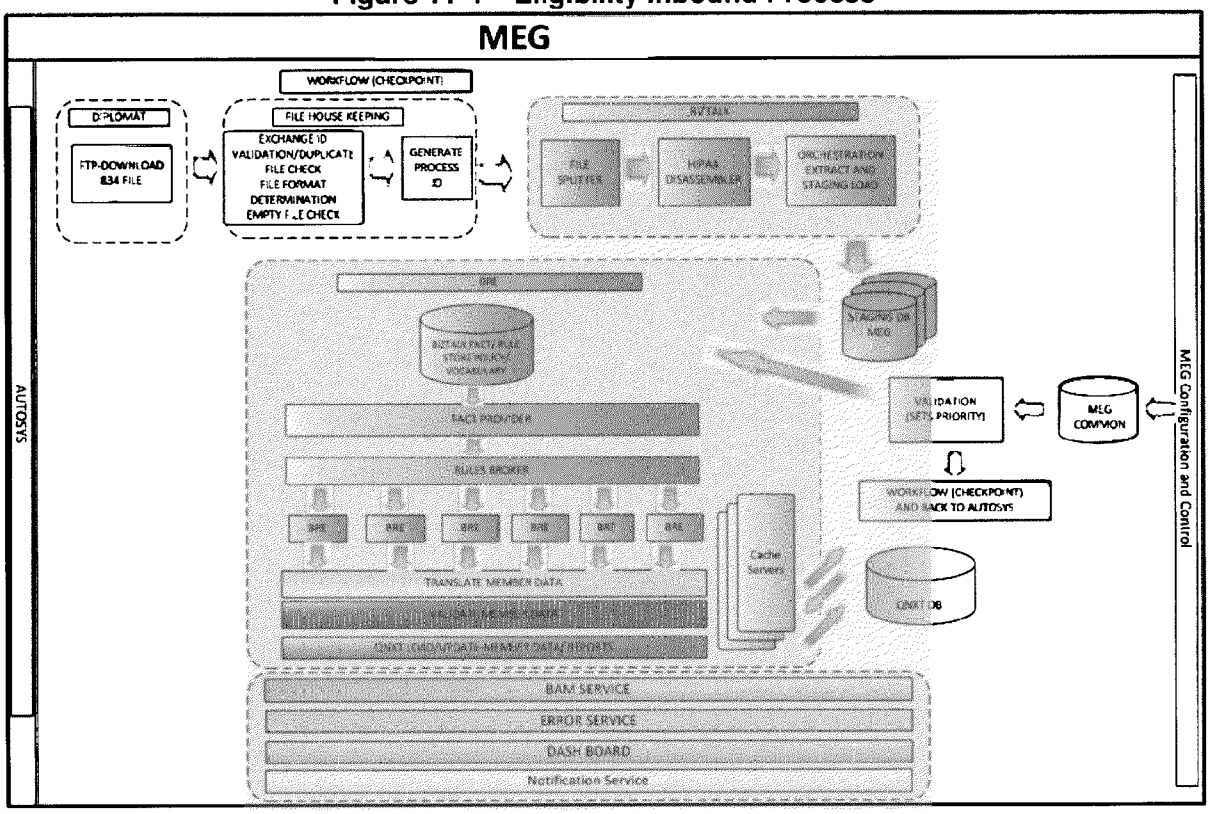
Figure 11-4 – Eligibility Inbound Process



The file then runs through a series of processes as described in the table below that include Translate, Validate and Load to ensure the accuracy of data before the eligibility information is processed into the QNXT platform.

Process	Description
Translate	• Validation of critical Member Level Information like Category of Aid or Medical Eligibility Code (ME Code), Region or County Of Residence, Date of Birth (DOB), Medicaid Number and SSN. Clean records are moved to the "validate" stage of the process. • Error records are flagged and reported to health plan Eligibility team for resolution.
Validate	• Process to identify member records as "Add", "Modify", "Continue" or "Term" utilizing key member data elements such as Medicaid ID/SSN, name, DOB, etc. • Molina terminates the enrollment of members who are not in the eligibility file; however, this rule can be modified as required by states to keep the members active until explicitly terminated.
Load	• Successfully validated member records are processed into QNXT. • Process includes Member PCP assignments as well Coordination of Benefits (COB) validation.

Operational Reports

In addition to standard reports, operational reports such as Membership Count, Invalid Service Area Code, Duplicate Medicaid ID, 834 Weekly Reconciliation Reports are also generated and provided to the health plan.

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Electronic Data Interchange (EDI) Claims

Molina Healthcare has entered into a partnership agreement with Emdeon to serve as its single source Electronic Data Interchange (EDI) clearinghouse for claims and encounter submissions to Molina Healthcare. The partnership, referred to as Managed Gateway Agreement, is a single-vendor solution for Molina Healthcare and helps manage its entire claim life cycle, thereby simplifying processes for its vendors and contracted providers. Emdeon will accept all electronic claims submitted from any direct provider, practice management system vendor, clearinghouse, or any other third party on Molina Healthcare's behalf. Emdeon's claim edits will be applied consistently to 100% of inbound electronic claims. Emdeon will also provide comprehensive claim tracking for both providers and payers' service representatives throughout the claim delivery cycle. Molina provider community benefits include:

- Electronic Data Interchange Utilization – Emdeon has the ability to influence higher Electronic Data Interchange utilization among Molina's provider community by helping them identify and overcome barriers to Electronic Data Interchange (Growth Program) adoption, resulting in greater savings to Molina in the form of reduced Electronic Data Interchange "churn", often experienced when competing Electronic Data Interchange vendors convince providers to switch clearinghouses;
- Improved auto-adjudication rates/few pended claims through consistent editing and pre-adjudication claim scrubbing; and
- Improved provider service with complete visibility and accountability in claim delivery.

Molina Healthcare is in discussion with Emdeon to explore a single source attachment solution that enables payers and providers to electronically transact documents supporting the adjudication of a claim.

Paper Claims (Future Vision)

In January 2010, Emdeon announced the purchase of Future Vision, Molina Healthcare's vendor for scanning and entry of paper claims and encounter submissions. This allows Emdeon to be a single point of entry for all Molina Healthcare's inbound claims and encounter processes, regardless of the method of the submission.

All paper HCFA encounters, HCFA and UB claims, including those with claim attachments are picked-up on a daily basis by Molina Healthcare's scanning and imaging vendor, Future Vision, to be scanned, OCR'd (Optical Character Recognition) and imaged. Future Vision performs a document preparation process; inventory control logs are created. The claims are scanned using batch count verification and high-level quality control processes.

Future Vision's quality control processes include a five-step process that is geared to perform comprehensive validation of data and character recognition results. Critical fields, including additional fields identified by Molina Healthcare, are verified. The claims are imaged and exported to a multi-page TIFF image file and the claims data is exported to a data file. The data files are run through a final system quality check and must be approved by the Future Vision account manager. Future Vision provides a turnaround of 24-48 hours from receipt of the claims.

Management Information Systems Operations staff connects to Future Vision's secure FTP site and download the data and image files. Molina performs a record count validation as well as verifies the Julian dates for the receipt date of claims. Once the validations are successfully completed, the files are processed through the Molina Electronic Data Interchange Gateway process described in further detail in the next section. The claim image files are unzipped into

Molina's imaging database and a final validation is performed to ensure the images are viewable. After the files have been loaded, a notification is submitted to the Claims department to inform them that the data has been successfully imported and is available for claims processing.

Molina Healthcare also leverages components of the Electronic Data Interchange Gateway to support Electronic Data Interchange with its subcontractors to process and administer HIPAA-compliant claims processing. Molina Healthcare performs oversight management with respect to these vendors. Retail Pharmacy claims, dental claims or other carve out vendors are processed using HIPAA-compliant formats by Molina's Pharmacy Benefit Manager and other carve out service providers. All subcontracted vendors submit encounter data to Molina using the HIPAA-compliant formats leveraging the HIPAA Electronic Data Interchange Gateway for encounter reporting to the State Medicaid Agencies and for eligibility and claims outbound requirements to Molina vendors.

Information Systems Implementation Plan

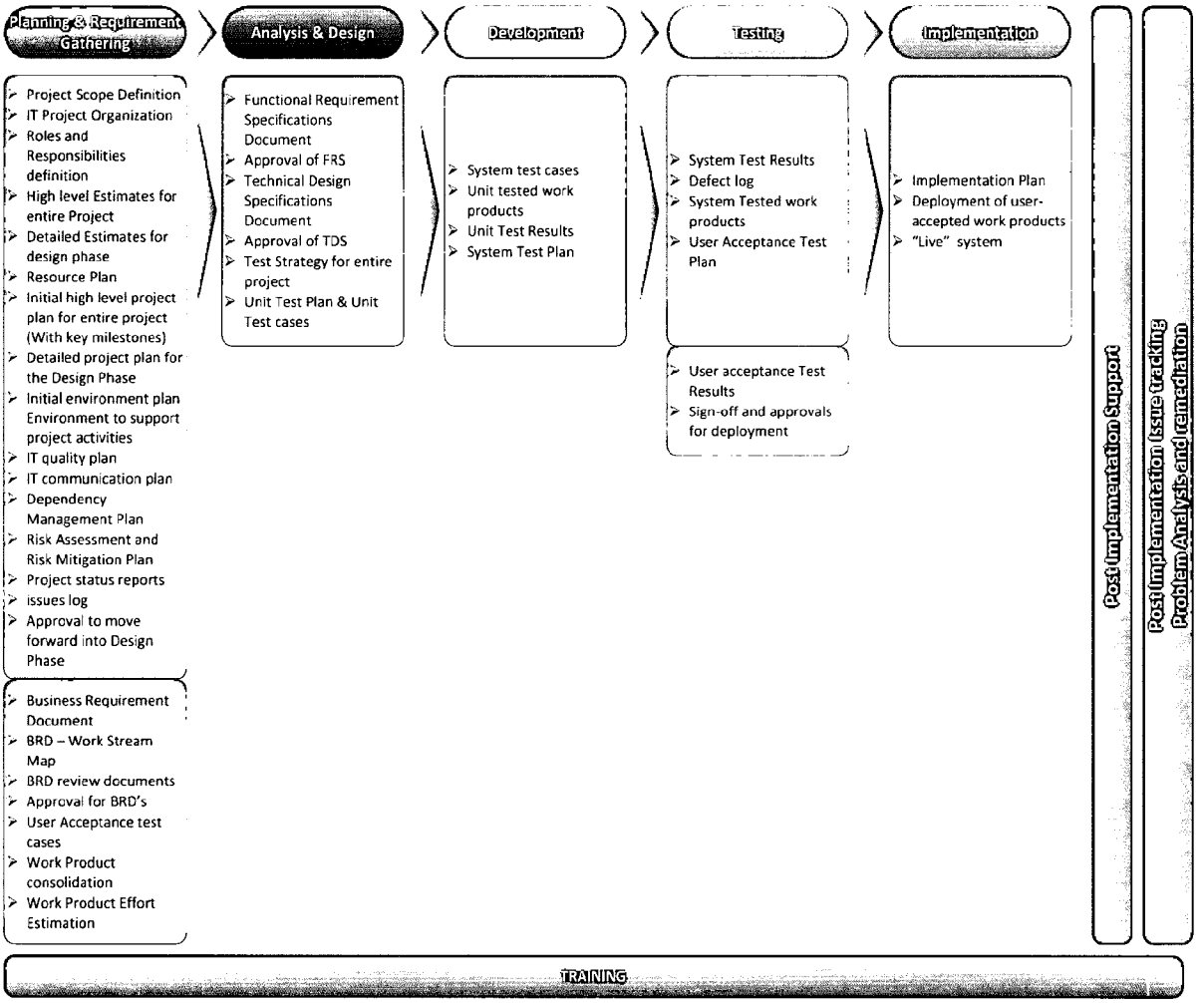
Molina Healthcare Information Technology has demonstrated the ability to successfully implement government sponsored programs in multiple states, including Long-term Care programs in Texas and Washington that are similar to the ALTCS program. Molina Healthcare Information Technology's approach utilizes a combination of proven project management and systems development life cycle methodologies that include milestones, tasks, resources and timelines to successfully deliver the functionality to support the implementation of a new health plan.

Molina uses a matrix-management approach for managing a health plan start-up initiative. A project manager from Molina Healthcare's Corporate Development department, reporting to a Project Steering Committee comprised of senior business and IT leadership, manages the overall initiative to ensure the project is on-track. The Corporate Development project manager works with cross-functional project managers to ensure deliverables meet project milestones and to manage issue resolution.

A project manager from IT is responsible for managing the IT work plan and identifying each functional area within IT where deliverables are required to support the operation. Each project manager is responsible for identifying, planning and delivering the functionality within their area.

Information Technology works with inter-departmental resources to develop requirements, design, develop, test and implement system solutions. The outcome of the requirements phase provides detailed estimates used to determine the number of IT resources required to complete the remaining phases. During the Analysis & Design phase, functional requirements are completed and used for development. IT then engages inter-departmental resources to complete user acceptance testing where the system is used to complete business processes as defined by the contract and state regulations. Upon approval of the testing phase, the production system and business operations are implemented. The project team provides post-implementation support and transitions knowledge to operational staff to ensure continuity and compliance with contractual requirements.

The graphic below depicts the main Software Development Life Cycle phases along with the key deliverables within each phase.



Upon contract award, Molina will collaborate with AHCCCS to implement the following detailed plan to ensure all Information Systems requirements for the ALTCS program will be met prior to the scheduled October 1, 2011 operational start date. The graphic below is an IT-specific excerpt from the comprehensive Implementation Plan currently used by the Molina implementation team.

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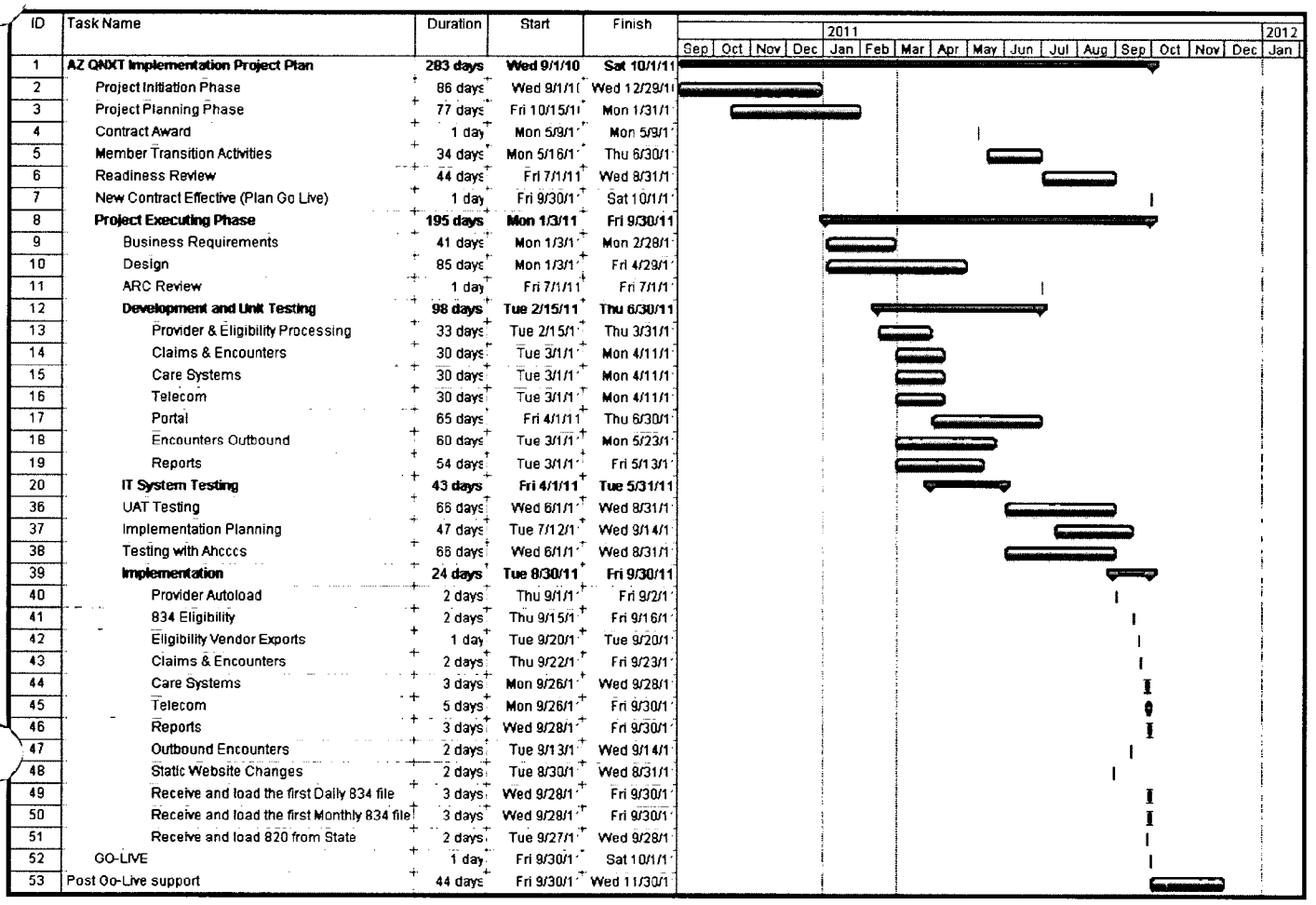

ID	Task Name	Duration	Start	Finish
1	**AZ QNXT Implementation Project Plan**	**283 days**	**Wed 9/1/10**	**Sat 10/1/11**
2	Project Initiation Phase	86 days	Wed 9/1/10	Wed 12/29/10
3	Project Planning Phase	77 days	Fri 10/15/10	Mon 1/31/11
4	Contract Award	1 day	Mon 5/9/11	Mon 5/9/11
5	Member Transition Activities	34 days	Mon 5/16/11	Thu 6/30/11
6	Readiness Review	44 days	Fri 7/1/11	Wed 8/31/11
7	New Contract Effective (Plan Go Live)	1 day	Fri 9/30/11	Sat 10/1/11
8	**Project Executing Phase**	**195 days**	**Mon 1/3/11**	**Fri 9/30/11**
9	Business Requirements	41 days	Mon 1/3/11	Mon 2/28/11
10	Design	85 days	Mon 1/3/11	Fri 4/29/11
11	ARC Review	1 day	Fri 7/1/11	Fri 7/1/11
12	**Development and Unit Testing**	**98 days**	**Tue 2/15/11**	**Thu 6/30/11**
13	Provider & Eligibility Processing	33 days	Tue 2/15/11	Thu 3/31/11
14	Claims & Encounters	30 days	Tue 3/1/11	Mon 4/11/11
15	Care Systems	30 days	Tue 3/1/11	Mon 4/11/11
16	Telecom	30 days	Tue 3/1/11	Mon 4/11/11
17	Portal	65 days	Fri 4/1/11	Thu 6/30/11
18	Encounters Outbound	60 days	Tue 3/1/11	Mon 5/23/11
19	Reports	54 days	Tue 3/1/11	Fri 5/13/11
20	**IT System Testing**	**43 days**	**Fri 4/1/11**	**Tue 5/31/11**
36	UAT Testing	66 days	Wed 6/1/11	Wed 8/31/11
37	Implementation Planning	47 days	Tue 7/12/11	Wed 9/14/11
38	Testing with Ahcccs	66 days	Wed 6/1/11	Wed 8/31/11
39	**Implementation**	**24 days**	**Tue 8/30/11**	**Fri 9/30/11**
40	Provider Autoload	2 days	Thu 9/1/11	Fri 9/2/11
41	834 Eligibility	2 days	Thu 9/15/11	Fri 9/16/11
42	Eligibility Vendor Exports	1 day	Tue 9/20/11	Tue 9/20/11
43	Claims & Encounters	2 days	Thu 9/22/11	Fri 9/23/11
44	Care Systems	3 days	Mon 9/26/11	Wed 9/28/11
45	Telecom	5 days	Mon 9/26/11	Fri 9/30/11
46	Reports	3 days	Wed 9/28/11	Fri 9/30/11
47	Outbound Encounters	2 days	Tue 9/13/11	Wed 9/14/11
48	Static Website Changes	2 days	Tue 8/30/11	Wed 8/31/11
49	Receive and load the first Daily 834 file	3 days	Wed 9/28/11	Fri 9/30/11
50	Receive and load the first Monthly 834 file	3 days	Wed 9/28/11	Fri 9/30/11
51	Receive and load 820 from State	2 days	Tue 9/27/11	Wed 9/28/11
52	GO-LIVE	1 day	Fri 9/30/11	Sat 10/1/11
53	Post Go-Live support	44 days	Fri 9/30/11	Wed 11/30/11

Molina will perform the following modifications and updates to its Information Technology systems to successfully implement the AHCCCS requirements for the ALTCS program. A detailed description of the Information Systems Implementation Plan is described below.

Activity	Description
QNXT Configuration	Identifying the ALTCS contract requirements, benefits, rates and fee schedule, and provider contract information to support the program needs.
Interface Development	Identification, development and implementation of all the required interfaces (including analysi of companion guides/technical specification documents) according to AHCCCS specifications.
Reports	State reporting requirements are identified and report specifications developed.
QNXT Integrated Applications	ALTCS program specific requirements for these applications are identified and developed.
Workflow processing	ALTCS program specific modeling of workflow management technology to ensure operational efficiency in the areas of Claims and Authorization processing.
Operations Processing Calendar	Development of ALTCS specific Information Technology Operations calendar to ensure timely execution of all extracts and reports due to AHCCCS.
Infrastructure	Assessment of Molina's Information Technology infrastructure to ensure that it meets the capacity and performance requirements of AHCCCS and the ALTCS program.

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12. Describe the Offeror's information system change order and software modification processes, the date of the last major version update, and indicate if there is a planned system conversion within the contract period (five years). If yes, indicate which subsystems were/will be affected and describe the planning and system implementation process.

Molina Healthcare Information Technology has a tightly controlled information system change and software modification management process to ensure that all changes or modifications are auditable across its enterprise infrastructure of hardware and software. The information systems change management process is structured to coordinate and inform business customers and Information Technology staff of any changes that impact any shared computing system or application under the direction or control of Molina Healthcare Information Technology. Molina Healthcare's information systems change management process is designed to protect Molina data processing and shared infrastructure from changes that are potentially disruptive. Information Systems Change Management is the ongoing process of communicating, coordinating, monitoring, and scheduling changes to the Molina Healthcare information system environment. Information Systems Change Management ensures that appropriate documentation, testing, notification, training, and recovery procedures are in place.

All systems and application changes must conform to the Molina Healthcare software development life cycle methodology. Software development activity must be traceable to a defined and approved Business Requirements Document. Once a Business Requirements Document is approved, Molina Healthcare Information Technology will create a conceptual and technical design that is submitted to the Architecture Review process. The design is reviewed by the Architecture Review Committee, and if it meets applicable standards, it is approved. During the development process the development team conducts continuous testing and integration to eliminate defects and ensure conformance with functional requirements. At the end of the development cycle, the new application or application change is submitted for User Acceptance Testing. All defects identified by the business testers are addressed, corrected, and then accepted by sign-off of the business requestor. Once sign-off is obtained the application or application change is released into production.

All necessary testing, User Acceptance Testing, and deployment readiness reviews must be completed before the proposed change is approved by the owning Information Technology Director. In some cases, multiple Information Technology Directors may own different parts of a change and all must approve the change. Business process owners must evaluate and approved the change based on their business perspective. Information Technology Directors must evaluate and approve the change based on their Information Technology and systems perspective. The implementation of a change request by Information Technology must follow the business request precisely for functional and business process correctness, however, there is a corresponding technical design that must fit within the greater Information Technology environment and the Information Technology Director must verify that all such designs meet Molina technical and architectural standards as well as any and all applicable regulatory or compliance standards such as SOX and HIPAA.

The selection of vendor software and systems follows a modified version of the Molina Software Development Life Cycle and Change Management process. Any new software or system must meet defined business requirements and will be subject to the same testing, sign-offs, Architecture reviews, production readiness reviews, and Change Management processes as internally developed applications.

Molina Healthcare's QNXT and Clinical CareAdvance applications are under a maintenance contract with the application manufacturer; therefore, any changes to the core system or application are managed and delivered by the vendor on a predefined release schedule for all installed base and the vendor's customers. The vendor has a formal process to collect product feedback and Product Enhancement Requests from all installed base/customers. Collected feedback and Product Enhancement Requests go through a review board to decide feasibility and value to the customer base, and approved changes go through the development, testing, documentation phases before release to the customers. The vendor publishes release notes detailing enhancements, modifications, updates and impacts for each release for their customers to make judgment if the release is appropriate for their health plans. If Molina decides to implement such a release, the vendor supports the implementation as required.

Upon contact award, ALTCS will be implemented on QNXT application version 4.8. Molina has made significant investments in the QNXT system and there are no plans to procure a new core administrative system or perform major enhancements to the QNXT platform at this time. However, the Clinical CareAdvance application is on version 4.6 for all Molina lines of business. To meet ICD-10 compliance requirements and take advantage of latest functionality and most current support agreement, Molina will start a project to implement version 4.8 of Clinical CareAdvance that is scheduled to be released in Q1 of 2012. After the Clinical CareAdvance 4.8 upgrade, there are no further plans for version or service pack upgrades.

In addition to the Business Requirements Document process, Molina also uses an automated Change Management Document system, maintained and governed by Molina Information Technology, to coordinate document changes. The Change Management Document system is used to create business and IT change requests and route them to the appropriate approvers. The Change Management process is governed by a group of key participants who compose the Change Management Board. The Change Management Board represents significant operational areas within Molina Information Technology and is charged with fully assessing the impact of any change proposed or implied within the Change Management Document system.

All necessary documentation and additional approvals are attached to the change request and are reviewed and approved by:

- Change Management Document Approvers – Molina Information Technology Manager, or above, accountable for the review and approval of changes to systems supported in their department.
- Change Management Board – This governance board is comprised of a cross-functional Molina Information Technology team that represents significant operational areas and disciplines within Molina Information Technology. Charged with fully assessing the impact of any change (proposed or implied) within a Change Management Document, the Change Management Board identifies final risks or conflicts that must be addressed prior to implementing new or changed systems.
- Molina Information Technology Associate Vice President – Provides the final review and approval of all non-emergent Change Management Documents.
- Chief Information Officer – Accountable for approval of all emergency Change Management Documents not scheduled for review or occurring off-cycle from Change Management Board meetings.

Molina will ensure that system changes affecting core processing functionality will be communicated on a timely basis and will not impact care to AHCCCS members. A description of the project work for upgrades and required deliverables for large Information Technology projects is described in the tables below.

Table 12-1 Upgrades Project Work

Phase	Key Activities
Environment set-up	Develop environment plan; Provide environments according to plan set-up security.
Inventory consolidation	Gather inventory information for all applications, interfaces, database objects, scripts and reports related to the QNXT instance being upgraded; Identify all source code; Establish change controls around source code.
Data migration and testing	Execute upgrade scripts; Validate the results: database schema and row counts; tune the upgrade scripts as necessary to meet performance requirements.
Functional and Technical Impact Assessment	Analyze all Functional Requirements Documents, Technical Documents and source code to identify the changes required as a result of the upgrade; Document the changes that need to be made in an impact assessment document; Estimate the effort and resources required to remediate and test the changes.
Remediation and System Testing	Create design documentation; Coding and unit testing; System test planning; System testing.
Functional testing and planning for End-to-end testing	Functional test case development; Functional testing; Issue tracking and User acceptance test results; Development of end-to-end test plan.
End-to-end Testing	Execution of test scripts; Issue tracking; Error correction; Re-testing.
Training	Preparation of training material; Scheduling training classes; Conducting training.
Deployment	Development of detailed implementation plan; Upgrade of production databases; Go-live validation.
Post implementation support	Post implementation Issue Tracking; Problem analysis and remediation; Complete transition to Molina Information Services.

Table 12-2 Sample Deliverable Scope

Deliverable Name	Description
Project Charter	High Level scope and Milestones
Environment plan	A document describing the technical environment requirements to support the upgrade project
Impact Assessment	Document identifying all changes required as a result of the upgrade
Design Document(s)	Documents defining all design changes required as a result of the upgrade
System test plan	Defines system test approach, test processes, testing roles and responsibilities and test cases
Functional test plan	Documents functional test cases that will be executed to ensure that the QNXT application functions as expected
End-to-end test plan	Test plan defining full monthly processing cycle, timing and dependencies for test execution and testing/test results sign-off responsibilities
User Test Defect Tracking Log and Results	Documentation of user testing issues and results; Support of User Acceptance Testing.
Training plan and training materials	Document describing who will be trained, how they will be trained, training logistics, etc. Training material will include training course outlines, user guides, etc.
Implementation plan	Document defining the details of all tasks required to deploy the upgrade into the production environment
Signoff and Approval	Approval to implement in production environment

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13. Indicate how many years the Offeror's IT organization or software vendor has supported the current or proposed information system software version currently operated by the Offeror. If Offeror's software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

Molina's core health plan information technology and systems operate on a single core managed care system called QNXT. QNXT was developed and is supported by TriZetto (formerly Quality Care Solutions, Inc.), and was originally designed specifically for health plans specializing in Medicaid. Molina Healthcare has utilized QNXT for 14 years; since the original implementation in 1997. Since that time, Molina Healthcare has completed several service packs and version upgrades successfully, including the upgrade for all Molina Healthcare business to QNXT version 3.4 which was completed by December, 2010.

All of Molina Healthcare's Medicaid markets are on QNXT 3.4 version supported by Trizetto. Plans are underway to upgrade all Molina Healthcare Medicaid markets to QNXT version 4.8 to accommodate ICD10 requirements. If Molina is awarded the ALTCS contract, it will be on QNXT 4.8 version.

The TriZetto Group, Inc.
Suena Lew Molina Client Account Executive
Office: 480-735-7144
Mobile: 480-383-3974

Corporate Headquarters:
567 San Nicolas Drive, Suite 360
Newport Beach, CA 92660

Arizona Regional Office:
14647 S. 50th St., Bldg 150
Phoenix, AZ 85044

14. Describe the Offeror's plans and ability to support current and future IT Federal mandates.

Molina Healthcare supports all current IT-related federal mandates, and has a proven track record of implementing new federal mandates on or before the applicable compliance date. Molina Healthcare employs technologies and processes that enable enhanced program administration. Molina Healthcare's IT architecture provides an overall framework for interoperability and secure data exchange in accordance with national standards.

Current IT Federal Mandates:

HIPAA 4010 Readiness
Molina Healthcare currently supports all HIPAA transactions, code sets and unique identifiers standards. In addition, Molina Healthcare complies will the HIPAA Security Rule standards. Current HIPAA transactions supported by Molina Healthcare include the X12 4010A1 versions of the HIPAA transactions, NCPDP 5.1 and the National Provider Identifier (NPI).

HIPAA 5010 Readiness
Molina Healthcare has achieved Level I HIPAA 5010 compliance and has commenced external testing with various trading partners. Molina Healthcare has developed 5010 Companion Documents and published them on its Web site. Molina Healthcare plans to complete its external testing for the remainder of 2011 with a planned cut-over to 5010 transactions effective January 1, 2012. Molina Healthcare pharmacy vendor, CVS Caremark is in progress with the implementation of the new NCPDP D.0 pharmacy transactions with a planned cutover of January 1, 2012.

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ICD-10 Code Sets Readiness

An ICD-10 Detailed Impact Assessment is in the final stages of completion. Prerequisite upgrades are currently being conducted on Molina Healthcare's core applications to versions that accommodate ICD-10 codes and Internal ICD-10 Remediation will begin in March 2011. As updated information is gathered from Trading Partners, State Agencies and Contracted Vendors the ICD-10 Remediation Plan will be updated. Molina Healthcare will begin testing with its Trading Partners on January 1, 2013 and will be ICD-10 compliant October 1, 2013.

Future IT Federal Mandates:

Molina Healthcare closely monitors federal legislative and regulatory activities pertaining to IT mandates including, but not limited to, HIPAA, HITECH and the Patient Protection and Affordable Care Act of 2010 (Health Care Reform bill). Molina Healthcare will support the following future IT federal mandates:

- Operating Rules for eligibility and claims status;
- Health Plan identifier;
- Electronic Funds Transfer (EFT) standard and Operating Rules for EFT and Remittance Advice;
- Standard and Operating Rules for Claims Attachment; and
- Operating Rules for Claims, Authorizations, Enrollment, and Premium Payment.

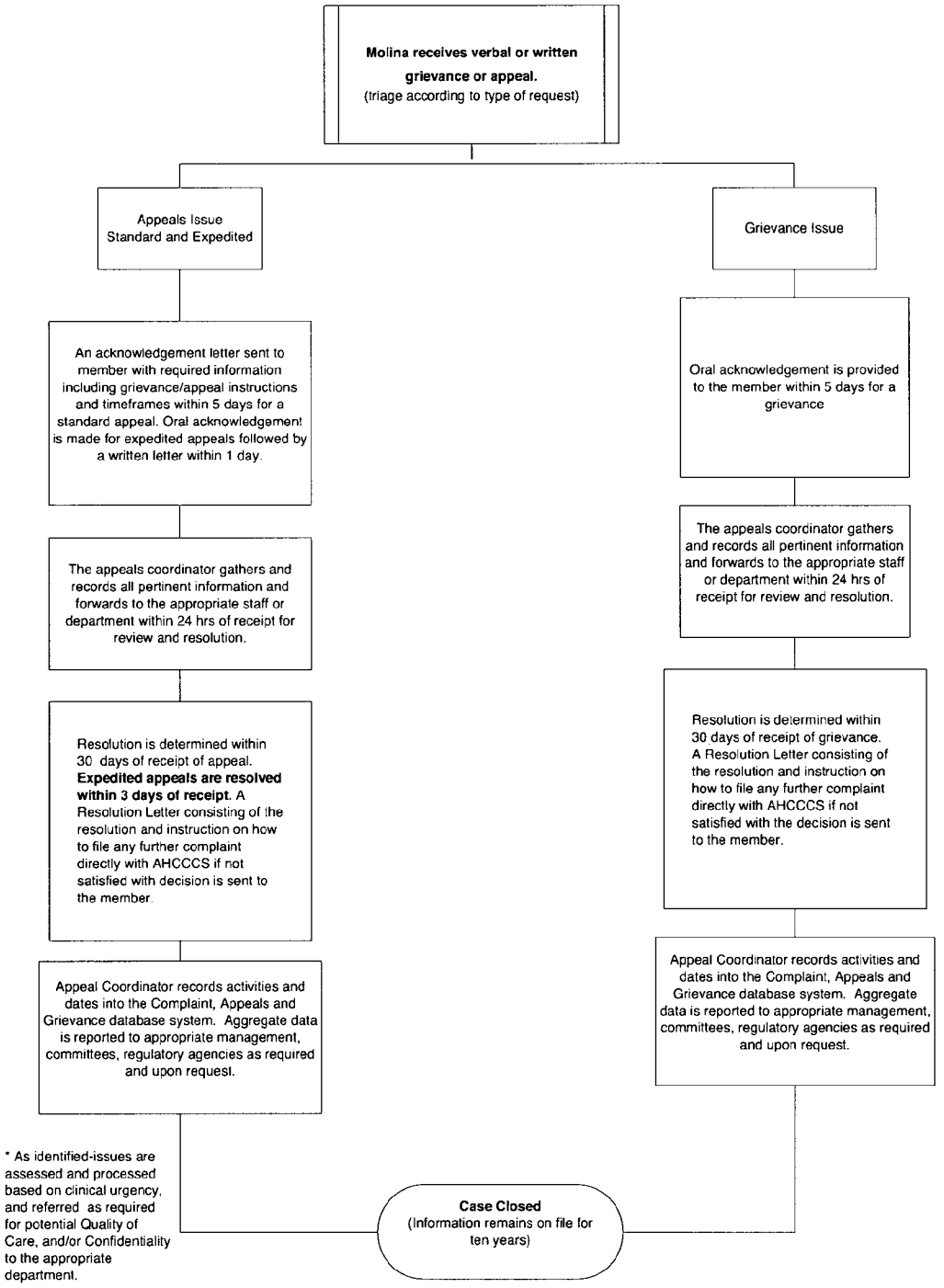
Grievance System

Grievance System Submission

15. Provide a flowchart and comprehensive written description of the Offeror's grievance system. At a minimum, the description should include the member grievance and appeal process, and the provider and subcontractor claim dispute process. Include in the description how data resulting from the grievance system is used to improve the operational performance of the Offeror. The submission requirement will be a maximum of four pages of narrative with a maximum of three pages of flowcharts.

Following is a detailed Grievance and Appeals process flowchart and a comprehensive description of Molina's Grievance System process.

Grievance and Appeals Process Flowchart



Molina's Grievance and Appeal process, and AHCCCS Fair Hearing processes, will provide Molina members with access to their right to take recourse to plan determinations. Written information describing the Grievance System including the grievance process, the appeal process, member rights, the grievance system requirements and timeframes, the availability of

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assistance in the filing process, and Molina's toll-free number for filing a grievance or appeal will be distributed in the Member Handbook and the Member Newsletter in English, prevalent non-English languages and in large format alternate formats such as large bold print. This information will also be accessible on the Molina Web site. Contracted providers will also be provided this information in the Provider Manual and Provider Newsletters.

Molina's Appeal and Grievance staff will serve as member advocates to ensure that all Molina members have access to the benefits and care to which they are entitled. The Appeal and Grievance department will consist of an Appeals Coordinator and an Appeals Manager who will address all grievance and appeal issues received from Molina members. The Appeals Coordinator will evaluate, review, and respond to appeals, grievances and AHCCCS Fair hearing requests in accordance with federal and state regulations. The Appeal and Grievance Manager will perform supervisory and administrative functions and will be fully accountable for the outcomes of the Appeal and Grievance department.

The process begins upon verbal or written receipt of a grievance or appeal by a member, their personal representative or their provider. Written requests are opened and date stamped, the content is reviewed to determine if the communication is a grievance or an appeal. Molina will use AHCCCS definitions of grievances and appeals to make this determination. A grievance will be defined as a member's expression of dissatisfaction about any matter or aspect of Molina or its operation other than a Molina action. An appeal will be defined as a request for a review of a Molina action, to include denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of a payment for a service. Appeals will be processed as either expedited or standard. Correspondence not considered an appeal or grievance will be routed to the appropriate department for handling.

A legal guardian may file an appeal on behalf of a minor or incapacitated adult without written consent, but any other person (including a provider appealing on behalf of a member) must provide an authorization signed by the member in order for Molina to act on the appeal. If required, Molina will send a consent form to the member. There are no time limits for filing a member grievance. Appeals should be filed within 60 calendar days after the date of a Molina action notification.

Molina will send an acknowledgement letter to the member within five (5) business days of receipt of a standard appeal, within one (1) business day for an expedited appeal and will orally acknowledge a grievance within five (5) business days. In the appeals acknowledgement letter, Molina will restate the member's issue and include the member's right to request an AHCCCS Fair Hearing and how to do so, the time frame for requesting a hearing (no later than 30 days after the date the member receives the Molina's notice of appeal resolution), and the address and phone number to use to contact Molina or AHCCCS to request a hearing. In addition, complete instructions will be provided for the process of presenting evidence in person or in writing, and how to review the member's case file and any other documents to be used in the hearing process.

Review and Resolution of Grievances and Appeals

The following information is entered and permanently maintained in the appeal or grievance record in the Appeals and Grievances database: the member's name; AHCCCS identification number; the date the appeal/grievance was received; the date of appeal/grievance acknowledgement; a brief appeal/grievance description/category; staff assigned for the

disposition; disposition; disposition date; disposition cause of delay (if disposition is greater than 10 business days from date of filing); and the member's notification date.

A hard copy file will be made and all documents pertinent to the case will be collected and placed in that file. If a case is referred to another department for review and response, a copy of the file will be made and the original retained in a secure area within the Appeal and Grievance department. All grievance and appeal files are retained for a period of not less than ten years.

The Appeals Coordinator will collect the necessary documents that are needed and forward to the appropriate department for a comprehensive review. An example of this is an appeal of a service denied for medical necessity would be directed to the Utilization Management department for review by a qualified clinician. Another example is a member's grievance regarding the behavior of a provider or staff would be directed to the Provider Services department. Quality of care issues would be routed to the Quality Improvement department, and any pharmacy issues would be reviewed by the Pharmacy department. Molina ensures that individuals who make decisions on appeals or grievances did not participate in the original decision and have appropriate clinical expertise in treating the member's condition if the grievance involves clinical issues or is regarding the denial of expedited resolution of an appeal.

The Appeals Coordinator monitors the status of the appeal or grievance to ensure complete and accurate resolution of appeals within 30 days of receipt and grievances within 30 days, but in no case longer than 90 days of receipt.

Any member, their provider or practitioner, or any party on behalf of a Molina member may submit a request for an expedited review. Appeals will be processed in an expeditious manner when normal time taken for a standard review could seriously jeopardize the member's life, health, or ability to maintain or regain maximum health. The determination as to whether a case is reviewed as expedited is based upon the member's or provider's request and their support for expedited review by Molina. If a case is not found to meet expedited review criteria, the appeal will be transferred by the 30-day timeframe for a standard appeal. Reasonable efforts will be made to give the member a prompt oral notice of the determination of the appeal, if an appeal is considered expedited. Molina will also send a written notice of this decision to the member within two (2) days. Expedited reviews will be forwarded to the Utilization Management department and a Medical Director for review.

Molina will provide members a reasonable opportunity to present evidence and allegations of fact or law in person and in writing, provide the member and his representative the opportunity before and during the appeals process to examine the member's case file including medical records and other documents considered during the appeals process and will inform the member of the limited time available in cases involving expedited resolution. Molina will ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a member's appeal.

When the review is complete, a resolution letter will be sent to the member within three (3) days for a grievance or standard appeal. Resolution of expedited reviews will be communicated to the member and the provider orally as soon as possible and within two (2) days receipt of the expedited appeal. The resolution letter will provide the following information: findings and conclusions; information considered in the investigation; disposition of the appeal; date of the resolution; member's right to request an AHCCCS Fair Hearing and how to do so, information on the right to request an AHCCCS Fair Hearing and how to do so; information on the right to request continuation of benefits pending an AHCCCS Fair Hearing and how to do so; and a

statement advising the member they may be held liable for the cost of those benefits if the AHCCCS Fairing Hearings decision upholds the initial Molina determination.

Appeal resolution may be extended 14 days at the member's request, or if Molina demonstrates to AHCCCS that an extension is truly needed and will benefit the member. If the extension is requested by Molina, a letter will be sent to the member giving the reason for the extension.

Continuation of Benefits
Molina continues extended benefits originally provided to the member until any of the following occurs: 1) the member withdraws; 2) the member has not specifically requested continued benefits pending a hearing decision within 10 days of Molina's mailing of the appeal resolution notice or, 3) the AHCCCS Administration issues a state fair hearing decision adverse to the member.

If Molina or AHCCCS reverses a previous decision to deny, limit or delay service, and services were not being provided pending the outcome of the appeal; Molina will issue an authorization promptly. If the member continued to receive services while the appeal or hearing was pending, Molina will pay for those services. If Molina or AHCCCS upholds a decision to deny, limit, or delay services and the member continued to receive services during the appeal or hearing, the member may be responsible for paying for the services.

Data Monitoring Process and Improving Operational Performance
Molina is committed to continuous quality improvements and will establish mechanisms to monitor data from the grievance system to identify opportunities for improvement. Performance is assessed to goals, performance thresholds and available benchmarks. Molina will share information about performance gaps and areas of improvement with primary care practitioners, specialists, and providers as appropriate, and include public acknowledgement of positive performance. Performance is also reviewed to assess the need for policy and procedure updates, tools and data collection approaches related to grievances, and propose changes that are appropriate. The Quality Improvement department retains oversight of the Quality Improvement Program Evaluation process and the Quality Improvement Work Plan in conjunction with the Member Services and Provider Services department. Every year a Quality Improvement Work Plan will be developed that includes activities to address the various measures and mechanisms to evaluate and provide feedback to members and providers. Through the annual Quality Improvement Program Evaluation process, the Quality Improvement Work Plan will incorporate any new activities to improve operations. Activities will be reported the Board of Directors in the Annual Quality Improvement Program Evaluation.

The Appeal and Grievance department will track grievances and produce a quarterly Grievance Analysis report as a required item on the agenda of the Member and Provider Committee meeting. Feedback from AHCCCS regarding any trends or findings is incorporated as part of the Quality Improvement process.

Analysis and Evaluation
Molina will perform quantitative and qualitative data analysis, and identify opportunities for improvement using the information contained in the Member Grievance Report, Authorization Request Report, Appeal Report, and the Claim Dispute Report. Quarterly and annual analysis will be performed to evaluate grievance and appeals using the following approach:

- Goals and performance thresholds for each area are developed and approved annually;
- Data collection approaches are designed to provide valid and reliable methods for reporting and analysis;

- The following methods are applied:
  - Identify the appropriate population and data source(s); and
  - Draw appropriate samples from the affected population, if a sample is used.
- Quantitative analysis includes a performance comparison assessment to previous measurement, to available averages, and to established internal goals;
- Conduct barrier (qualitative) analysis when gaps in performance are identified:
  - Barrier analysis includes a comprehensive root cause analysis and barrier assessment;
  - Activities and barriers are reviewed as part of the evaluation of effectiveness;
  - The analysis and barrier assessment provides further insight into issues that may have contributed to the cause(s) and performance gap in achieving the established goals; and
  - Opportunities for Improvement (OFI) are developed and implemented.

Reporting
The Enrollee Grievance, Authorization Request and Appeals, and Provider Claims Dispute reports will be submitted to AHCCCS Division of Health Care Management on the first day of the second month following the month being reported. Molina will generate and submit each report with a cover letter summarizing the data reported. The three separate reports will contain all of the AHCCCS required fields found in the AHCCCS Grievance Reporting System Guide.

Provider Claims Dispute
Molina has written processes and procedures in place for providers to submit provider claims disputes for determination. All claim disputes must be submitted in writing within the following timelines:

- Within twelve months after the date of service;
- Within twelve months after the date that eligibility is posted; or
- Within sixty days after the date of the denial of a timely claim submission, whichever is later.

Upon receipt of the claim dispute, Molina will send a letter of acknowledgment to the provider. This letter is retained in the application for future reference. The dispute will be reviewed by appropriate personnel of the claims department for review and resolution. The dispute will also be reviewed to ensure that the provider has included factual and legal details and any documents which support the facts of the case (e.g., payment, specific claim denial, quick pay discount). If Molina receives a claim dispute lacking in details, it may be denied.

Molina utilizes the Provider Dispute Resolution application to track provider claims disputes. The provider's written dispute and supporting documentation are imaged and loaded into the shared folder and linked to the Provider Dispute Resolution application where the dispute is assigned a case number. All claims information associated with the indicated disputed claims ID is pulled into the application from QNXT (core claims processing system). The Provider Dispute Resolution application provides review, management, tracking, reporting, correspondence and workflow capability for quick and systematic auditable resolution of provider disputes.

If a claim dispute resolution is favorable to the provider, the dispute is submitted for adjustment to be performed in the QNXT claims processing system. The Notice of Decision containing the outcome of the dispute is generated and sent to the provider. If the resolution is not favorable to the provider, the Notice of Decision will contain information as to how the provider can request a state fair hearing which must be received within 30 days from the receipt of the notice. The Notice of Decision is retained in the Provider Dispute Resolution application for future reference.

Corporate Compliance

Corporate Compliance Submissions

16. Describe the Offeror's Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff involved in compliance along with staff levels of authority. The submission requirement will be a maximum of three pages of narrative plus one organizational chart.

Molina Healthcare has established a comprehensive Corporate Compliance Program integrated across all of its health plans with the mission of deterring and detecting fraud and abuse and reporting any suspected fraud or abuse to state and federal agencies. Molina Healthcare's Corporate Compliance executive staff will support the Molina Healthcare of Arizona Compliance Officer to establish a compliance plan that ensures compliance is integrated into every aspect of its business and corporate culture.

The foundation of Molina's compliance program will be built upon Molina Healthcare's Compliance Plan established in December 1998. The Compliance Plan is a living document designed to increase efficiencies, reduce waste, and improve the quality of services provided. The Compliance Plan is reviewed periodically and amended as needed to reflect changes in the law and the healthcare marketplace. The Compliance Plan includes a Code of Conduct to ensure that each Molina employee or representative abides by and upholds the law and internal policies that govern the company.

The Compliance Plan specifies the structure of the Compliance Program and includes organizational goals to ensure that all applicable laws and policies, including the requirements, rules, and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Deficit Reduction Act of 2005 and the Code of Federal Regulations at 42 CFR 438 are met. Molina's compliance goals will ensure that its employees and representatives understand that they play an individual role to ensure compliance and to adhere to legal and contractual responsibilities.

Molina will implement health plan policies, procedures, and training that specifically adhere to and support the Fraud and Abuse Policy provided in ACOM, Chapter 100. Molina will implement policies and procedures internally and with providers to ensure immediate notification of any suspected fraud or abuse to the AHCCCS Office of Program Integrity (OPI) or Office of Inspector General (OIG) as directed by AHCCCS within 10 business days of discovery in accordance with confidential AHCCCS Referral for Preliminary Investigation form guidelines. Notifications will include suspected fraud or abuse that involved AHCCCS funds, contractors, or sub-contractors even if resolved internally. Other issues will also be researched and the findings will be promptly reported, including potential overpayments identified by the AHCCCS OPI or OIG as directed by AHCCCS. Molina will attempt to recover any overpayments identified after conducting a cost benefit analysis to determine if such action is warranted. The OIG will be advised of the final disposition of the research and advised of actions if any are taken by Molina.

Molina will collaboratively work with AHCCCS to identify Medicaid managed care fraud and abuse, determine the applicability of federal requirements for the AHCCCS program, and seek innovative ways to prevent and/or detect fraud and abuse.

The components of Molina's Compliance Program will include activities to prevent, monitor, audit, report, ameliorate, and continuously improve health plan-specific compliance with state, federal and contractual requirements. These components will include:

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- Education, training, and retraining of Molina's employees, representatives, and contractors, including the network providers verifiable by AHCCCS;
- Written policies, procedures, and internal controls that focus on and facilitate preventing, detecting, and reporting fraud and abuse activities both internally by Molina's employees and representatives, and externally by members and network providers;
- Training of existing staff and new hires on the Compliance Program, including policies pursuant to the Deficit Reduction Act of 2005 regarding the federal False Claims Act, administrative remedies for false claims and statements, relevant Arizona state laws related to false claims and statements and whistleblower protections under such laws;
- A system of monitoring, auditing, inquiring, investigating and responding to compliance matters, including controls to prevent, detect, and report fraud and abuse activities; respond to electronic, telephonic or written requests for information within the time frame specified by AHCCCS; and provide documents, including original documents, to representatives of the Office of the Inspector General (OIG) upon request;
- Ameliorative processes to facilitate compliance when deficiencies are identified;
- Consistent enforcement and discipline in appropriate instances of non-compliance up to and including termination of an employee or contractual relationship, if warranted;
- Effective lines of communication and mechanisms, including a corporate 'hot line' and secure email capability accessible only by the Corporate Compliance Officer, to facilitate:
    - Anonymous, good faith reporting of suspected non-compliance with Federal or State law, government or company policies and procedures, and
    - Confidential and/or anonymous submission of complaints or concerns regarding questionable accounting, internal accounting controls or auditing matters, as well as timely and accurate reports of such submissions to the Corporate Audit Committee and Board of Directors; and
- Articulating and demonstrating that retaliation against good faith reports of instances of suspected non-compliance will not be tolerated.

Compliance Officer's Level of Authority and Reporting Relationships
Molina Healthcare's Vice President of Compliance directs and is advised by the Corporate Compliance Committee comprised of representatives from the Internal Audits, Claims, Finance, and Human Resources departments.

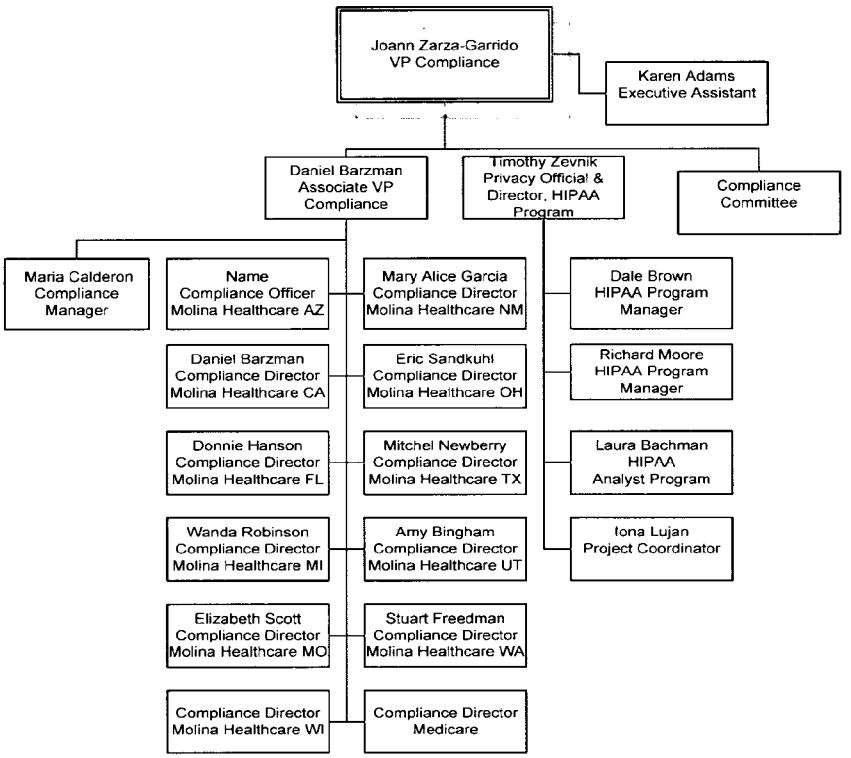
Molina Healthcare of Arizona's Compliance Officer will be the on-site official responsible for implementing, overseeing, and administering Molina's Compliance Program, including fraud and abuse control. The Molina Compliance Officer will report directly to the Molina Healthcare Associate Vice President Compliance, is advised and supported by the Corporate Compliance Committee and is supported through oversight of the Molina Board of Directors. The Compliance Officer will be available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Program Integrity and/or the Office of the Inspector General (OIG), as directed by AHCCCS.

Molina's Compliance Officer has direct access to Molina's Chief Executive Officer (Plan President), Board of Directors, senior management, and legal counsel. The Compliance Officer has the authority to initiate reviews and investigations as deemed appropriate based upon

information related to fraud and abuse, including information reported anonymously and confidentially.

Molina's Compliance Officer will also receive assistance from Molina Healthcare's Associate Vice President Compliance who will also act as a consultant for the preparation of the health plan's compliance plan and the execution of health plan-specific requirements and activities.

Chart 16-1 – Corporate Compliance Organizational Chart



Oversight and direction of Molina's HIPAA program activities will reside in the Molina Healthcare Compliance Office. Molina Healthcare ensures HIPAA compliance through oversight of all HIPAA activities, e.g., privacy, security, and transactions and code sets.

Certain operational functions, including credentialing, claims processing, and post-processing review of claims, will also be provided by Molina Healthcare to leverage existing expertise while utilization, quality review, provider education and employee training will be conducted by Molina staff. To ensure the integration of compliance activities for all Molina's operational components, the Compliance Program teams will work closely to ensure that the Compliance Program and Compliance Plan is thoroughly compliant with contract requirements. Molina's goal is to exceed the expectations of AHCCCS through compliance activities, which include rigorously monitoring and auditing, with or without notice, both internal activities of Molina's staff and external activities of Molina's members and providers.

For all functions, whether at the corporate or state plan level, Molina's monitoring and auditing processes will be utilized to identify areas of compliance deficiency, respond to reports of suspected non-compliance and assess continuing compliance and the effectiveness of

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corrective measures implemented to correct previously identified compliance deficiencies. Where appropriate, individuals with specific investigative experience in the management of fraud investigations will be utilized to investigate instances of healthcare fraud. Molina will establish standing contracts with such individuals for that purpose.

Auditing and monitoring will not be performed in any single fashion and may include, but will not be limited to desk audits, surveys, interviews, document audits, phantom patient claims, and phantom provider claims or inquiries. In instances of non-compliance, enforcement, corrective and/or disciplinary action will be taken. Follow-up to minimize risk of reoccurrence will also be conducted. Molina will cooperate with any on-site reviews and/or electronic, telephonic or written requests for information or other requested assistance as appropriate.

Finance and Liability Management

Finance and Liability Management Submissions

17. Submit the organization's three most recent audited financial statements and the related parent company financial statements if applicable. The Offeror may exceed the three-page limit. Existing ALTCS Contractors which have met this submission requirement through current contract requirements do not need to resubmit the three most recent financial statements.

Note: The organization refers to the separate corporation established for the purposes of this contract. If no separate corporation currently exists, the Offeror should submit audited financial statements for the line of business most like the services provided under this contract.

Please see Attachment 17-1 – 2008 Audited Financial Report, Attachment 17-2 – 2009 Audited Financial Report, and Attachment 17-3 – 2010 Audited Financial Report for the three most recent audited consolidated financial statements of Molina Healthcare, Inc. Molina Healthcare of Arizona, Inc., the Offeror and a subsidiary of Molina Healthcare, has just recently been formed and has no audited financial statements. Please see Attachment 17-4 – Molina Healthcare of Arizona Balance Sheet.

18. Submit the organization's plan for meeting the Performance Bond or Bond Substitute requirement including the type of bond to be posted, source of funding and timeline for meeting the requirement.

Molina's parent company, Molina Healthcare will provide a Performance Bond of standard commercial scope issued by a surety company authorized to do business in the state of Arizona to AHCCCS for as long as it has AHCCCS-related liabilities of $50,000 or more outstanding, or 15 months following the termination date of this contract, whichever is later, to guarantee: (1) payment of its obligations to providers, non-contracting providers, and non-providers; and (2) performance by Molina of its obligations under this contract. The Performance Bond shall be in a form acceptable to AHCCCS as described in the ACOM Performance Bond Policy. The initial amount of the Performance Bond will be equal to 80 percent of the total capitation payment expected to be paid to Molina in the first month of the contract year, or as determined by AHCCCS. This requirement will be satisfied by the Offeror no later than 30 days after notification by AHCCCS of the amount required. Offeror's parent company plans to have the Performance Bond issued through UnionBanc Insurance Services, Inc.

19. Submit the organization's plan for meeting the minimum capitalization requirement.

Molina's parent company, Molina Healthcare will make a capital contribution of cash to meet the minimum capitalization requirement within 30 days of contract award. On a quarterly basis, Molina's parent company, Molina Healthcare, will review for accumulated fund deficits. In the event of a fund deficit, Molina's parent company, Molina Healthcare will fund the deficit through a cash capital contribution within 30 days after the quarterly draft or final annual financial statements in which the deficit is reported are due to AHCCCS, or in a time frame otherwise requested by AHCCCS.

D. Program

Table of Contents

** Unless otherwise stated, references to "Molina" are specific to the Molina Healthcare of Arizona health plan. "Molina Healthcare" refers to the corporate parent company Molina Healthcare, Inc.*

D. PROGRAM

Case Management Submissions

20. Describe how the Offeror has or will implement inter-departmental coordination between case management and other areas of the organization to improve member health and service outcomes. Provide an example of how the Offeror improved member health or service outcomes because of inter-departmental coordination.

Molina's Case Management team works in close collaboration with other departments in order to communicate and utilize all information that is available to maximize access to quality care with good health outcomes while controlling costs and achieving high member satisfaction. Inter-departmental coordination occurs within clinical operations as well as through ongoing communications with other departments and access to other shared information. The following examples describe some of the key inter-departmental coordination efforts between case management and other areas of the organization to improve member health and service outcomes.

Clinical Operations Inter-departmental Coordination

Molina's Care Management services include Case Management, Disease Management and Utilization Management functions. These services will be supported by Molina's Nurse Advice Line, available 24 hours a day, 365 days a year to answer members' or members' representatives' questions. Case Managers receive daily reports describing Nurse Advice Line activity to communicate new information and ensure appropriate follow-up occurs. Case Management team members will share with other team members their knowledge and expertise as licensed nurses, social workers, qualified behavioral health professionals, pharmacists and medical directors. Inter-departmental meetings led by Case Management staff ensure that all aspects of a member's care needs are considered. Particular attention is paid to the integration and coordination of behavioral health and medical service management across inter-departmental functions. For example, members identified for Disease Management services are screened for depression and when appropriate receive an additional depression assessment. Case Managers then contact the member's PCP to coordinate appropriate referrals and enroll the member into specific Disease Management programs. The Case Manager facilitates communication and coordination among cross functional inter-departmental teams and the PCP to efficiently integrate behavioral and physical health services in a culturally sensitive manner.

Data Analytics Inter-departmental Coordination

Molina's Case Management team collaborates with data analytics staff to identify service delivery issues and members in need of additional Case Management interventions. Examples of Case Management's inter-departmental collaboration with data analytics staff include:

- Claims data identification of frequent Emergency Department use for services that could be more appropriately provided through outpatient facilities or community behavioral health resources.
- Claims data identification of high-risk pharmacy utilization such as failure to fill psychiatric medications, narcotic misuse, poly-pharmacy and off-label prescribing patterns.
- Claims data identification of potentially misaligned treatments with diagnoses, such as in the prescription of an antidepressant without a mood disorder diagnosis. This may indicate that the PCP, or other non-psychiatric prescriber, may be focused on other physical treatment needs and prescribed the antidepressant as a secondary treatment. Such a case would require further investigation, assessment and follow-up.

- Data analysis of Case Manager's performance, such as review of case activity, timeliness of contacts and interventions, progress in achieving goals noted in the care plan and inter-rater reliability of service authorizations.

Provider Services Inter-departmental Coordination
Case Managers will work closely with Provider Services and participate in the Network Operations Committee, a multi-departmental standing committee dedicated to overseeing provider network strategies and ensuring that general network access, service availability and appointment timeliness scheduling requirements are met. Case Managers will share with Provider Services information about their assigned members' experiences accessing services, such as customer service in the provider's office, patient satisfaction, facility condition and handicap access issues. The Molina Provider Services representative will then work with the provider office to address the issues raised and will communicate the results with the Case Manager who will share the information with the member. Case Managers working directly with provider offices can also relay changes in office information to Molina Provider Services staff, such as provider contact numbers, locations and office hours. If a network need is identified and a provider is identified to fill that need, Case Management staff make a referral to Provider Services to work on contracting with that provider. Updated information is included in the Molina Provider Directory used inter-departmentally by Case Management, Member Services and other teams.

Quality Assurance/Quality Improvement Inter-departmental Coordination
The Case Management team regularly communicates with the Quality Assurance/Quality Improvement departments regarding service delivery to members. Inter-departmental communications include data analyses of:

- Provider under- and over-utilization of services;
- Established use of best practice models; and
- Provider satisfaction surveys results.

Case Management staff work with the Quality Assurance/Quality Improvement departments to develop and implement performance improvement plans. Results of data collection and the assessment of performance improvement plan success are also shared with Provider Services staff who engage the provider in related discussions.

Information Technology (IT) Inter-departmental Coordination
The Case Management team relies upon the expertise of the IT department to support customized reporting of member information and demographics, authorization and claims data, provider performance and access issues, and Case Management assignments and performance, etc. Inter-departmental communications between Case Management and IT staff ensures appropriate data is analyzed to meet specific state contract requirements and improve the Case Management services provided to members.

Information Systems that Support Inter-departmental Coordination
Inter-departmental coordination will be supported by use of the fully integrated electronic care management documentation system, Clinical CareAdvance, and the authorization/claims system, QNXT. Clinical CareAdvance facilitates inter-departmental communications through functional applications that manage assessments, screening tools, care plans, memos, schedules, tasks, forms, and progress notes. Clinical CareAdvance has the capability to track time sensitive actions with a full range of alert options and notifications that keep Case Managers and cross-functional teams apprised of the whole picture that comprises members'

status and care needs. QNXT allows for sharing of member eligibility status, benefits, service authorizations, utilization and service provider information. These system functions enable expedient exchange of information among all inter-departmental staff in support of effective and efficient administration of Case Management activities.

Examples of Improved Member Health and Service Outcomes
The following Case Management example illustrates how inter-departmental coordination improved member outcomes. Based on standard Utilization Management trend report data, a member, Linda, with frequent Emergency Department visits was identified.

Linda was seen in the Emergency Department 15 times in one month with a primary diagnosis of cellulitis. Case Management led an inter-departmental team meeting to review Linda's Emergency Department utilization and other specific claims data details. The inter-departmental review of the data indicated that Linda had been receiving wound care every other day through the Emergency Department facility. As a result, Linda's Case Manager scheduled a home visit and learned that Linda believed the Emergency Department was her only resource. The Case Manager informed her that home health skilled nursing could also provide wound care. The Case Manager contacted Linda's PCP to request home health nursing visits so that wound care could be administered in Linda's home. Shortly thereafter, Linda scheduled a visit to her PCP to review her wound care progress and discuss other potential health issues.

An example of inter-departmental coordination that improved service outcomes is demonstrated in Molina Healthcare's operational efficiencies in administering dual eligible benefits for John, a 68 year old with Molina Medicaid coverage and a non-Molina SNP plan. When John's multiple medical needs worsened, he required a reassessment of his Home and Community Based Services plan. The Case Manager worked with John's PCP to ensure that the non-Molina Medicare services were being provided. The Case Manager also kept the PCP informed of changes in John's care plan and ensured that the provider of the Home and Community Based Services followed appropriate billing procedures. Through inter-departmental coordination, Molina Healthcare ensured successful navigation of the complexities of John's dual eligible benefits to ensure services were provided and billed by the appropriate source.

21. Describe the Offeror's plan for monitoring and improving, as needed, the level of consistency among case managers with regard to the assessment of HCBS member needs and service authorizations.

Maintaining consistency in the assessment of HCBS member needs and the service authorization process begins with effective and comprehensive Case Management training followed by ongoing oversight and re-evaluation. All Case Managers will utilize Molina's proven Case Management process in which there is a consistent approach to member assessment and service coordination.

Comprehensive Training
All ALTCS Case Management staff will receive uniform classroom training in home and community-based long-term care services. Training focuses on accurate assessment of needs and the coordination of ALTCS services and authorizations to maximize members' success in achieving the greatest degree of independence possible. Performance standards and expectations are included in the training of Case Managers. Supervisory resources are available at all times to ensure an ongoing understanding of Case Management roles and responsibilities. The initial orientation consists of 80 hours of classroom training.

Molina uses a mentoring program that partners new hires with seasoned Case Managers during the first three months of employment. This ensures the new Case Manager receives individualized guidance and support to review cases and situations. Mentors also provide regular constructive feedback to help new Case Managers develop necessary skills.

Ongoing Case Management training is provided in regularly scheduled sessions on at least a quarterly basis. In these sessions, Case Manager's review updated and new policies and procedures, become familiar with new programmatic features, and review case studies. Additional bi-weekly Case Management staff meetings provide the opportunity to review challenging cases and reinforce consistency in the assessment and authorization process.

Some key areas of Case Management Training focus include:

Training Topics	Outcome Objectives
HCBS Services	Ability to explain and offer options to members
Assessment of Need Process and Timelines	Ability to accurately assess and observe functional status of members to produce accurate and consistent determination of needs
Pre-Admission Screening and Resident Review (PASRR)	Understanding the PASSR purpose and process
Systems Training	Ability to enter accurate and complete data in: Clinical CareAdvance - Clinical documentation QNXT- Authorizations Client Assessment and Tracking System (CATS)
Government Programs and Terminology	Ability to explain Medicaid, Medicare, Dual Eligibility, ALTCS
Coordination of Benefits	Ability to explain the COB process to members and research member status in the IT systems
Cultural Sensitivity	Understanding diverse cultural and linguistic characteristics of members and specific impact
Community Resource Assistance	Ability to assist members to access auxiliary resources
Dual Eligibility Coordination	Ability to coordinate Medicaid and Medicare benefits and help members to access care

Ongoing Oversight Focused on Consistency

To ensure consistency in Case Manager's assessment of needs and service authorizations for members receiving HCBS, Molina Case Managers will use evidence-based practices, practical experience, industry standards, and internal benchmarks.

Molina's Case Managers will receive ongoing supervision to ensure consistent, quality case management activities are conducted with the objective to improve members' health and quality of life. Ongoing supervision consists of quality performance reviews that include caseload monitoring, quarterly case file audits, and checks for member assessment and service coordination authorization consistency. Case Managers will meet with their supervisors monthly to review progress, discuss issues, and set goals and objectives. Case Managers will receive feedback during these sessions and have access to supervisors on a daily basis.

Re-Evaluation

Molina's Case Management will use its inter-rater reliability tool and outcomes based process model to re-evaluate consistency among Case Managers with regard to the assessment of HCBS member needs and service authorizations. The objective of the re-evaluation process is to evaluate consistency in applying appropriate criteria (inter-rater reliability), identify areas for

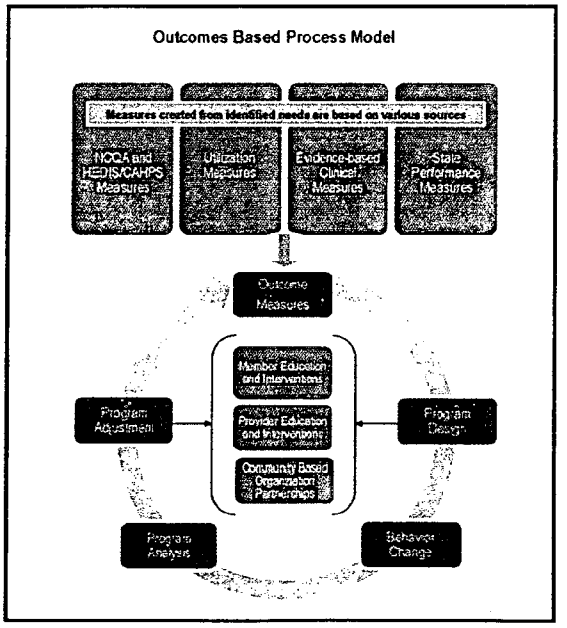
training or retraining, identify barriers and opportunities for improvement, and monitor employee performance.

Molina will use an inter-rater reliability process to measure the consistency of the Case Management decision making process, including the application of related policies and procedures. The inter-rater reliability process includes evaluating critical areas such as respecting the member's rights, utilizing observation and interviewing techniques, application of the Uniform Assessment Tool (UAT), providing explanation and knowledge of all HCBS services, completion of the Cost Effectiveness Study (CES), completion and documentation of the care plan including distribution of a copy to the member, authorization of services in QNXT within designated established timeframes and follow-up contact with the member to ensure member satisfaction with services.

The inter-rater reliability process includes:

- Regular staff meetings to review and discuss case files, outcomes, discrepancies and opportunities.
- Quality Review Audits (Non-Physician) where Case Managers review 10 case files every three months to analyze the information for consistency in application of criteria.
- The Case Management Administrator will calculate individual and overall department performance and prepare a summary report for each Case Manager. The individual performance score will be included in the Case Manager's performance review.
- Meetings to provide a forum for discussion of outcomes and implementation of modifications to processes.

Molina Healthcare's Quality Oversight Committee will monitor and track specific Molina Case Management activities on a quarterly and annual basis to ensure consistency is met across all functions, to help identify areas of concern and make recommendations to improve Case Management systems and processes.



Molina will also apply an Outcomes Based Process model to analyze specific conditions, diagnoses, operational processes, services or populations for which measurable outcomes are desired. The process continues as a cycle of ongoing monitoring as outcomes are re-measured and the specific programs are enhanced with each cycle. Once approved for implementation, various departments and subcommittees continuously monitor the implemented activities and track the performance measures that have been defined.

The Outcomes-based Process Model includes the following steps:

- Establish standards and benchmarks;
- Collect data;

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- Analyze data and determine performance levels;
- Identify opportunities for improvement;
- Prioritize opportunities;
- Design and implement interventions, including corrective actions; and
- Measure effectiveness and adjust program design as necessary to achieve desired behavioral change.

Molina's improvement methodology is designed to address gaps in performance. Approaches to improve quality and performance include the following activities:

- Develop, modify or update organizational policy and procedures;
- Address gaps in staffing patterns, personnel or training needs;
- Deploy new, or modify existing systems, operations and tools; and
- Communicate results, changes and updates internally and externally.

Any problems detected with the intervention, or significant variation from performance standards, are reported for further review and action. Case Management administrator staff review and monitor information on a quarterly basis. Results and change in processes to positively impact outcomes are shared with the Case Management Team on an at least an annual basis.

To ensure adequate staffing meets case management requirements, each Case Manager's caseload will not exceed a weighted value of 96 as described in Section D, Paragraph 16, Case Management. Historically, Molina Healthcare has experienced low turn-over for Case Management staff; however, should a Case Manager leave the organization, Molina will immediately identify and evaluate the Case Manager's caseload and begin the transition process to redistribute membership among Case Managers without exceeding the maximum caseload capacity. The newly assigned Case Manager will proactively contact the member to arrange an on-site visit, discuss the changes and ensure that the member is comfortable with and understands the transition.

22. Describe the process the Offeror will employ in assessing and meeting the needs of complex care members via service planning and coordination of multiple providers and involved entities specifically for 1) members needing behavior management and 2) members with complex medical care needs.

Recognizing that ALTCS members have challenging medical, behavioral health, and long-term care needs, Molina will coordinate a comprehensive array of home- and community-based long-term care services and provide coordination and utilization management of acute inpatient medical care, outpatient care, behavioral health, preventive services and other care.

The Molina Case Management Process

Molina's Case Management service planning and coordination process will begin with a comprehensive assessment of the member's health status, including an evaluation of their physical, behavioral health and other psychosocial needs. Within seven business days of a new member's enrollment, the assigned Case Manager will contact the ALTCS member to schedule an initial assessment. The subsequent face-to-face visit will be completed by a Case Manager within 12 business days of enrollment to perform the following tasks:

- Initial assessment of health status, including condition-specific issues;
- Documentation of clinical history, including medications;
- Initial assessment of activities of daily living;
- Initial assessment of mental health, including cognitive functioning and substance abuse;

- Initial assessment of life planning activities;
- Evaluation of cultural and linguistic needs preferences or limitations;
- Evaluation of caregiver resources; and
- Evaluation of available benefits.

The Case Manager will use the first-visit assessment results and other information, such as physician and facility medical records and ongoing care plans, to form a complete and accurate understanding of the member's needs. The Case Manager will then work with the member and the member's family or representatives, the PCP and other providers in the member's treatment team to develop an integrated care plan to meet the member's primary, specialty and acute care service needs.

The Case Manager will develop and maintain care plans to outline services that meet the member's needs in the most effective manner. The Case Manager will be fully aware that the care plan must be coordinated with the member and/or member's family/representative to ensure mutually agreed upon approaches to meet the member's needs within the scope and limitations of the program. As part of the process of developing the care plan, the Case Manager will educate the member and member's family on the need to report the unavailability of services and/or other service problems so that issues can be addressed in a timely manner. The care plan will promote consumer direction and self-determination and may include information for non-covered services. Molina's Case Manager will be aware of the members' benefit-specific eligibility requirements, limitations and exclusions, but may substitute combinations of other services, within cost effectiveness standards, as well as integrate non-covered community resources/services based on the member's needs.

Member progress toward goals and overcoming barriers will be assessed and documented on at least a quarterly basis or as frequently as needed. Care plan goal adjustments will be made based on the unique and changing needs of the member and will consider such things as the member's ability to overcome barriers to care and meet treatment goals. Ongoing assessment, reassessment, goal adjustment and modification of the care plan are considered core Case Management activities and will be completed and documented in a timely manner. Changes to care plans will be made in collaboration with the member and/or caregiver, and the Medical Home. Case Managers will also share care plan changes with all additional service providers, particularly in the instance of members with multiple medical needs or other complex issues such as co-occurring acute medical and behavioral health needs.

One of the key objectives of Molina's Case Management program will be to ensure coordination between the PCP Medical Home and other levels of non-primary care, such as specialty and complex care, behavioral health, hospital stays, Emergency Department visits, medication management, nutritional education, institutional care, transition of care, community and support services, and wellness and dental services. Molina's Case Managers will act as a critical link between the member and the Medical Home to provide care planning, health education and resource coordination. As a team, the Case Manager, the PCP, and the member and member representatives will work together to share information about all services being utilized, empowering members to actively contribute to their health management.

Case Management for Members with Behavior Management Needs
Behavioral Case Management needs are managed by qualified behavioral health professionals, or by a team consisting of a medical Case Manager and qualified behavioral health professional if a member presents with co-morbid physical health and behavioral health care needs. If a

member presents a primary physical health care need and is not in mental health treatment other than the ongoing prescription of medications, the case will be managed by the physical health Case Manager with consultation of the qualified behavioral health professional. If, for any reason, a case is managed solely by a physical health care Case Manager and the member is receiving mental health treatment, the Case Manager will meet and document regular case reviews with a qualified mental health professional. In order to ensure a complete chain of responsibility, when multiple Case Managers participate in coordinating services, each will address their respective areas of physical health and behavioral health expertise in communicating with providers. To minimize confusion for the member, the assigned lead Case Manager will act as the primary point of contact for the member to ensure efficient communications. To facilitate easy and immediate case review, information exchange, task assignments and maintain clear roles, documentation is shared in a single electronic case file accessible only by involved Case Managers to ensure confidentiality in compliance with HIPAA regulations.

These cases will require coordination and communication among an integrated care team that spans working with the member's PCP and other medical specialists, facility based services, the mental health center team including the community case manager, psychiatric prescriber, program managers (e.g., day treatment or clubhouse), and other community and rehabilitative supports (e.g., faith-based, educational, job training).

Additionally, the Case Manager will coordinate specific behavior management services including family support and home care training as well as self-help and peer support services with the goal to achieve improved member health in the most cost effective manner. It is the responsibility of the Case Manager to ensure that all information is exchanged, understood and acted upon in a manner that best meets the complete treatment and service needs of the member and provides the necessary assistance to the member's family or representatives. The Case Manager will work to ensure that the member and/or family or representative are in agreement regarding the member's care plan and that the plan is understood within the context of the scope and limitations of the available services. The Case Manager also instructs the member and/or family or representative how to report any unavailability of services or any other service delivery issue. Any such reported problems will be investigated and addressed by the Case Manager as soon as possible following the report.

Case Management for Members with Complex Medical Needs
Case Managers who are registered nurses are assigned to members with complex medical needs. This specialized expertise is critical to identify and address all of the member's medical issues and current care providers in an effective and timely manner. The Case Manager serves as a conduit for essential communications and sharing of information, such as the care plan. For members with complex medical needs, the Case Manager will actively promote communication by contacting all providers, gather information on current services and issues, and may be involved in coordinating a case conference with the providers and/or attending appointments with the member. An example of the Case Management required for complex medical needs is illustrated by John, who had multiple medical issues including diabetes, congestive heart failure and arthritis. Unfortunately, John's PCP was unaware of his deteriorating condition which was uncovered by the Case Manager during a regularly scheduled home visit. John had gained weight, was having difficulty breathing and was depressed. The Case Manager contacted John's PCP and an appointment was arranged. The PCP determined that a referral to an endocrinologist and cardiologist was appropriate. John was also prescribed anti-depressants.

Following the appointments with specialists and updated medication management, John's situation stabilized, enabling him to remain living independently. Additionally, the Case Manager proactively assessed the member for other needs and identified resources within the community to support the member in the least restrictive setting. This comprehensive level of care coordination is critical to ensure the member maintain and/or improve his overall condition.

23. Describe the Offeror's process for assessment and care planning of members for home-based services by case managers.

Molina Case Managers will utilize a person-centered approach to collaboratively develop a comprehensive plan of care that promotes living in the least restrictive setting. All Molina Case Managers will follow a strict code of ethics to respect members' rights, provide information for informed decision making, promote empowerment to choose the best service options available and act as an advocate for members to best serve their needs.

The Molina assessment process will begin within seven business days of a new member's enrollment, when the assigned Case Manager will contact the member to schedule an initial face-to-face visit at the member's place of residence. During the on-site visit, the Case Manager will perform an assessment to review strengths, identify needs, develop a service plan and create a plan of care. If a member is unable to participate due to cognitive impairment or other limitations, the Case Manager will contact a member representative for care planning, including establishing service needs and setting goals. Throughout the process, the Case Manager will clearly communicate information to the member's representative and, to the extent that they are able to understand, to the member. The Case Manager will confirm that the member will be present for the visit. The Case Manager will complete the on-site visit to initiate the service plan within 12 business days of member enrollment, or sooner if the Case Manager is alerted that the member has more immediate needs. The Case Manager will bring a Member Handbook and specifically explain the Member's Rights and Responsibilities including procedures for filing a grievance and/or appeal. The Case Manager will obtain a signed acknowledgement that the member and/or member's representative has received and understands the information.

Throughout the entire Case Management process, the Case Manager supports and encourages members, to the extent that they are able, and members' families to actively participate in identifying strengths and needs, making decisions, and developing a plan. Molina Case Managers will consider various information resources, including the face-to-face discussion with the member and/or member's representative, recommendations from the member's PCP and other service providers, and the Preadmission Screening (PAS), if appropriate, to develop a plan of care. During the face-to-face discussion with the member, the Case Manager will systematically assess the member's strengths and needs in several areas, including functional abilities, medical conditions, behavioral health, social/environmental/cultural factors and existing support system. The Case Manager will complete a Uniform Assessment Tool (UAT) to determine the member's level of care. The UAT is used to assess the acuity of nursing facility residents, and to determine the nursing facility rate used when developing the Cost Effectiveness Study for HCBS members.

Building on members' strengths, the Case Managers will assist members to develop goals that address the issues identified in the care planning process and outline specific steps for the member to achieve each goal. The Case Manager will ensure goals are written with clear expectations from the service delivery and care coordination processes. The Case Manager will make certain that care plans include member-specific, measurable goals, specify a plan of

action or intervention to meet goals, and include a time frame for attaining the desired outcome. At each assessment visit, the Case Manager will review the goals and document detailed progress and changes that may be needed.

Molina Case Managers will complete retrospective assessments for members who have been receiving HCBS services during the prior period coverage to determine if the services were medically necessary, cost effective and provided by a registered AHCCCS provider. If all criteria are met, the Case Manager will create retro-authorizations for reimbursement and document the information in a separate service plan and care plan; however, the cost of HCBS retro-authorizations cannot exceed 100 percent of the cost of institutionalization for that member. The Case Manager will follow-up on permitted reimbursement, refunds and billing activities surrounding Assisted Living Facility services provided during the prior period coverage. For services that do not meet all criteria during the prior period coverage, Molina will send the member a notice of the decision and provide information on how to file an appeal.

Molina Case Managers will complete an annual Cost Effectiveness Study for all elderly and/or physically disabled members with potential for placement in a Home and Community Based (HCB) setting and for those elderly and/or physically disabled members currently placed in an institutional setting who have discharge potential. Cost effectiveness of services is crucial to the success of ALTCS and must be placed in high priority when developing service plans for members. Molina Case Managers will complete a Cost Effectiveness Study prior to initiating ALTCS services and will enter the data into the Client Assessment and Tracking System (CATS) within 10 business days of the date the action took place. If services are already in place at the time of the member's enrollment, the Case Manager will complete the Cost Effectiveness Study within 12 business days of the enrollment. The Case Manager will update the Cost Effectiveness Study when there is a change in placement to HCBS or there is a change in services that would potentially place the member's costs at greater than 80 percent of institutional cost.

Molina Case Managers will fulfill ALTCS placement goals to maintain members in the most integrated, least restrictive setting (based primarily on the member's choice of options) and meet cost effectiveness standards. The Case Manager will discuss the availability of needed services with the member and/or member's representative after the needs assessment is completed. The Case Manager will discuss the most appropriate service placement with the member and/or member's representative. Topics of discussion will include member's choice, necessary HCBS services, HCB settings, availability, cost effectiveness, covered services associated with care in a nursing facility compared to services provided in the member's home or HCB setting, member's Share of Cost, and room and board cost responsibility. If the member chooses to be admitted to an assisted living center, the Case Manager will ensure that the member exercises their choice for single occupancy by completing the Single Occupancy Form. The Case Manager will inform the member that if the member chooses to live in their own home, they cannot be required to enter into an alternative residential placement setting that is more cost effective than the HCBS as long as the cost of the HCBS is cost effective.

The Case Manager will inform the member that they may select their spouse as their paid caregiver for medically necessary and cost effective services (not to exceed 40 hours in a 7 day period). The Case Manager will inform the member that this choice may have a financial impact on the eligibility of their household for publicly funded programs, including AHCCCS. If the member chooses the spouse as their paid caregiver, the Case Manager will assist them with completing the Spouse Attendant Care Acknowledgement of Understanding form.

The Case Manager will inform the member that upon agreement to the service plan the Case Manager will submit the request for authorization. Molina will make a determination regarding the provision of services requested within 14 calendar days after receipt of the request or three business days if the member's life, health or ability to attain, maintain or regain maximum function would otherwise be jeopardized. The Case Manager will communicate with the member that services deemed to be medically necessary for newly enrolled members will be provided no later than 30 days of enrollment. For existing member, services deemed to be medically necessary will be provided no later than 14 calendar days following the determination. The Case Manager will notify the member of any long-term care services that must be prescribed and will coordinate the request with the PCP. The Case Manager will assist the member select or change a PCP. The Case Manager will develop a written service plan that reflects services to be utilized, appropriate coding/modifiers, frequency or quantity of service, and units of measure. The Case Manager will obtain the member's signature on the service plan and if they agree or disagree with each service authorization. The Case Manager will develop or update the service plan at each service review, at least every 90 to 180 days, and provide a copy to the member along with a copy of the Important Member Rights Notice Form. The Case Manager will retain a copy of the signed service plan for the case file.

If at any time the member disagrees with the assessment, authorization or determination of services, the Case Manager will give them with a written notice of action that explains their right to file an appeal. The Case Manager will explain the process for appealing the decision and associated timelines, including the process to continue services without change until an appeal determination is reached. The Case Manager will explain that the member will receive a notice in the mail from Molina to notify them of an adverse determination and the process for requests for hearings and appeals, and will provide needed assistance.

To prevent a gap in critical services, the Case Manager will assist the member to accurately complete the AHCCCS/ALTCS Member Contingency/Back-Up Plan, associated forms as outlined in the AMPM and the disaster/emergency plan for their household. The Case Manager will ensure that the contingency plan will include timely action steps the member can take to report a gap in service, the toll-free AHCCCS telephone number, Molina's 24-hour telephone number; instructions to complete and submit the Critical Service Gap Report form and a Member Service Preference Level form. Once the Case Manager is aware of a gap in critical services, they will directly assist to resolve the issue within two hours and provide the member with a detailed explanation of the reason for the gap, an alternative plan to resolve the gap and any possible future gaps.

The Case Manager is responsible for ongoing monitoring of services and placement of each member assigned to their caseload and will assess appropriateness and cost effectiveness of services and/or placement and will review them in the member's presence within the time frames as outlined in AMPM Policy 1620. The Case Manager will upload the required information into the Client Assessment Tracking System (CATS) within 10 days of the initial visit. Additionally, information regarding the visit and outcome will be documented in the Clinical CareAdvance application within 24 hours of the visit. Authorizations will be entered into the QNXT Information Technology system.

In an effort to support and facilitate placing the member into the least restrictive setting, the Case Manager will follow the Transitional Program standards for members who have improved in medical and/or functional status to the extent that they are no longer at immediate risk of institutionalization. Upon notification of the member's status, the Case Manager will discuss the

level of care with the member and/or representative and that transition to the HCBS setting must occur within 90 days of the Transitional Program effective date. A Preadmission Screening reassessment will be requested via the electronic Member Change Report form and will follow-up with ALTCS if no response is received within 60 days following submission. The Case Manager will ensure that the member continues to receive all covered HCBS services. If temporary short term (up to 90 days) nursing facility placement is necessary, the Case Manager will work with the member and facility to ensure proper transfer back to the home setting.

Ongoing contact with the member is performed by the Case Manager to ensure that the agreed upon plan and services are effective and satisfactory. Member feedback is actively sought by the Case Manager. On-site visits to re-evaluate the services and member satisfaction are performed at least every 90 days and more often if complications occur.

24. The Offeror must submit responses to the following four case management scenarios.
A. Oscar is a 42 year old male.

A Case Manager will contact the facility within 7 days of Oscar's enrollment to inform them that he is now a Molina member and that a Case Manager will contact Oscar to schedule a face-to-face visit. The Case Manager will contact Oscar and describe the Molina Case Management program services. The Case Manager will schedule an on-site visit to include Oscar's wife, April as soon as possible. Oscar will be asked for permission to contact his PCP and care providers. Oscar's Case Manager will work to build a trusting relationship with Oscar and his family as an essential component of effective care planning.

The Case Manager will begin to gather information from providers and the facility prior to the scheduled on-site appointment to identify the services Oscar is receiving and services that may still be needed by Oscar and his family. The Case Manager will gather additional information about Oscar's report of depression with somatic complaints, irritability and anger, including whether he has received a psychological evaluation for these issues. If he has not yet been evaluated, the Case Manager will work with the Nursing Facility to provide the necessary services. If he is currently receiving treatment for these issues, the Case Manager will note to include the identified interventions in the care plan. If psychiatric medications are prescribed, it will be important for the Case Manager to help determine who will carry responsibility for prescribing and outpatient therapy referrals once Oscar leaves the nursing facility. The Case Manager will also seek clarification of mental status changes given the report of confusion, disorientation and poor memory to determine if these symptoms can be attributed to an identified head injury secondary to the fall or if they are new complaints since his transfer to the nursing facility.

The Case Manager will provide Oscar with written information about Molina, including the Case Manager's contact information, Molina's toll-free number, and necessary consent and acknowledgement forms. In addition, the Case Manager will explain the Member's Rights and Responsibilities under the ALTCS program, including the procedures for filing a grievance and/or an appeal. A copy of these rights and responsibilities will be provided to Oscar in the Member Handbook. Oscar will be required to sign and date a statement indicating that he has received the Member Rights and Responsibilities information in writing, that they have been explained to him, and that he clearly understands them.

During the initial meeting, after meeting with Oscar and April together, the Case Manager will also ask for separate meetings with Oscar and April to identify concerns that they may want to discuss privately. Depending on the previous psychological evaluation information, the Case

Manager may conduct a depression screening using the Hamilton Depression Scale or PHQ-9 to gauge Oscar's current depression risk. During the visit, the Case Manager will also gather information from Oscar about his goals such as confirming his desire to return home, challenges, complaints, successes, progress toward and barriers to meeting goals related to his medical, psychosocial and family support system needs. Together with Oscar and April, the Case Manager will establish and prioritize care plan goals. A thorough explanation of ALTCS covered benefits and services will be reviewed and accessible community services will be discussed. The Case Manager will review with facility staff how Oscar is progressing, what issues have been identified, and what additional services need to be coordinated. The Case Manager will serve as Oscar's advocate to address his complaints of substandard care and lack of age appropriate activities and will gather information from the facility to understand the circumstances leading up to Oscar's outbursts and the actions taken by the facility. The Case Manager will also work to determine what resources may be needed to support Oscar, Oscar's wife and children as they come to terms with impact of his disability.

By the completion of the visit, the Case Manager will have begun the process of building a trusting relationship with Oscar and April; made contact with Oscar's current facility staff to determine progress, issues and solutions; and established immediate and long-term goals in an initial care plan. At this point, interventions will focus on Oscar's progress while in the facility, although it will be critical to begin the process of coordinating services in the community for his eventual discharge. All information will be recorded in Clinical CareAdvance, Molina's internal electronic care management system. While meeting with Oscar, the Case Manager will record information in Clinical CareAdvance via a laptop computer.

A successful transition of care to move Oscar from one level of care to another will be largely depent on the quality of care coordination and communication facilitated by the Case Manager. The Case Manager will also share timely updates and make frequent contact with Oscar and Ajpril to empower them to actively participate in Oscar's care. Once the care plan is formulated, the Case Manager will print and deliver a copy to Oscar and distribute a copy to his PCP and other appropriate care providers.

Oscar's transition from the facility to his home will require considerable preparation by the Case Manager who will continue to follow Oscar closely after his return home to ensure a successful transition. The Case Manager will coordinate caregiver services and develop a back-up plan should caregivers not arrive as scheduled. The Case Manager will inform Oscar and April of the option for April to be his paid caregiver for up to 40 hours per week, which may help alleviate April's concerns about needing to find full-time work. The Case Manager will also ensure that Oscar and his wife are fully aware of medications prescribed and his scheduled follow-up appointments with his PCP and specialists. The Case Manager will ensure that the home is accessible and safe for Oscar and that he, his family and providers agree to the care plan details. The frequency of the Case Manager's on-site visits will be dependent on the intensity of services needed, the stability of Oscar's status and the complexity of the services provided. Visits can occur from several times a week to twice yearly. More frequent visits are anticipated at the onset of Case Management and may decrease in frequency as needs are met. Following each visit, the care plan will be reviewed, and modifications to goals and interventions will be updated and shared with Oscar, his PCP and other appropriate care providers.

The Case Manager will also work with Oscar and April to develop a mutually agreed upon service plan that takes into consideration Oscars varied conditions, social environment and cultural factors to ensure cost-effective service planning that promotes independence and

dignity in the least restrictive setting. The Case Manager will validate that the written service plan includes all authorized services with a date range, unit of service and related costs. In addition, the Case Manager will update Oscar's providers with pertinent information to support the providers' planning, delivering and monitoring of services. The Case Manager will obtain Oscar's signature on the service plan, provide a copy to him and retain the original in the case file.

The Case Manager will also share important information with April regarding programs available for caregiver relief. The Case Manager will remain a key participant in Oscar's ongoing care by working as an advocate for Oscar and his family. The Case Manager will also serve to integrate all aspects of Oscar's care and facilitate cross-discipline communication and exchange of information. If Oscar enters into behavioral health treatment (other than medication management) and the Case Manager is not a qualified behavioral health professional, such a professional will be consulted and results noted in the case file. This supports the Case Manager's ability to effectively bridge coordination of Oscar's physical and mental health service needs.

Oscar's Care Plan
During the initial visit, the Case Manager solicit Oscar and April's full participation to establish immediate and long-term goals for the dynamic care plan that will change over time as goals are met and Oscar's status changes. The care plan will be reviewed a minimum of every three months by the Case Manager, Oscar and April. Oscar's initial care plan will include:

Immediate goals
1. Oscar will experience increased service satisfaction at the nursing facility with:
   - Sensitivity to his care; and
   - Age-appropriate activities and roommate.
2. Oscar's independence will improve as evidenced by:
   - Increased ability to feed himself;
   - Increased participation in physical therapy;
   - Improved skill level to easily maneuver his custom wheelchair; and
   - Development of a bowel program.
3. Oscar will have improved coping skills with:
   - Participation in behavioral health treatment;
   - Report of improved mood and decreased anger and irritability;
   - Improved program participation;
   - Appropriate sleep cycles; and
4. Oscar will demonstrate improved mental status:
   - Either secondary to behavioral health interventions and improved mood; or
   - With rehabilitative supports for identified head trauma.

Long-term goals
1. Oscar's home meets criteria for his safe return:
   - Identify and address home safety issues;
   - Identify and coordinate HCBS;
   - Identify non-paid caregiver resources (spouse, brother);
   - Identify paid caregiver services and begin recruiting process; and
   - Identify other services in the community that may be of interest or assistance.

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2. Home is accessible:
   - Initiate process for minor home modifications to enlarge entrance and master bathroom doorways and include ramps as needed; and
   - Assess and identify shower and/or bathtub needs.
3. Appropriate transportation is made accessible by:
   - Discussing, training and empowering Oscar and April to use the Medicaid Transportation Program for medical needs;
   - Identifying organizations in the community to assist with appropriate transportation for non-medical needs; and
   - Obtaining a van lift if a van is available.
4. Oscar will effectively adjust to his return home by:
   - Following home programs;
   - Exhibiting decreased irritability and anxiety;
   - Participation in adult day care and habilitation programs as desired and necessary;
   - Identification of and providing for personal care needs; and
   - April receiving respite care.
5. Return to work success evidenced by:
   - Identification of contributions that Oscar can make.

B. Magda is an 83 year old female.

Whenever possible, Molina provides a Case Manager that speaks the member's native language. If there is a Romanian-speaking Case Manager available, they will be assigned to Magda's case. If there is not a Romanian-speaking Case Manager available, Molina will use a language line and/or on-site interpreter to communicate with Magda.

In this scenario, the Case Manager is meeting with Magda at her residence for a scheduled reassessment. Because of Magda's diagnosis of dementia, her daughter, Raquel, will participate in the reassessment process, with Magda's permission. During the reassessment visit, the Case Manager will discuss Magda's and Raquel's perceptions of Magda's progress toward previously established goals. If any barriers to the achievement of the goals are mentioned, the Case Manager will address them accordingly. Given Magda's relative isolation and limited ability to communicate with those around her, the Case Manager will conduct an initial assessment to screen for possible mood issues. The Case Manager will give Magda and Raquel a Member Handbook to specifically review and explain the Member's Rights and Responsibilities, including procedures for filing a grievance and/or appeal. Magda and Raquel will be required to sign and date a statement indicating that they have received the Member Rights and Responsibilities information in writing, that they have been explained, and that they clearly understand them. The Case Manager will note that Magda does not qualify for Medicare and all services will be covered under Medicaid benefits.

The Case Manager learns that Magda has received a new diagnosis of early dementia and that Raquel reports Magda has had increased confusion and requests an increase in attendant care hours. Although Magda has early dementia, the Case Manager will encourage Magda to participate in the discussions. The Case Manager will listen and answer Magda's questions and will encourage Magda's participation in setting goals. The Case Manager will assess Magda's current functional, medical, behavioral and social strengths and needs, and will review and modify Magda's service plan and care plan goals based on changes in her condition. The Case

Manager will complete the Uniform Assessment Tool (UAT) to record information about Magda's strengths and needs to determine her level of care. The Case Manager will update Magda's information in the CATS system within 14 days of the reassessment.

Through careful assessment, the Case Manager will determine that Magda's condition does not support additional hours of medically necessary care. After the assessment, but prior to initiating any change in services, the Case Manager will inform Magda and Raquel of the determination of the assessment. Because the hours of care will be reduced, the Case Manager will review the details of the assessment data with Magda and Raquel to help them understand the reason for the change in services. The Case Manager will explain the process for appealing the decision and associated timelines, including the process to continue services without change until an appeal determination is reached. The Case Manager will explain that Magda will receive a written Molina notification of the adverse determination, that the notification will include the process for requests for hearings and appeals, and that the Case Manager will be available to assist Magda and/or Raquel if they require assistance.

In response to the reported lapses in attendant care services, the Case Manager will first confirm that the service provider is a registered AHCCCS provider. If so, they will notify the service provider of the concern of inconsistent service and schedule an appointment to meet directly with the provider to resolve the issue. If not, they will work with Magda and her family to identify an AHCCCS provider that can provide the necessary care. The Case Manager will emphasize to the provider of attendant care that "no shows" put the member at risk and cannot be tolerated. All incidents of "no show" attendant care will be handled as a potential quality of care issue and referred to the Quality Assurance Department for follow-up and tracking. In addition, Provider Services will be made aware of the "no show" issue and additional provider education will be scheduled. If further delays in service occur, the attendant care provider will be discontinued and replaced by an alternate provider. The Case Manager will also review and update the contingency plan to ensure it contains the AHCCCS toll-free line and Molina's toll-free 24/7 Nurse Advise Line. In addition, the Case Manager will review the process for reporting a gap in service and encourage Magda and/or Raquel to immediately call the Case Manager to report any gap in services so that the Case Manager can help resolve the issue in a timely manner. The Case Manager will also review the Critical Service Gap Report form to use if they choose to send in a written report regarding a gap in service. The Case Manager will randomly call the home to monitor the consistency of attendant care services. Additionally, Molina will provide a supplemental resource to manage gaps in service through ResCare HomeCare who will work collaboratively with Molina to enforce timely reporting of service gaps and timely provision of home based services.

The Case Manager will discuss all attendant care options, including the Self Directed Attendant Care (SDAC) option. The Case Manager will explain to Magda and Raquel that members choosing to participate in this service must be interested in actively managing their own health care and be willing to take responsibility for obtaining and maintaining SDAC services. Whether they choose to remain with the original attendant care provider or switch to a new provider, the Case Manager will establish a plan to ensure that care is provided consistently, including developing a written back-up plan in case of emergencies.

The Case Manager will explain other avenues to provide additional care to Magda, including respite and adult day health. Per Raquel's specific request, respite services will be explored. The Case Manager will provide explanations of possible choices the member may select from for respite benefits, limits and scope of services, including respite care in the home, care

provided by a licensed institution facility, or by an approved HCB alternative residential setting. The Case Manager will discuss the available options with Magda and Raquel to help them make an informed decision on the type of respite that is suitable.

The Case Manager will obtain details of Magda's fall history, gait and balance, and the medications she is taking as these could impact stability. The Case Manager will share this information with Magda's PCP to request a physical therapy evaluation and possible treatment plan to help improve Magda's gait and balance, and prevent future falls. Given the sudden onset of falls, the Case Manager will discuss with the PCP the possible need for a neurological referral to determine the cause.

Since it was communicated that Raquel is having difficulty scheduling appointments with Magda's current PCP, the Case Manager will explore this issue further with Raquel to better understand the issue and expectations. The Case Manager will ask Raquel to allow Molina some time to resolve the issues before changing PCPs. The Case Manager will explain to Raquel that in light of Magda's health concerns and her recent falls, consistency and continuity of care are best served with minimal changes in providers. The Case Manager will also engage Molina's Provider Services department to assist with a timely resolution of the PCP appointment setting issues.

Another important area that the Case Manager will discuss during this visit is how Raquel is dealing with the change in her life now that she is providing oversight and care for her mother. Available support for caregivers will be discussed and resources identified to prevent burnout that could jeopardize Magda's ability to remain in Raquel's home. The Case Manager will research local support groups in the community to assist Magda to attend church. The Case Manager is aware that language and cultural barriers can affect how Magda receives care and will work to find ways to address cultural barriers. The Case Manager will continue contacting the member and family at least quarterly, and more often as necessary.

Together with Magda and Raquel, the Case Manager will facilitate the development of a mutually agreed upon, appropriate and cost-effective service plan that will be based on Magda's functional limitations while considering her diabetes, dialysis and onset of dementia. The Case Manager will encourage Magda and Raquel to consider any social, environmental and cultural factors that may impact the service plan. In addition, the Case Manager will touch base with service providers to discuss their assessment of Magda's needs and status. The Case Manager will ensure that the written service plan will include all authorized services with a date range, unit of service and related costs. In addition, the Case Manager will update Magda's providers with pertinent information to support the providers' planning, delivering and monitoring of services. The Case Manager will obtain Magda's and Raquel's signatures on the service plan, provide a copy to them and retain the original in the case file.

The Case Manager will continue to have regular contact with Magda and Raquel regarding the plan and effectiveness of services. Regular follow-up and feedback regarding the attendant care provider services will also be performed.

Magda's Care Plan
Magda's updated care plan will include the following immediate and long-term goals.

Immediate goals
1. Magda will receive optimal appropriate services evidenced by:
    - Maintaining her current level of health;

- No unmet need identified; and
- Living safely in her daughter's residence.

2. Attendant care services will be consistent as demonstrated by :
   - Development of an effective contingency plan;
   - Absence of attendant "no shows";
   - If there are "no shows", they are minimal and replacement is available in a timely manner; and
   - Full understanding of the Self Directed Attendant Care (SDAC) option.
3. Magda will maintain continuity of care by:
   - Keeping her current PCP; and
   - Keeping her service providers.

Long-term goals

1. Magda will continue to receive her care in the least restrictive setting by:
   - Continuing to reside in her daughter's home;
   - Receiving HCBS appropriate for her needs; and
   - Receiving reassessment of her needs at least every 90 days.
2. Magda and her family will develop a community support system.
3. Magda will maintain or progress to her highest functional level through:
   - Coordination of care; and
   - Residing in the most integrated and least restrictive setting.
4. Magda's gait and balance will improve as evidenced by:
   - No further falls; and
   - Development of a home exercise program to help her gain strength.

C. Wanda is a 66 year old female who has been on ALTCS for the past 6 months.

Using a quality of care approach, Molina's Case Manager will ensure Wanda's safety is a major priority and will work with her son, the Assisted Living Facility and her physician to achieve positive outcomes.

The Case Manager will begin by contacting Wanda, her son, and the Assisted Living Facility to immediately schedule a face-to-face visit at the facility. Since the son moved Wanda without contacting the Case Manager, it is critical to contact the son and build a relationship with him. The Case Manager will ensure that the son is informed of the role of the Case Manager and the importance of his presence for the visit, especially because of Wanda's confused state. The Case Manager will work from the outset to establish a working relationship built on trust with Wanda, her son and the Assisted Living Facility in order to work collaboratively to assess Wanda's long-term care needs, develop an efficient service plan and establish an effective care plan.

After introductions are made, the Case Manager will ensure that Wanda and her son receive a copy of Molina's Member Handbook and specifically review and explain the Member's Rights and Responsibilities, including procedures for filing a grievance and/or appeal. The Case Manager will obtain a signed acknowledgement that they have received and that they understand the information. The Case Manager will explain, in detail, the role and benefits

provided by a Case Manager and request that Wanda's son engages the Case Manager in all activities surrounding Wanda's care.

Even though Wanda is confused, the Case Manager will encourage Wanda to participate in the discussions. The Case Manager will listen and answer Wanda's questions and will encourage her participation in setting goals. The Case Manager will assess Wanda's current functional, medical, behavioral and social strengths and needs. The Case Manager will also review and modify Wanda's service plan and care plan based on changes in her condition. Although Wanda may not be due for her annual Uniform Assessment Tool (UAT), because of her change in condition, the Case Manager will complete one with information from the assessment of Wanda's strengths and needs to determine Wanda's level of care. The Case Manager will update Wanda's information in the CATS system within 14 days of the reassessment.

Along with the assessment, the Cost Effectiveness Study (CES) will also be completed. The CES will determine if placement in an HCB setting is appropriate. The Case Manager will explain to Wanda and her son that placement at the Assisted Living Facility will be considered appropriate if the cost of HCBS for Wanda does not exceed 100 percent of the net cost of institutional care and HCBS can meet her needs. For the purpose of this scenario, the Case Manager will assume that Wanda meets criteria to appropriately and cost-effectively stay in the Assisted Living Facility. The Case Manager will update the CES if there is a change in placement or a change in services that would increase cost. The Case Manager will enter the CES data into the CATS system within 10 business days of the assessment.

The Case Manager will work to understand Wanda's ongoing treatment, the impact on her status and Long-term Care services, and if future hospice care will be necessary. All elements of treatment can have an impact on Wanda's quality of life and functional status, therefore, the Case Manager will make every attempt to keep apprised of the services and status.

The Case Manager will also work to improve communications with the Assisted Living Facility staff, will ensure contact information is shared and will encourage the Assisted Living Facility staff to update the Case Manager about any changes in Wanda's condition.

The Case Manager will gather information from the Assisted Living Facility about Wanda's falls and notify them that the falls will be reported to the Quality Improvement Department to determine if it is a quality of care issue. The Case Manager will work closely with the Quality Improvement Department to investigate the issue and determine if Wanda's safety is at risk. Preventing falls will be essential to avoiding further injuries and the need for higher levels of care. If the facility already has a falls-prevention program, the Case Manager will confirm the facility falls program is effective for Wanda's circumstance. The Case Manager will review with Wanda and her son the particular actions in the falls prevention program specific to Wanda's condition to prevent further falls. If a falls-prevention program is not already in place, the Case Manager will strongly encourage the facility to develop one and will offer support by sharing Molina's falls-prevention program and acting as a resource for its development. It is hoped that in appropriately addressing Wanda's many care needs, she will become less combative as an expression of agitation, confusion and frustration. However, if Wanda continues to evidence such difficulty, the Case Manager will also provide support to the facility staff in behavior management by reviewing situations that trigger Wanda's combative episodes and developing a process to anticipate and de-escalate these events. If behavior management interventions meet with limited success, the Case Manager will also help facilitate a psychiatric consultation for

evaluation of underlying mental health treatment needs that are becoming expressed through these behaviors, such as a treatable depression.

Even though Wanda's physician is in the MAP's network and not in Molina's network, the Case Manager will work directly with her physician to communicate the services currently being provided under ALTCS and to share the care plan and any subsequent updates. It is important to understand that Wanda and her son have an established relationship with her physician; therefore, the Case Manager must be diligent to communicate with Wanda's physician to ensure the success of the Long-term Care services. The Case Manager will also discuss with her physician the new diagnosis of pelvic cancer, the planned treatment, and the identification of other specialists, such as an oncologist and radiation oncologist. The Case Manager will also inquire about Wanda's worsening behaviors.

The Case Manager will contact the Network Development team to request Wanda's physician consider joining Molina's network or a single patient contract arrangement. Regardless of the providers network participation status with Molina, the Case Manager will follow-up and remain in contact with the existing or any new providers.

The Case Manager together with Wanda and her son, will develop a mutually agreed upon, appropriate and cost-effective service plan that will be based on Wanda's functional limitations while considering her diabetes, peripheral neuropathy, hypertension, congestive heart failure, confusion and pelvic cancer. The Case Manager will encourage Wanda and her son to consider any social, environmental and cultural factors that may impact the service plan. In addition, the Case Manager will touch base with all service providers to discuss their assessment of Wanda's needs and status. The Case Manager will ensure that the written service plan will include all authorized services with a date range, unit of service and related costs. In addition, the Case Manager will update Wanda's providers with pertinent information to support the providers' planning, delivery and monitoring of services. The Case Manager will obtain Wanda's and her son's signatures on the service plan, provide a copy to them and retain the original in the case file.

The Case Manager will continue to have regular contact with Wanda and her son regarding the plan and effectiveness of services. Regular follow-up will be conducted and feedback regarding Wanda's Assisted Living Facility care services will also be shared.

Wanda's Care Plan
During the visit, the Case Manager will work with Wanda and her son to establish a care plan that will include the following immediate and long-term goals.

Immediate Goals

1. Wanda will remain safely in her Assisted Living Facility setting with no falls and no further injuries by:
   - Following the falls-prevention program; and
   - Immediately identifying and resolving any threat of injury.
2. Wanda's son will understand the role and benefits of the Case Manager demonstrated by:
   - Notifying the Case Manager when changes occur; and
   - Contacting the Case Manager to report unmet needs.
3. The facility will understand the role of the Case Manager expressed by:
   - Notifying the Case Manager of changes in condition; and
   - Contacting the Case Manager if additional services are needed.

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Long-term Goals

1. Wanda will remain in the Assisted Living Facility without complications as evidenced by:
   - No hospitalizations.
2. Wanda will receive required treatment for pelvic cancer demonstrated by:
   - No missed treatments.
3. Wanda will maintain optimal level of health exhibited by:
   - Proper nutrition; and
   - Adequate hydration.
4. If hospice becomes appropriate, discussions will take place about this option with Wanda and her family.

D. Roger is a 39 year old male.

The Molina Case Manager's focus is to promote choice, dignity, independence, privacy and self-determination. To accomplish this, the Case Manager will begin by contacting Roger and Roger's sister, Joyce, within seven calendar days to begin communication and relationship building. During the initial contact, the Case Manager will explain Molina's Case Management program to Roger and Joyce, and provide information about Molina's health plan coverage. The Case Manager will also set-up an appointment to meet face-to-face in the home as soon as possible and ask for permission to contact Roger's PCP. The Case Manager will work from the outset to establish a working relationship built on trust with Roger and Joyce in order to work collaboratively in assessing Roger's Long-term Care needs and establishing an effective care plan. The Case Manager will assess Roger's current functional, medical, behavioral and social strengths and needs and will use the Uniform Assessment Tool (UAT) to determine Roger's level of care. The Case Manager will also enter Roger's information into the Client Assessment and Tracking System (CATS) within 14 days of the assessment.

During the visit, the Case Manager will provide written information about Molina, including the Case Manager's contact information, Molina's toll-free number, and necessary consent and acknowledgement forms. The Case Manager will record information in Clinical CareAdvance, Molina's electronic care management system, via a laptop computer. During the visit the Case Manager will gather information from Roger and Joyce regarding his goals, challenges, complaints, successes, and progress toward and barriers to meeting goals. An immediate concern for Roger and Joyce is the impact of the recent loss of their mother, and the changes this brought to their lives and living arrangements. During the initial meeting, Roger and Joyce will be given the opportunity to meet with the Case Manager separately in order to identify any issues or concerns that either may like to address privately. The Case Manager will discuss with Roger if he wishes to continue living with his sister or would prefer to explore other options. Together with Roger and Joyce, the Case Manager will establish and prioritize goals that will be noted in Roger's care plan. A thorough explanation of potential benefits and services that can be accessed under the ALTCS program will also be reviewed.

Roger and Joyce will be asked for the necessary permissions and release of information to discuss his care plan needs with the appropriate providers, agencies and community supports. The Case Manager will try to make contact with Roger's PCP and any other known medical and behavioral health providers from the state of his previous residence. In addition to physical transition of care issues, the Case Manager will work to gain a better understanding of the mental health supports and treatments Roger was receiving at the time of his relocation. If not

already transferred, the Case Manager will help to obtain medical records from the previous providers and distribute them to the new integrated care team comprised of physical and behavioral health care providers.

The Case Manager will inquire about Roger's functional/work history prior to the traumatic brain injury and determine whether he has the interest and ability to engage in meaningful work. Given the reports of impulsive behavior, the Case Manager will also assess the likelihood that Roger has a substance abuse issue.

The Case Manager will help Roger and Joyce link to the appropriate mental health resources in his new community by facilitating a prompt referral. This will likely include referral to the local community mental health center for an intake assessment for services such as community case management, peer support services, day treatment or other wrap-around community mental health services. The Case Manager will also help link Joyce to these agencies for assistance in behavior management and family support.

In addition to these services, the Case Manager will determine whether the new PCP will provide prescription of psychiatric medications. If a need is identified for psychiatric assessment, medication consultation, or ongoing medication management by a psychiatrist or psychiatric nurse practitioner, the Case Manager will also assist in ensuring that this is facilitated (presumably through the community mental health center) with follow-up and continued consultation with the PCP and other providers. The PCP is required to establish a file for any behavioral health information received, even if prior to meeting the member for the first time and pending entry into the formal medical file. The PCP must document their review of the information received with a notation or their initials. Similarly, any PCP request for information received from a behavioral health provider must be met within 10 business days and include, at a minimum, current diagnoses, medications, lab results, last PCP visit, and recent medical hospitalization information. The Case Manager will support the successful exchange of information with the proper releases among all providers of the integrated physical and behavioral health care team.

For the purpose of this scenario, the Case Manager will assume that Roger wishes to remain living in his sister's home. Support for Joyce, as Roger's primary caregiver, will be critical. Therefore, the Case Manager will work closely with Joyce as Roger's guardian and pay particular attention to address how Joyce is coping with the realities of Roger now living with her. Resources will be identified to address Joyce's concerns and support needs in order to prevent burnout that can jeopardize Roger's ability to remain in this home setting. Given the report of Roger having previously attended a day program of some kind, the referral for behavioral health services may lead to similar day treatment, clubhouse or other structured activities that will help reduce Roger's boredom, irritability and moments of disorientation and in turn alleviate some of Joyce's stress. Joyce may also require behavior management supports that include instruction in the use of positive reinforcement that is better aligned with other wellness objectives. While it is true that cigarettes can be a powerful reinforcement tool, given Roger's history of upper respiratory infections, this may be contrary to his whole-health goals. The Case Manager will explain to Roger the dangers smoking poses to his health and assist him with a plan for smoking cessation, if he is willing. Roger may benefit from peer support services designed to assist him in understanding and participating in his behavioral health treatment. Roger may also benefit from behavioral health personal assistance services.

If the Case Manager is not a qualified behavioral health professional, they will conduct an initial consultation followed by quarterly consultations with a qualified behavioral health professional for the duration of Roger's behavioral health treatment given that it will likely extend beyond medication management alone. The review and discussion of Roger's status and treatment plan will be documented. There will also be documentation of review of psychotropic medications, such as notation of the purpose of the medication, effectiveness, and adverse effects. Any noted concerns (e.g., side effects, poor response) must also be reviewed with the consulting qualified behavioral health professional or prescriber. The consultation and plan of action will also be documented in the case file.

At the completion of the initial home visit, the Case Manager will have established a working relationship with Roger and Joyce. As a collaborative team, they will have discussed issues and solutions, completed the initial assessment form, established immediate and long-term goals and initiated building a service plan. At this time, interventions will focus on quickly identifying resources and services that can help support Roger in his home and community.

Roger's Care Plan

Development of the care plan is a detailed process that establishes goals for positive outcomes. During the initial visit, the Case Manager will work with Roger and Joyce to establish immediate and long-term goals. The care plan is a progressive document that will change over time as goals are met and Roger's status changes. Care plans are reviewed a minimum of every three months by the Case Manager. The initial care plan will include the following immediate and long-term goals.

Immediate Goals

1. Roger will be seen for a behavioral health intake assessment at the community mental health center.
2. Treatment records from prior medical and behavioral health providers will be requested with proper release of information and reviewed by his new integrated care providers.
3. Previous medications will be reviewed by Roger's new PCP with prescriptions written as clinically indicated.
4. Any specialist needs will be assessed by the PCP and facilitated if indicated (e.g., neurology consultation for seizure disorder or other sequelae of the traumatic brain injury).
5. Joyce, as Roger's guardian, will receive family support and behavior management assistance in concert with Roger's entry into behavioral health care.
6. Roger will enter into regular supportive activities following entry into behavioral health care and experience reduced boredom and irritability. Peer support services will help Roger engage in, understand and continue treatment.
7. Roger and Joyce will receive support and counseling as necessary to help in coping with the loss of their mother and resultant change in living arrangements.

Long-term Goals

1. Roger will successfully remain in the care of his sister in her home or will successfully transition to another appropriate setting of his choice.
2. Roger will maintain a beneficial working relationship with his treatment team and peer support counselors.

3. Roger will report satisfaction in attending structured activities regularly at the community mental health center.

Medical Management Submissions

25. Describe how utilization data is gathered, analyzed, and reported by the Offeror. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. The submission requirement will be a maximum of three pages of narrative. Additionally, the Offeror must include three sample utilization reports that demonstrate how data is gathered, analyzed, monitored and evaluated when a variance has been identified. Each sample should be no more than one page.

Molina will develop a written Medical Management/Utilization Management (MM/UM) plan that describes its methodology to meet or exceed the standards and requirements contained in Chapter 1000 of the AHCCCS Medical Policy Manual. The MM/UM plan will include how utilization data is analyzed and managed. Provider and member utilization patterns of under- and over-utilization will be monitored and evaluated on an ongoing basis using data maintained in Molina's core information technology system, QNXT. QNXT data includes claims, membership, provider, authorization, pharmacy and other encounter data. Molina's Utilization Management staff will analyze data gathered from QNXT, medical record reviews, HEDIS statistics and other Utilization Management records to generate reports that identify opportunities for improvement. Molina's Medical Management/Utilization Management Committee will review and analyze the data, interpret any variances and develop interventions based on their findings.

Provider Utilization

Using QNXT data, providers' utilization data, such as hospital and Emergency Department utilization, will be compared to the average provider's utilization in the same category to flag outliers. Resources to establish comparable data include:

- Historic plan data from a single Molina health plan that establishes utilization patterns and thresholds;
- Historic plan data from other Molina health plans for similar lines of business, geographic regions, populations and provider types;
- NCQA Quality Compass;
- Thomson Length of Stay Data
- Percent Paid to Medicare;
- State Medicaid results;
- Other regional health reporting initiatives;
- Comparative data from companies that provide utilization review guidelines;
- Comparative data, thresholds and benchmarks provided by associations; and
- Evidenced based utilization standards from medical literature.

By comparing individual provider's utilization data to a larger group, Molina can identify providers whose utilization patterns are at the extremes. The Medical Management/Utilization Management Committee, comprised of a multidisciplinary team of health plan leaders and chaired by Molina Healthcare's Medical Director, evaluates utilization trends, identifies anomalies in utilization, investigates specific details when necessary and initiates actions to address potential issues. The committee meets on a quarterly basis.

Based upon the situation, the Medical Management/Utilization Management Committee may recommend Provider Services staff conduct provider education to review contract requirements and resolve issues. The Quality Improvement Committee is notified of situations that affect quality of care or impact members' health. This committee is responsible for acting on findings, conclusions, recommendations, and outcomes reported to it by the Medical

Management/Utilization Management Committee, the Delegation Oversight Committee and the Pharmacy and Therapeutics Committee. The Quality Improvement Committee works with the local Medical Director and other staff to develop interventions and action plans to provide a method to monitor, evaluate and measure improvement outcomes.

Member Utilization

Molina monitors and evaluates member utilization data to detect variances such as under- and over- utilization, inappropriate pharmacy utilization and inappropriate Emergency Department utilization. For example, to monitor and evaluate inappropriate Emergency Department utilization, Medical Management/Utilization Management Committee staff generates an Emergency Department high user report at least monthly. Members who demonstrate frequent non-emergent Emergency Department visits, defined as greater than three visits per month, are considered to be at-risk for avoidable hospital admissions and will receive a direct mail communication with education materials that describe appropriate use of Emergency Department services. If, after initial contact, the member continues to inappropriately utilize the Emergency Department, the Case Manager will contact the member to identify the member's motivation to misuse the Emergency Department and offer assistance to resolve the member's challenges. The Case Manager will continue to support the member to ensure access to care in the right setting and reinforce the member's efforts to comply.

See the following sample utilization reports that demonstrate how Molina will gather, analyze, monitor and evaluate data when a variance has been identified.

Sample #1: Emergency Room Utilization Report

Molina Healthcare of New Mexico Emergency Room Utilization Report

In mid 2008, Molina Healthcare of New Mexico conducted an analysis of the Emergency Room (ER) utilization for its Aged, Blind, and Disabled (ABD) membership. Utilization and costs were found to be very high, with over 1,000 ER visits/1,000 members. Cost per visit was near $1,200 and per member per month (PMPM) cost was over $80.

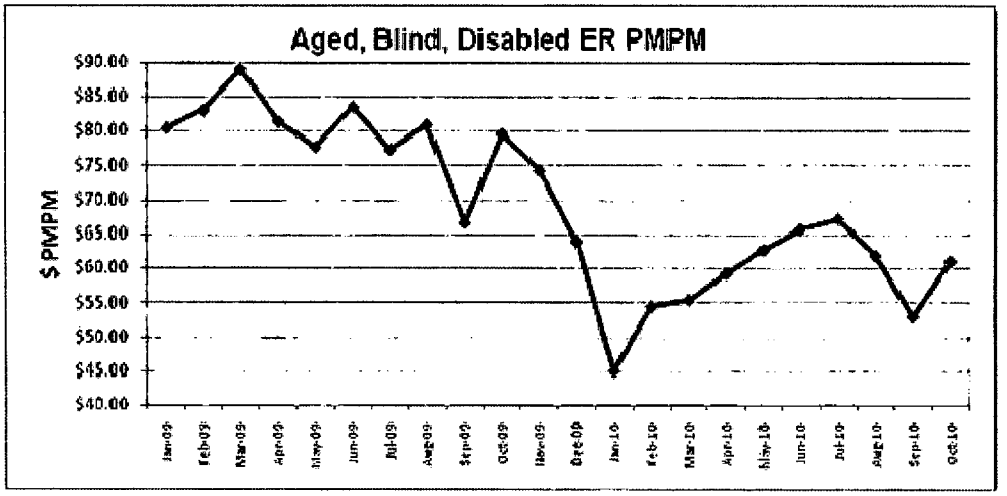
Opportunities for improvement were identified, including:

- Identify and manage members with frequent visits to ER;
- Identify inappropriate visits to ER for non-emergent, non-urgent conditions (per prudent layperson standard) and withhold payment to hospitals (no member responsibility);
- Improve access to primary care and urgent care centers; and
- Improve outpatient hospital contracting.

A multidisciplinary team was assembled and an action plan developed to capture opportunities for improvement. Implementation began in early 2009 and actions taken included:

- Developing a report of individual members using ER frequently;
- Redoubling efforts to educate members regarding appropriate and inappropriate use of ER;
- Contracting with Community Health Workers (CHWs) to help high utilizing members navigate to primary care;
- Implementing medical reviews of ER claims and denying payment to hospitals for non-emergent, non-urgent conditions such as coughs and colds (no member responsibility);
- Offering hospitals triage rates to screen members and schedule follow-up with primary care;
- Identifying and contracting with all urgent care centers;
- Increasing reimbursement for after-hours office care CPT codes; and
- Improving outpatient hospital contracts.

Over the past two years significant improvements have been realized in ER utilization and costs. Visits per 1,000 have decreased 25 percent to 750, cost per visit decreased 30 percent to $850, and PMPM costs decreased about 25 percent to $60 PMPM.



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Sample #2: Prescription Drug Utilization Report

Molina Healthcare of New Mexico Prescription Drug Utilization Report

In early 2008, Molina Healthcare of New Mexico conducted an analysis of Prescription Drug costs for the overall managed Medicaid (Salud!) membership. Per member per month (PMPM) costs were in the high $30s. Generic prescription fill rates were in the low 80 percent range. Analysis of expenditures for generic, brand and specialty pharmaceuticals were analyzed and indicated that the rates being paid to the then contracted Pharmacy Benefits Management (PBM) vendor were not optimal.

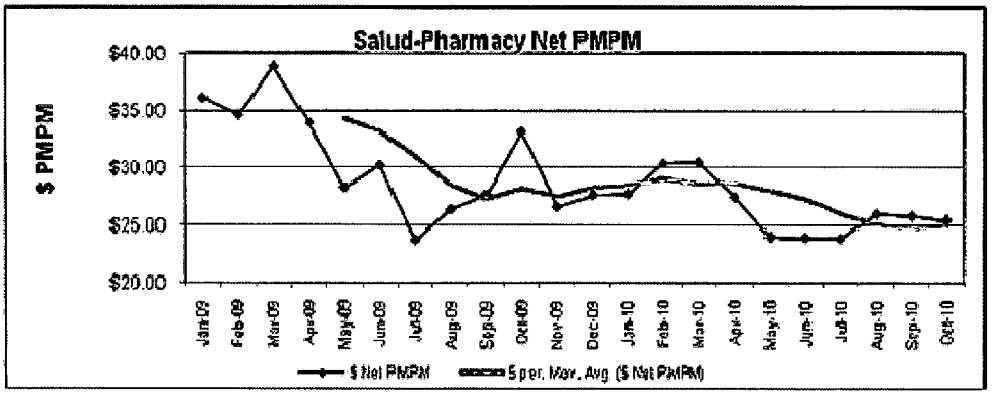
Opportunities for improvement were identified, including:

- Switch PBM to one with more competitive pricing;
- Ensure that all available generic formulations are available to members;
- Revise the Preferred Drug List (PDL) to decrease options for each therapeutic class from all or multiple drugs in a class to two or three selected drugs;
- Increase communications with contracted providers regarding the importance of utilizing generic medications whenever possible; and
- Improve prescription drug prior authorization process to ensure that non-preferred medications, or high cost specialty medications, are used only when medically necessary.

Based on the identified opportunities for improvement, the following actions were taken:

- The plan did not renew the contract with the existing PBM, but instead contracted with a different PBM that offered significantly more competitive pricing;
- The new PBM was instructed to ensure that available generic formulations were accessible to membership;
- The PDL was streamlined while maintaining appropriate access to sufficient numbers of medications in every therapeutic class;
- Additional communications to all contracted providers were mailed or posted on the plan provider Web site encouraging use of generics; and
- The Pharmacy prior authorization process was optimized to ensure appropriate clinical information is received to review medical necessity for selected medications. This was balanced with steps to minimize administrative burden to providers and their office staffs.

Since these changes were implemented about two years ago, Pharmacy PMPM spending has decreased by 25 percent and generic fill rates have risen to 87 percent.



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Sample #3: Radiology Utilization Report

Molina Healthcare of New Mexico Radiology Utilization Report

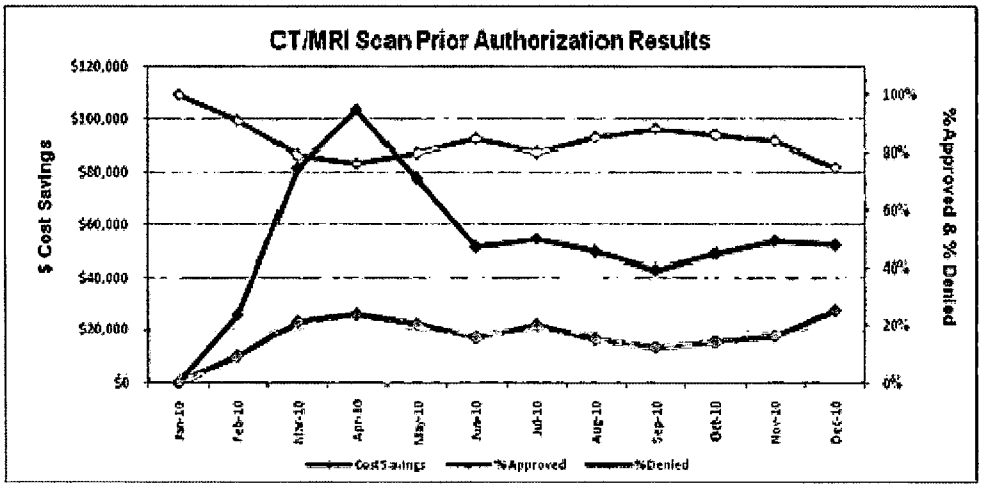
In late 2009, Molina Healthcare of New Mexico conducted a review of overall healthcare costs by service type. One area reviewed was radiology services. Although there were no readily apparent or applicable national benchmarks for radiology costs or utilization for a Medicaid population, this area seemed to have potential opportunities for improvement. The health plan decided to focus more attention on high-end radiology procedures such as Computerized Tomograms (CTs) and Magnetic Resonance Imaging (MRI) scans. In January, 2010, the number of monthly requests for CT or MRI scans was 5 per 1,000 members.

Although a Prior Authorization requirement existed for CT and MRI scans, the process was essentially a notification only process. No coverage denials were being made. A review was completed on a sample of previously approved requests, and it was determined that in many instances, the use of a CT or MRI scan was not supported by the available clinical documentation. The main issues identified included:

- Inadequate or no physical exam of the affected body area.
- Failure to obtain plan radiographs evaluating the area.
- No attempts or incomplete attempts at conservative management of the symptoms.

The decision was made to begin applying InterQual criteria to all requests for CT and MRI scans. This was implemented February 1, 2010.

The results of the program were immediately apparent. The number of requests for these procedures trended down during 2010, reaching a low of about 2.8 requests per 1,000 members by year end. The percent of approved procedures decreased from 100 percent and to about 80–85 percent. The denial rate reached 15–20 percent. Overall cost savings for 2010 were approximately $640,000, or about $0.65 PMPM.



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26. Provide an example of how the Offeror's analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

One example of Molina Healthcare's use of data analysis to identify an intervention opportunity that altered unfavorable utilization patterns occurred in the Molina Healthcare of Texas health plan. Molina Healthcare of Texas administers health benefits to members who are Medicaid eligibles in the Texas ABD program called STAR+PLUS. In April 2008, Molina Healthcare of Texas' Medical Advisory Committee reviewed diagnosis utilization reports that indicated diabetes consistently ranked in the top ten inpatient and outpatient diagnoses. Recognizing that members with diabetes are more susceptible to acute illness and have poorer health outcomes than non-diabetics and considering the volume of affected members, Molina Healthcare of Texas hired a diabetes-experienced health educator. The health educator developed health education materials that focused on members' needs to obtain specific tests, including HbA1c and high blood pressure. Service Coordinators (similar to ALTCS Case Managers) distributed the educational materials to members through direct mail and during routine home visits. Additionally, Molina Healthcare of Texas partnered with a laboratory to conduct in-home HbA1c lab testing. Chart reminders were also sent to PCPs reminding them to conduct regular HbA1c tests for members with diabetes. The table below shows the results of these efforts that increased the number of diabetic members obtaining important screening tests.

Table 26-1 – Diabetic Screening Results

Measure Description Diabetic Members Screening	2009 Rate	2010 Rate	Improvement	2009 NCQA National Mean
HbA1c Testing	68.65%	81.07%	12.42%	80.1%
High Blood Pressure	35.03%	55.4%	7.67%	55.3%

By implementing these interventions, Molina Healthcare of Texas educated members about the importance of screening tests and their responsibility to take steps to obtain regular diabetes health monitoring. The result was a significant improvement in diabetic screening for members, with a 12.42% increase in the rate of diabetic members receiving HbA1c tests and a 7.67% increase in the rate of diabetic members receiving high blood pressure screening.

27. Describe existing or planned Chronic Care/Disease Management programs that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by the Offeror to improve member outcomes.

Individualized care plans include enrollment into appropriate Disease Management programs that promote member participation to meet achievable goals and objectives. Lifestyle issues such as smoking, activity and exercise level, weight, nutrition, and substance abuse can influence the scope and requirements of the individualized care plan. Members' progress toward goals and overcoming barriers will be assessed by Case Managers and updated as needed.

Molina offers the following Disease Management programs that are designed to improve health care outcomes for members with chronic illnesses:

Cardiovascular Disease Program (Heart Healthy Living)

The *Heart Healthy Living* program is designed for adults 18 years of age or older with a confirmed diagnosis of hypertension, coronary artery disease and congestive heart failure. Closely managing care for these members can reduce inpatient and Emergency Department utilization and re-hospitalization rates for members with diagnoses of heart failure.

Chronic Obstructive Pulmonary Disease (COPD) Program (Healthy Living with COPD)
The *Healthy Living with COPD* program is designed for adults 35 years of age or older with a confirmed diagnosis of COPD. Providing a continuum of coordinated, comprehensive care reduces the incidence of acute episodes requiring emergency treatment and promotes improved quality of care for members.

Diabetes Program (Healthy Living with Diabetes)
The *Healthy Living with Diabetes* program is designed for adults and children with a confirmed diagnosis of diabetes (non-gestational and/or non-steroid-induced). The program provides long-term, ongoing care to prevent acute episodes and complications of Diabetes and to improve members' quality of life.

Asthma Program (Breathe with Ease)
The *Breathe with Ease* asthma program is designed for adults and children at least two years of age that have a confirmed diagnosis of asthma. The *Breathe with Ease* Disease Management program strives to improve outcomes through continual, rather than episodic, care. Providing a continuum of coordinated, comprehensive care reduces the incidence of acute episodes requiring inpatient or Emergency Department treatment.

Pregnancy Care Management
Molina Healthcare offers two programs that target high-risk pregnancies with significant success in improving women's health and birth outcomes:

- Motherhood Matters[SM] Pregnancy Health Management Program
  The *Motherhood Matters Pregnancy Health Management Program* is a population-based pregnancy program, for all pregnant women of any age. The Motherhood Matters team forms a partnership with patients and families, teaching them to become active, responsible participants in the care and management of the pregnancy. The program strives to reduce costly hospitalizations through identification, trimester-specific assessments and interventions appropriate to the potential risks and needs identified. Early intervention and the provision of coordinated care over a continuum of settings can dramatically reduce the incidence of complications, pre-term hospitalizations and poor pregnancy outcomes.
- 17P Program
  Molina Healthcare's Utilization Management team facilitates the administration of Alpha-hydroxyprogesterone caproate, a.k.a. "17P," an injectible medication shown to substantially reduce the rate of recurrent preterm delivery. This treatment can significantly reduce pre-term births.

Depression Care Management
The Depression Care Management program is intended for adults 18 years of age or older participating in one or more of Molina Healthcare's chronic disease management programs. The goal of the Depression Care Management program is to promote improved mood and quality of life and to achieve improved health outcomes.

For each program, specified measures are identified for monitoring, analysis and evaluation.

Table 27-1 – Disease Management Program Quality Measures

Cardiovascular	COPD	Diabetes	Asthma	Pregnancy
Member/family satisfaction with the program	Member/family satisfaction with the program	Member/family satisfaction with the program	Member/family satisfaction with the program	Member/family satisfaction with the program
Decrease in Inpatient or Emergency Room utilization	Emergency Room visit rate for COPD among adults ≥ 35 within the health plan products enrolled in the program	Comprehensive HEDIS® measures	Emergency Room visit rate for asthma among children and adults (ages 2 and over) by product line	HEDIS® Prenatal and Postpartum rates
Decrease in re-hospitalization rate for participants with diagnosis of heart failure	Hospitalization rate for COPD among adults ≥ 35 within the health plan products enrolled in the program	Increase in self-blood glucose monitoring	Hospitalization Rate for asthma among children and adults (ages 2 and over) by product line	Percent of participants with completed prenatal screening assessment
Appropriate HEDIS® measures	Pre-post self-efficacy changes in actively enrolled participants	Pre-post self-efficacy changes in actively enrolled participants	HEDIS® asthma medication measures by product line	
Pre-post self-efficacy changes in actively enrolled participants	Pre-post behavioral changes in actively enrolled participants	Pre-post behavioral changes in actively enrolled participants		

These measurements of clinical outcomes, utilization and savings indicators are captured in the Disease Management tracking system. Each Disease Management program is evaluated annually for improvement and enhancements by Molina's Quality Improvement Strategies Committee, which provides direction and oversight of all Disease Management programs. This annual review includes:

- Assessing the effectiveness of program interventions through review of HEDIS clinical outcomes;
- Comparing outcomes to health plan established goals and thresholds;
- Identifying performance change for selected metrics, as needed;
- Identifying improvement opportunities and barriers; and
- Designing interventions targeting the subpopulation whose behavior and/or clinical results were suboptimal or not improving at the expected rate.

Additionally, annual reports are discussed at the Quality Improvement Committee and Clinical Quality Management Committee for comment and ongoing recommendations intended to improve member outcomes.

28. Describe the process used by the Offeror for the adoption and dissemination of clinical criteria used for decision making that would ensure consistent application of the criteria for clinical decision making.

Molina Healthcare adopts evidence-based clinical guidelines to ensure consistency in its approach to determine medical necessity, approval of service authorizations and the treatment of specific diseases. These clinical guidelines are based on national guidelines such as the

American Diabetes Association *Guidelines for the Diagnosis and Management of Diabetes*; the National Heart, Lung, and Blood Institute's *Expert Panel Reports for Asthma*; and The American Psychiatric Association *Practice Guideline for the Treatment of Patients with Major Depressive Disorder*, as well as information available from sources such as the Centers for Disease Control and the Institute of Medicine; American Colleges for Specialties, such as American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and others; state and federal regulatory agencies; clinical evidence and other published, scientific medical information resources; the Hayes directory and customized Technology Assessment Reports; and the National Preventive Care guidelines.

Guideline development includes the following considerations to ensure its application and appropriateness for the member population:

- Conditions of particular relevance to the member population;
- High volume services within the member population;
- Acute and chronic care diagnoses that are appropriate for case management;
- Availability of national evidence and standards of care; and
- Collective clinical experiences of practicing board-certified physicians familiar with the needs of the member population.

Molina continuously assesses current practices and ensures the timely development, maintenance and dissemination of practice guidelines to providers and staff. Molina has several categories of practice guidelines:

- Decision Criteria for Making Medical Necessity Determinations;
- Medical Coverage Guidelines for New Technologies;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines.

Molina Healthcare has established a standardized formal process to address the appropriate review, use, application and availability of evidence based clinical criteria used by Molina health plans to determine medical necessity and appropriateness of services required for making coverage determinations. The clinical criteria used are:

- Based upon scientific evidence, whenever practicable;
- Purchased externally (McKesson InterQual Criteria) as decision support criteria, developed internally as Medical Coverage Guidance documents, and used on a routine basis in accordance with standards and guidelines adopted from national accreditation organizations and federal and state regulatory agencies;
- Reviewed when known changes to technology occur along with an annual review of the procedures for applying them;
- Updated by McKesson on an annual basis and when changes to technology occur; and
- Approved by Molina Healthcare's Medical Management/Utilization Management Committee designated to review and approve utilization management processes on an annual basis.

Molina Healthcare medical necessity criteria are based on the best available clinical evidence supporting safety and efficacy such as the approved and acceptable resources for clinical criteria listed below in order of importance:

- Applicable Federal or State mandates and guidelines;

- Corporate guidance documents addressing new or existing technology;
- McKesson Interqual Criteria/Thomson's Length of Stay Guidelines by Diagnosis and DRG or comparable clinical decision support criteria selected for use by Molina Healthcare;
- Hayes Technology Assessments or comparable evidence-based review products selected for use by Molina Healthcare;
- Agency for Healthcare Research and Quality guidelines, Up to Date, Apollo's Managed Care Guidelines, technology assessments established by nationally accepted governmental agencies, physician specialty societies, associations or academies and published in peer reviewed medical literature;
- Well controlled or prospective cohort/comparison studies (preferably two independent studies) published and referenced in medical or scientific literature with relevant clinical evidence supporting the assertion that the requested modality would provide benefit to the member and a clinical advantage over its competitors; and
- Specialty consultations by a third party reviewer.

The Chief Medical Officer is responsible for coordinating Quality Improvement activities, which includes oversight of development, dissemination, implementation, monitoring and evaluation of practice guidelines. Practice guidelines are reviewed annually and are updated as new recommendations are published. Once guidelines are approved, they are disseminated to network providers through the Chief Medical Officer, who is also responsible for overseeing communication of guideline information and updates to network providers in collaboration with the Utilization Management, Provider Services and Quality Improvement departments.

Dissemination to Providers
Guidelines and other criteria are distributed to contracted practitioners at least annually via the Provider Manual, which contains all health plan policies. Additionally, the Provider Manual will include all items specifically required by AHCCCS for the ALTCS program. Updates to the Provider Manual are facilitated by the Provider Services Manager and incorporated into the document at the next scheduled release. The Provider Manual is available on the provider Web site or in hardcopy/CD upon request and is audited quarterly to ensure all required items are posted and updated in a timely manner. Guideline information is also made available to providers on a case-by-case basis as part of Molina's Utilization Management process. Guidelines are always made readily available to all providers and members upon request.

To ensure network providers are educated regarding practice guidelines, Molina identifies relevant topics for training through tracking of trends, national recommendations, and provider communications with Molina. The assigned department or subcommittee develops the training method and applicable materials for distribution to Molina's network providers. Materials may also include the guideline source documents such as published peer-reviewed literature, nationally available guidelines, At-A-Glance summaries, and instructions on where to access materials from Molina staff and/or external sources.

Utilization Management Inter-Rater Reliability
Molina has established policies and protocols to ensure all guidelines and criteria are consistently applied, and trains, monitors and reviews Utilization Management staff on an ongoing basis. Annual inter-rater reliability reviews and internal audits monitor the consistency of decision making for each level of Utilization Management staff and Medical Directors in

applying guidelines and criteria and following Utilization Management policies and procedures. Results are presented to the Medical Advisory Committee to seek external physician input and identify opportunities for improvement.

Molina annually assesses the consistency of decisions made by Medical Directors using McKesson's Interrater Reliability tool. Using this software application, all Medical Directors take standardized tests that measure their consistency in applying criteria. The process includes assessment of the appropriateness of clinical information reviewed, criteria applied, medical decision making, and in the case of denials, the wording of the reason for denial. Results are shared with the Medical Directors, who meet after each review cycle to discuss findings and ways to achieve greater standardization between reviewers. Findings of the inter-rater reliability reviews and interventions undertaken are also reported to the Medical Management/Utilization Management Committee, the Medical Advisory Committee and the Quality Improvement Committee.

The Utilization Manager implements written policies and procedures for annual inter-rater reliability reviews to ensure the appropriateness and consistency of decisions made by Utilization Management nurse reviewers. Using McKesson's Interrater Reliability tool, all nurse reviewers take standardized tests that assess their consistency in applying criteria. The results are reviewed during Utilization Management staff meetings and the appropriate application of criteria is discussed. Monitoring activities also include review of compliance with policies and procedures, such as documentation requirements and appropriate referrals to disease management and case management. If a deficiency is identified during the course of the inter-rater reliability review process Utilization Management supervisory staff analyzes the deficiency and develops a training plan to provide feedback and interventions to solve discrepancies. The individual staff member, as well as the entire staff, is re-trained when a deficiency is identified along with re-evaluation in circumstances in which performance is unsatisfactory. A formal report of inter-rater discrepancies and the resulting interventions is presented to the Medical Management/Utilization Management Committee and the Quality Improvement Committee on an annual basis.

Quality Management Submissions

29. Describe how the Offeror identifies quality improvement opportunities. Describe the process utilized to select a performance improvement project, and the process utilized to implement or enhance multi-departmental interventions to improve care or services. Include information on how interventions will be evaluated for effectiveness.

Molina will monitor internal data and external reports to identify quality improvement opportunities and guide program recommendations. By identifying the clinically relevant, priority health needs of ALTCS members, Molina will select performance improvement projects that support improved member care.

Each year, Molina will establish program priorities and performance goals for its Quality Improvement Program and monitor its progress in achieving these priorities and goals. Molina's Quality Improvement Program is based on a collaborative model that acknowledges that providers and members are the primary drivers of care. Using the principles of the quality improvement process as a foundation, Molina will systematically monitor and identify opportunities for improvement. Identified opportunities and gaps in performance may result in the development of performance improvement projects.

The Molina Healthcare Board of Directors has ultimate authority and accountability for the quality of care and services delivered to members and for the direction of the Quality Improvement program. The Board of Directors delegates authority to the Quality Improvement Committee for monitoring and operational oversight. This multidisciplinary team, chaired by the Chief Medical Officer, includes senior management representation from all operational and administrative functions including clinical, business and administrative staff. The Quality Improvement Committee reviews data from Quality Improvement activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by subcommittees or by specific departments. The Quality Improvement Committee develops and presents the annual Quality Improvement Program, Work Plan and prior year Annual Program Evaluation, as well as quarterly summaries of activities to the Board of Directors.

Project goals or performance thresholds are developed based on the professional literature, as well as practical experience, industry standards and available national benchmarks. Project evaluation includes an assessment of goals/performance thresholds. Specific sources used to identify goals and/or performance thresholds include:

- HEDIS/CAHPS Technical Specifications;
- NCQA Quality Compass and National Benchmarks;
- Regulatory Standards and Requirements;
- External Quality Review Organization (EQRO) Requirements;
- Molina's Performance Thresholds and Goals; and
- U.S. Preventive Services Task Force (USPSTF) Recommendations.

When an opportunity is identified, targeted interventions are developed by the Quality Improvement department or the responsible functional area in collaboration with the designated subcommittees. This structure and linkage ensures inter-departmental expertise and accountability for the interventions and final outcomes. At the conclusion of the project and annually, the overall effectiveness of the project is evaluated. A project may also be initiated to align with areas identified by state requirements and priorities, EQRO results, Performance Improvement Projects (PIP), HEDIS reporting and NCQA requirements.

The types of data/information monitored to identify opportunities for targeted performance improvement projects include the following:

- HEDIS reporting data;
- Utilization Management process data and internal monitoring reports;
- Claims review process/Encounter data trends;
- Member and provider feedback, including grievances and requests;
- Medication prescribing or usage trend data and reports; and
- Department or Committee requests.

Molina incorporates data from these varied resources to design, implement, monitor and evaluate performance improvement projects as outlined below.

1. Improve the health status of the health plan membership through:
   - Implementation of programs to address the priority needs associated with the major high-risk, acute and chronic illnesses;
   - Monitoring outcomes against national practice standards and address gaps; and
   - Enhancing care and services across primary and specialty practitioners.
2. Identify appropriate safety and adverse events error avoidance initiatives in collaboration with all providers of care through:
   - Evaluation of pharmacy data for drug interactions alerts, recalls, and utilization;
   - Intervention for identified safety issues through case management and review;
   - Collection of data regarding hospital activities; and
   - Tracking quality of care issues, and adverse events, and taking action.
3. Evaluate the continuity and coordination of care through analysis of data to assess:
   - Transition of Care processes and the effectiveness of inter-provider communications;
   - Provider adherence to medical record keeping and documentation standards;
   - Program referral and enrollment timeliness and appropriateness; and
   - Facilitation and arrangements with community and social service programs.
4. Monitor over-utilization and under-utilization reviewed by interdisciplinary teams and the provider network through:
   - Utilization review and case management reports addressing service delivery processes.
   - Quantitative analysis of medical, behavioral health, pharmacy and utilization profiles.
5. Evaluate access and availability of care and service through:
   - Geographic availability to primary care physicians, key specialists, hospitals and other health care services, and taking action to address gaps in the network.
   - Appointment access and availability, after-hours care, and taking action to address gaps.
   - Evaluation of Member Services telephone access, including access for hearing impaired.
6. Manage health care practitioner and provider credentialing/re-credentialing to include:
   - Peer review and credentials process that ensures providers meet criteria.
   - Peer review of investigated quality of care issues, adverse events and corrective actions.
7. Measure member and provider satisfaction and associated improvement activities through:
   - Review of all sources of member and provider satisfaction including, CAHPS Surveys, disenrollment information, grievances and appeals, and act on opportunities.
   - Monitor observance to antidiscrimination laws, including reasons for disenrollment.

8. Evaluate the effectiveness of Quality Improvement activities in producing measurable outcomes and improvements in the care and service provided to members through:
   - Organization of multidisciplinary teams, including clinical experts, to analyze improvement opportunities, determine actions for improvement, and evaluate results.
   - Document activities and outcomes in regulatory approved quality improvement format.
   - Track the progress of quality activities through appropriate quality committee minutes and review/update the Quality Improvement work plan quarterly.
   - Revise interventions as required based on analysis.

Molina's Quality Improvement Program and performance improvement projects fully integrate physical health and behavioral health quality monitoring and improvement. The program is structurally integrated through joint Quality Improvement committee and subcommittee activities. Behavioral Health providers participate on Quality Improvement committees and subcommittees. Through this committee participation, network providers:

- Review and provide feedback on proposed practice guidelines, preventive health standards, clinical protocols, health management programs, quality and HEDIS® results, new technology and any other clinical issues regarding policies and procedures;
- Review proposed Quality Improvement study designs; and
- Participate in the development of performance improvement plans and interventions to improve levels of care and service.

In cases where specific specialty feedback or assistance is needed, community physicians/specialists/practitioners are used to provide feedback on proposed interventions or programs. As needed, focus groups of practitioners may be used for assisting with the design or evaluation of specific programs.

A designated Behavioral Health Practitioner will participate in developing clinical and service activities for behavioral health. This ensures the planning, design, implementation, review and follow-up of quality improvement activities encompassing behavioral health. The designated Behavioral Health practitioner responsibilities include:

- Participating in the adoption of Behavioral Health best practice guidelines;
- Consulting and making recommendations on behavioral health projects/initiatives;
- Providing a Behavioral Health perspective on identified issues, assessment of potential and confirmed Behavioral Health quality of care concerns and member safety issues, providing recommendations for further action as it relates to behavioral health; and
- Screening member and provider material for identification and communication of behavioral health needs.

30. Describe how the Peer Review Committee is structured and utilized by the Offeror and how its reviews/decisions are made and incorporated into the Offeror's quality management process.

Molina will designate a Professional Review Committee (Peer Review Committee) to make recommendations regarding credentialing decisions, to review and monitor ineffective provider performance, and to evaluate adverse actions in accordance with AMPM Chapter 900. The Professional Review Committee will meet at least quarterly, keep confidential minutes using a standard format, and report its activities to the Quality Improvement Committee. Composed of

provider network practitioners, the committee will also be responsible for performing peer review of medical information when requested by the Medical Director, who chairs the committee, and recommending actions based on peer review findings, if needed. Professional Review Committee members must be current representatives of Molina's practitioner network. The Professional Review Committee representation will include at least five practitioners, one practitioner from each of the following specialties:

- Family Practice or Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

Additionally, surgical specialists and internal medicine specialists may participate on the committee as appropriate.

Molina will work with the Professional Review Committee to strive to ensure that network practitioners are competent and qualified to provide continuous quality care to Molina members. The Professional Review Committee will meet quarterly and will be responsible for reviewing and evaluating the qualifications of applicant practitioners and for approving or denying applicants for participation. In addition, the Professional Review Committee will review credentialing policies and procedures annually and recommend revisions, additions and/or deletions to the policies and procedures.

Molina uses established criteria in the review of practitioners' performance. All adverse actions taken by the Professional Review Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986. Molina practitioners who fail to meet the minimum credentialing standards or who fail to meet performance expectations pertaining to quality of patient care will be subject to corrective action, suspension or termination from provider network participation. Suspension or termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the opportunity to appeal has been afforded to the practitioner. Molina reports to appropriate authorities whenever the Professional Review Committee takes or recommends any adverse action based upon unprofessional conduct.

Lists of providers who fall short of the established performance threshold will be submitted to the Professional Review and Quality Improvement Committees to determine if there is evident improvement in performance or if there is a need for a corrective action plan and recommendations that target the specific areas of non-compliance. Outcomes data supplied in these reports will:

- Identify any need to intervene with a specific provider;
- Identify results that may be indicative of a systemic problem/need;
- Identify solutions to address the problem/need; and
- Identify opportunities for further improvements and enhancements to quality of care practices.

If providers fail to show improvement when re-audited within 180 days and it is evident that recommended actions have not been implemented, the Professional Review Committee will review the audit findings and make recommendations to the Quality Improvement Committee. Molina utilizes a multidisciplinary committee process to review, analyze and act upon the results of network and provider monitoring. The results of the Quality Improvement Committee's analysis will determine if the provider's panel should be frozen, or if removal from the network is

warranted. This multidisciplinary approach also ensures that inter-related issues are communicated effectively throughout the organization, analyzed from multiple perspectives, and integrated solutions developed. All monitoring, outcomes analysis and follow-up is overseen operationally by the Medical Director and Quality Management Coordinator.

This reporting and monitoring is viewed as a first step rather than as a definitive step in identifying aberrant practice patterns. No conclusions will be made or actions taken without thorough evaluation of the data and the practice context.

In addition, Molina's Professional Review Committee will respond as needed to situations that pose a threat to the health or safety of members. In such instances, the Medical Director and the Quality Improvement department conduct a systematic review of the potential quality of care issue, which may include referring the case to the Professional Review Committee for further review and recommendation. Following any necessary interventions, a reevaluation of processes would be conducted. Findings may also be reported to the Board of Directors, AHCCCS and other entities as appropriate.

31. The Offeror must submit responses to the following two quality-of-care scenarios. The Offeror should clearly identify each case scenario and describe the process that will be utilized beginning with when it becomes aware or is made aware of the situation. Timeframes should be included as appropriate. The submission requirement will be a maximum of three pages per scenario.

A. The Offeror is notified of an immediate jeopardy at a facility in a rural county that has been operating without a license for several months. Efforts by the Offeror and the Arizona Department of Health Services to assist the owner in submitting the license renewal and supporting documentation have been unsuccessful. Six Medicaid members reside in this facility, two of which are enrolled with another Medicaid Contractor. The only other placement in the service area, an assisted living home, was recently shut down due to abuse and neglect of residents. There is one nursing facility in the geographic service area.

Upon learning that a contracted facility has been operating without a license, Molina's Provider Services team will directly contact the facility to inquire about obstacles preventing the provider from renewing their license and will contact the Case Managers assigned to Molina members within that facility to ensure they are aware of the situation. The Case Managers will make an immediate visit to the facility to determine whether the failure to renew licensing is the result of any safety issues putting the members at risk. Meanwhile, the Molina representative assigned to communicate with the Arizona Department of Health Services about Immediate Jeopardy situations will contact them to share Molina's concerns. The appropriate representative will also contact AHCCCS personnel to keep them apprised of the situation as it develops. An inter-departmental meeting of the Network Operations Committee, including the Provider Services team that contacted the facility and the Case Management team serving those members, will explore options to help the facility and the members who reside there. If the facility is deemed unsafe, the Case Management team will take immediate steps to transport members to a care setting where they can remain safely while more permanent plans for new living arrangements are made. If the facility is safe, alternative options will be exhausted, such as exploring whether there is an opportunity for other credentialed facilities to take over management or ownership of the unlicensed facility.

Case Managers identify that four of the facility residents are Molina members and that two others are enrolled with another Medicaid contractor. The Molina representative communicating with AHCCCS will make them aware that two non-Molina ALTCS members also reside in the home and will notify the Arizona Department of Health Services that only four of the residents

are Molina members and two other Medicaid members residing in the facility are enrolled with another Medicaid contractor.

Case Managers will contact the Molina members and their support systems to inform them of the situation, the potential impact on their residence there and the steps Molina will take to ensure they receive needed care. In the case that a facility closing is imminent or that a facility is found to be unsafe, Molina forms a multidisciplinary team consisting of Case Management, Compliance, Quality Management, Provider Services, Member Services and Health Services staff. The team will focus on member safety, continuity of care and other issues that could affect quality of care to develop a strategy and implement a plan that ensures members are effectively transitioned to another setting. The objective of the transition plan will be to ensure that Molina's members transfer to a setting where they can receive quality care, preferably in a setting located as close to their current residence and support system as possible. The team will identify the nearest licensed facilities capable of providing the required level of care. If the nearest licensed facility is located outside of the geographic service area, the Case Manager will work with the Provider Services department to verify that there are no closer options. The member is kept apprised of the options throughout the process. If the nearest licensed facility is located out of state, such as may be the case in a border town or region, the Case Manager will contact AHCCCS, DHCM and ALTCS to inform the entities of the situation and submit a written request for approval to transfer the member. Since the approval for out-of-state facilities is limited to six months, the Case Manager will ensure they are contacted for re-approval as needed. Throughout this process, Molina would work closely with the Department and ALTCS to keep them aware of progress and to discuss their recommendations and concerns.

Upon identification of a potential transfer setting, Molina Case Managers will contact the members, their support systems and the PCP, within one business day to discuss available options and develop a plan of action. When needed key specialty providers and discharge planning staff at the facility will be involved in these conversations. Possible options for each member will vary depending on member need, choice, support system, available community resources and facilities. Alternative living arrangement and care arrangement options may include:

- Transitioning the member into their home with family;
- Transferring the member to a similar facility outside of the immediate area;
- Relocating the member to another type of Assisted Living Facility as close as possible to the existing facility.

Arrangements and transfers must be appropriate, in the best interest of the member and foster improvement or maintenance of the previous level of care. Coordination of services between member, family, transferring service providers, receiving service providers and PCPs will be conducted by the Case Manager and documented in the Clinical CareAdvance electronic medical record system. The Case Manager will coordinate transportation, services and community resources so that there is as little impact to the member and family as possible.

The Case Manager will collaborate with the member, the PCP, and any specialists currently serving the member to develop an individual transition plan, plan of care and service plan that addresses the member's specific needs. The transition plan will include any needed services, clear directions relative to medications and follow-up services required. The member's updated plan of care will include methods of safe and appropriate transfers to the new location. The care plan will also address safety concerns, acclimating and familiarizing members to the new living arrangements and any concerns the member may have relative to the transition.

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The service plan for the member will be individual and unique to their specific level of care and need. Each member will be reassessed by a Case Manager and their service plan updated to reflect appropriate services planned. The Case Manager will share the new information with the member's PCP and create service authorizations.

The Case Manager will make contact with the member within the first 24 hours of the transfer and again 5 days post transfer to ensure member satisfaction. During the transfer of services period, the Case Manager will be on site at the new location to welcome the member, make introductions and provide assistance as needed.

In the case that there is only one facility in a specific geographic service area, Molina will take proactive steps to share the concern about the lack of licensed facilities with AHCCCS to discuss strategies for filling this gap. Additionally, Molina will visit other contracted licensed facility owners to inquire if they are planning to open new facilities in the deficient service area.

Alternate accommodations may not be available in the immediate geographic area; Molina will evaluate the situation and determine the most appropriate, safe accommodations for its members. When indicated, Molina will make arrangements for accommodations in other communities or even in bordering states if necessary, to ensure the safety of its members. Molina's sub-contracted transportation vendor will work closely with the recovery team to provide applicable transportation.

B. The Offeror is notified of an immediate jeopardy at 4:15 P.M., on a Friday, before a holiday weekend, that a nursing facility in the Phoenix area will not have air conditioning/cooling available for approximately four days. Arizona Department of Health Services licensing staff, local city staff, and the Ombudsman are on site. Reporters are on the way. It is July and currently 116 degrees outside. There are 48 Medicaid members in the facility spread out across several AHCCCS Contractors.

In this scenario, at the time Molina receives the news of immediate jeopardy, a Case Manager will immediately begin execution of the emergency preparedness disaster plan by traveling to the nursing facility. Upon arrival the Case Manager will meet with the Arizona Department of Health Service licensing staff, local city staff, and the Ombudsman to take immediate action to temporarily move the members to a safe, cool location. If non-Molina members are not represented by their health plan, Molina will also help transition those members. In the meantime, Molina's Provider Services department will call the nursing facility to learn more about the situation while Molina's leadership team quickly gathers to discuss the issues and develop a strategic plan to relocate the members until the air conditioning/cooling systems are restored. The strategic plan will include actions to safely transport members to an alternate nursing facility location, identification of a primary public relations contact to deal with questions from the press and coordination of support from local stakeholders.

After the initial move of Molina members and other residents to a safe location, the Case Management team will use claims data and authorization reports to verify the identity of each Molina member residing at that facility. The Case Management team will work with Provider Services to develop a list of appropriate nursing facilities that can accommodate the members until the air conditioning/cooling systems are restored. At the temporary location, the Case Manager will update the Molina members and will engage the member and/or member's representative to discuss and choose an alternative nursing facility, and assist with their transportation.

Molina will place member safety at the top of its quality of care priorities and will leverage Molina Healthcare's direct experience with emergency preparedness and disaster planning to

adequately respond to this emergency. The emergency preparedness process allows an opportunity for the Case Manager to discuss a realistic plan with the member, member's family and facility before an emergency occurs. Identifying safeguards during disaster planning allows for a less stressful atmosphere among members, caregivers and providers. Molina's disaster policies and procedures provide a guide for the Case Management and other inter-departmental teams. Molina's strategic approach to emergency preparedness and disaster planning is designed to create a plan that is realistic and uncomplicated with goals to facilitate timely access to care, eliminate barriers to access acute medical services and confirm acknowledgement of a plan with which the member feels comfortable. Case Managers and Provider Services will work together to achieve these goals.

Molina will manage the immediate jeopardy to provide continuity of care to the members and preserve their safety by following the emergency preparedness disaster plan and executive-approved strategic plan. The Molina Case Manager will ensure that each member's specific skilled nursing needs can be met at the accepting facility, including ventilator, dialysis, wound vacuum treatment, total parenteral nutrition, and intravenous antibiotics. Molina's Case Management team will work with the member and the member's family to develop a transitional plan in preparation for their relocation focusing on their self-awareness and understanding of their health and the possible impact the changes may have on their health. The Case Managers will concentrate on ways to improve the member's self-awareness and understanding of their health issues by encouraging them to actively participate in the change in their plan of care and promote empowerment by encouraging self-advocacy of their care if possible. The Case Manager will appeal to the member and member's family in a calm and confident manner to gain their trust and encourage them to be actively involved with directing their care.

The Case Manager's primary task of coordinating care through this transition includes:

- Performing initial screening of members with the most needs;
- Assessing emergency plan for members identified as high-risk in the initial screening;
- In coordination with Provider Services, sharing the information with the PCP; and
- Providing ongoing coordination of referrals and services.

Molina's Case Management team will generate a list of facilities where members may transfer, including:

- Family's home
- Assisted living
- Residential care
- Adult foster home
- Nursing home facility

The Case Managers will speak with all members and families in this facility to determine transition plans. The Case Managers will also identify the most medically vulnerable members and assess if an acute care setting would be most appropriate.

Molina's Case Management team will facilitate the temporary relocation of the members. If the member's family is able to accommodate the transition of the member to their home and the member is agreeable, the Case Management team will immediately begin transfer activities such as scheduling transportation, notification to the PCP and securing medication availability. If the member's family cannot accommodate the transition of the member into their home the Case Management team will initiate calls to other facilities to inquire about availability and secure a bed. The member will be provided with a listing and information of alternative living

arrangements. Once the member has made a choice, the Case Management team will begin transfer activities such as transportation, notification to the PCP and securing appropriate medical services.

After completing the proper forms, assessments and screenings, Molina's Case Management team will provide temporary authorizations for services. Molina's Provider Services and Credentialing teams will collaborate with the Case Managers to ensure that any transfer facilities are in good standing with the Arizona Department of Health Services and Molina. Provider Services would also assist by obtaining any member-specific letters of agreement with non-contracted facilities to specify required services, negotiated reimbursement and member hold-harmless terms.

Alternate accommodations may not be available in the immediate geographic area; Molina will evaluate the situation and determine the most appropriate, safe accommodations for its members. When indicated, Molina will make arrangements for accommodations in other communities or even in bordering states if necessary, to ensure the safety of its members. Molina's sub-contracted transportation vendor will work closely with the recovery team to provide applicable transportation.

In tandem with coordination of care to ensure member safety and continuity of care, Molina will put into action the Network Recovery Plan.

Molina understands that ALTCS services are provided to potentially vulnerable enrollees with complex health and social needs. As such, Molina is committed to maintaining an up-to-date and effective plan for caring for its members in the event that Molina experience the loss of a major provider, this would include nursing facilities and assisted living facilities. At a higher level, Molina will establish a health plan culture which reinforces each staff member's responsibility to manage to the needs of Molina's enrollees and to the contract between Molina and AHCCCS. Molina will establish cross departmental teams to support this culture of responsibility throughout the organization. This cross departmental approach will eliminate departmental silos and improve early identification of issues with providers and promote more effective recovery in the event of a network loss. Molina's Director of Compliance will hold ultimate responsibility for Molina's Network Recovery Plan. The Network Recovery Plan will feature three key functional areas: Early Intervention and Monitoring; Recovery Action; and Post Recovery Evaluation. Following are key features of each of these functional areas as they relate to nursing facilities and assisted living facilities:

- Early intervention and monitoring – Molina considers Case Management, Member Services, and Provider Services staff members to be the eyes and ears of the organization. These staff members are trained to indentify early indications of future issues with Molina facilities. Early indications of potential network loss will be monitored in Molina's Professional Review Committee on a continual basis, to identify network issues and resolve them efficiently. The Professional Review Committee is empowered to take immediate actions to address identified early indicators.
- Recovery Action – In the event of the loss of a nursing or assisted living facility, any member of the established Molina Business Recovery Team may initiate an immediate meeting of this multidisciplinary team. The team will include the leaders of the Case Management, Medical Services, and Provider Services departments, as well as the Plan President and Medical Director. The team will always approach recovery in such a way so as to promote

the best quality of care for the member; minimize disruption to the member and to providers; and affect the outcome that will minimize future disruption to the provider and the member.

- Post Recovery Evaluation – The recovery team will meet to assess the effectiveness of their recent actions and to identify areas for improvement. They will assess if any early indicators of facility loss were present and if the indicators were properly identified. Lessons learned will be incorporated into the recovery plan.

Molina will incorporate the following general considerations into the operation of the health plan:

- Network will be adequate to ensure the availability of alternative contracted providers.
- Where Molina offers no alternative contracted provider, non-contracted providers will be utilized.
- Molina Healthcare is a multistate operation, and as such features contracted providers in adjoining states. This may prove especially helpful in rural areas of Arizona.

32. Describe and provide an example of the Offeror's experience and commitment to improving quality of care and performance in specific measures of health care services. Describe how this commitment is spread throughout the Offeror's program.

Molina profiles the quality of care delivered by its providers through clinical initiatives, re-credentialing profiles and performance indicator monitoring such as after-hours access. The provider profiling process creates a consolidated profile that aggregates clinical, utilization, administrative and satisfaction metrics to allow an integrated view of provider performance. These data provide the basis upon which Molina builds provider assistance initiatives to help improve quality of care and performance.

Molina administers a program of systematic supports designed to improve provider care delivery, including education and outreach that aids providers in developing meaningful relationships with their patients to improve health outcomes and quality of life. Relevant topics to enhance training and education are identified through performance trend tracking, changes in national recommendations, and provider communications with Molina, such as suggestions made to their Provider Service Representative or direct requests submitted to the Medical Director. Educational programs, training methods and training materials are regularly developed for distribution to Molina's network providers. Materials may include guideline source documents such as published peer-reviewed literature, nationally available guidelines, At-a-Glance summaries and instructions on where to access materials from Molina staff and/or external sources. Molina communicates with and educates network providers through methods such as the Practitioner Provider Manual, *Just the Fax* news bulletins faxed directly to offices, Continuing Medical Education (CME) presentations, the *Partners in Care* newsletter, and information easily accessible on Molina's Web site. The *Partners in Care* newsletter is published several times during the year and is distributed to all Molina providers by mail. The newsletter is also posted on Molina's Web site and is used to communicate information on Quality Improvement activities as well as a range of relevant information for providers, including contact information to access Molina staff.

Other resources and tools are distributed to practitioners to enable ongoing care management at the physician's office and to support preventive services that can improve health outcomes and reduce costly Emergency Department visits. These may include disease flow sheets, comorbidity reminder stickers, HEDIS reminders, exam posters, and topic-specific patient education flyers. Through the dissemination of these resources, Molina seeks to meet a primary goal of the Quality Assessment and Performance Improvement (QAPI) program, which is

partnering with its contracted practitioners to ensure the provision of quality care and service to its members.

Molina will implement provider performance measures in Arizona that monitor if providers are offering services that increase access and availability, ensure appropriate utilization, and comply with clinical guidelines. The following primary categories for PCP profiles will be evaluated:

- **Primary Care Access/Availability** – Patient utilization of the Emergency Department can be an indicator of lack of access to their PCP. Non-emergent Emergency Department visits or visits for issues treatable in a PCP office are important measurements, in addition to a PCP's compliance with after-hours access. Appropriate utilization of services and meeting after-hour access requirements should be reflected in rates that meet or exceed established thresholds. An open panel and extended hours provide appropriate accessibility to services and increased utilization of benefits. The open panel and extended hours measures should be monitored and considered as part of the administrative portion of the incentive program for profiled providers.
- **Prevention and Use of Services** – Performance measures that monitor preventive care and use of services support provider adherence to clinical practice guidelines. Compliance with periodicity tables for immunizations and well-child checks indicate access as well as providing early prevention of childhood disease. To improve or increase utilization of services, it is important to identify providers who fall below established thresholds so that efforts can be made to determine the cause and appropriate corrective actions to improve service rates.
- **Appropriate Utilization** – Emergency Department utilization and inpatient admissions should be analyzed to ensure that providers are delivering appropriate care in appropriate settings. Office visit rates should be compared to network averages to ensure that members are encouraged to utilize PCP services for non-emergent benefits.
- **Member Satisfaction** – Quality of care/service is often reflected in the number of complaints received from members. To ensure that network providers meet expectations for quality service, it is important to include this factor in the provider profile. Quality of care issues are a red-flag indicator demonstrating immediate need for review and possible corrective action. Quality of service complaints should also be monitored for emerging trends to ensure that members are treated with dignity and respect.
- **Clinical Quality of Care** – Some quality of care indicators demonstrating potentially suboptimal treatment are measured via re-admissions, potentially avoidable admissions and post-op complications. Measures can be obtained from Utilization Management and Quality Improvement reports. In addition, appropriate testing and prescriptions for diagnosed conditions indicate quality of care.
- **Administrative Efficiency** – Encounter data completeness and quality impact the accuracy and validity of most metrics and thus the ability of the plan to identify best practices and provider issues. Meaningful dialogue with providers is often based on the premise that performance reported reflects actual performance, and reported performance is based on the data submitted.
- **Fraud, Waste and Abuse Activities** – Molina will monitor claims data and pharmacy data to identify provider practice patterns with an elevated opportunity for fraud, waste or abuse.

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This activity will help to ensure members are receiving care from the most appropriate providers.

Participation in Molina's Quality Improvement Program is a contractual obligation for all Molina network providers. Molina's Quality Improvement Program includes components designed to help practitioners improve their care delivery in areas such as preventive care, Early Periodic Screening, Diagnosis, and Treatment, chronic disease management and inpatient hospitalization case management. Information regarding the Quality Improvement Program is outlined in the Molina Provider Manual disseminated to every provider upon contracting and emphasized during new provider orientation as well as follow-up education sessions.

The Molina Quality Improvement Committee and Medical Advisory Committee routinely monitors reports on clinical indicator data, including the results of EQRO reviews, to identify trends that require action and opportunities to incorporate results into the Quality Assessment and Performance Improvement (QAPI) program. Molina Healthcare collects HEDIS and other quality data for its managed care programs to identify and address opportunities for improvement in health care and member services. Molina's experienced expert statisticians, analytic staff and clinicians, through a combination of claims analysis and review of medical record reviews, assess effectiveness of care, access and availability of care, use of services and member satisfaction. Corporate resources work with local staff to implement effective interventions to bring about improvements in access to services and continuity of care. Results are presented to the Quality Improvement Committee to identify barriers and opportunities for improvement.

An example of Molina's ability to utilize data to provide needed services is Molina's Missed Services report. The reports are linked to member demographics in Molina's main data platform QNXT. Members with identified gaps in service receive telephonic reminders about missed services during inbound member contact with Molina staff. By reminding members to get needed preventive and other health services, Molina supports improved member health outcomes. The results of the monitoring program are tracked and reported along with HEDIS® scores, EPSDT reports and annual program evaluations, including over- and under-utilization trend analysis. The Quality Improvement Committee conducts an extensive review of the results of the reports to recommend actions for incorporation into the strategic plan.

33. Describe how feedback (complaints, survey results etc.) from members and providers is or will be used to drive changes and/or improvements to the Offeror's operations. Provide a member and a provider example of how feedback was used by the Offeror to drive change.

Molina provides multiple avenues for member input and feedback that allows for systematic improvement. Upon identification and analysis of an identified trend, the designated Molina committee and department designs appropriate interventions. Member input and feedback mechanisms are displayed below:

Member Input and Feedback Mechanisms			
Complaint/Grievance Process	**General Satisfaction Surveys**	**Program Participant Satisfaction Surveys**	**Provider-Specific Feedback**
• Member Complaints / Grievances • Provider Grievances and Appeals on Member's behalf	• CAHPS • Website Usability	• Disease Management Program • Case Management Program • Behavioral Health Services • 24 Hour Nurse Advice	• Molina's Web site and ePortal • On-site visits Provider satisfaction surveys

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Input and Feedback from Complaints/Grievances
The Member Services department reviews member input and feedback gleaned from the complaint/grievance process. Molina ensures that members, guardians and caretakers have access to the grievance process by providing them with assistance through each step, ensuring their understanding and ease of use. Molina will have a formally structured Grievance Committee available for members whose grievance cannot be handled informally. The Grievance Committee will be multidisciplinary and will have at least 25% representation by Molina members and may have one (1) member from the State if required based on the nature of the issue.

In addition, the Quality Improvement department trends the results which includes quantitative and qualitative analysis. The Member and Provider Satisfaction Committee reviews the findings, action plan and department activities and provides further recommendations. As part of Molina's Quality Improvement efforts, reports are generated on a routine basis. Report design enables the Member Services department to quickly identify potential problems, and allows for immediate referral to the Quality Improvement department for investigation and appropriate corrective action. The Member Services department monitors member complaints for appropriateness of services and refers identified trends to the Quality Improvement department. The Quality Improvement department will present cases to the Medical Director who makes a determination as to the appropriateness of the care delivered. Provider appropriateness of care and quality of care investigations tracked and trended for potential negative patterns. Member complaints about the appropriateness of care will initiate a service improvement activity and will be reported to the State.

Input and Feedback from General Surveys
Molina incorporates the results of member input and feedback from the annual performance review of the Consumer Assessment of Healthcare, Provider and Systems (CAHPS®) Member Satisfaction Survey. Member input provides a means to assess and improve member satisfaction, accessibility to services, as well as availability of the provider network. Molina's Quality Improvement Program and Work Plan outline activities based on CAHPS results and the process for identification of improvement opportunities. CAHPS performance survey measures provide a means to evaluate the care and services provided. These measures are at the core of Molina's Quality Improvement activities. Molina's staff, network providers' quality teams and committees review annual survey results to assess performance to benchmarks, performance thresholds, trended to previous performance and/or goals and to identify gaps and develop action plans.

Input and Feedback from Members Using Specific Services or Program Enrollment
Satisfaction surveys are administered to members who have used one or more of the programs covering Disease Management, Case Management, Behavioral Health Services or the 24 Hour Nurse Advice Line using standard survey methodology. Results are reviewed in aggregate at least annually to ensure member feedback is incorporated into the annual program evaluation. Performance is compared to goals to identify gaps and opportunities for improvement for incorporation into the strategic planning.

An example of Molina's commitment to program changes that resulted from member input regarding access to care includes an expanded Community Outreach and Retention Program in the New Mexico Plan. An increase in the resources dedicated to this department was realized to help more people access healthcare. Special emphasis has been placed on outreach to the Native American population. A Community Outreach Manager, and six Outreach and Retention Coordinators – each focusing on a different part of the state – work with New Mexico local

health clinics, providers, small employer groups, churches, chapter houses, schools and other organizations to help these groups understand how their clients may be able to access healthcare through the New Mexico Salud! Program. Molina's coordinators are ethnically diverse, bilingual and possess the compassion necessary to develop partnerships with the community and reach out to assist vulnerable, underserved populations.

Input and Feedback from Consumers of Behavioral Health Services

Behavioral Health program features are developed and implemented in close alliance with consumers and consumer advocate groups. It has been demonstrated repeatedly that including the "consumer voice" in these efforts leads to improved treatment adherence, support service utilization and preferred outcomes. The Substance Abuse and Mental Health Services Administration (SAMHSA) included the perspectives of behavioral health service consumers, their families and other advocates in determining the "Ten Fundamental Components of Recovery" to guide the efforts of consumers, providers and healthcare managers alike in achieving wellness. Molina strives to attend to each of these factors in care management including: self-direction, individualized and person centered planning, individual empowerment, holistic care, non-linear interventions, strengths based growth, utilization of peer support, respect for the individual, and the fostering of responsibility and hope.

Consumers and consumer advocates are members of the Molina Healthcare National Advisory Committee. This committee meets semi-annually to review Behavioral Health program development and to gain guidance and information from a breadth of participants representing academic centers, community mental health providers, public policy advisors, in addition to our consumer issues experts. Presently, Peter Ashedon, CEO of the Depression and Bipolar Support Alliance, a national consumer support and guidance network, as well as Cynthia Wainscott, member of the Board of Directors for Mental Health America, the nation's oldest community-based network committed to promoting mentally healthier lives, serve on this committee. While this committee provides a forum for broad concepts and oversight, Molina will build a community based consumer advisory panel as well. This panel will provide direction and feedback specific to the local program development and management of behavioral health services as well as their integration with other medical care management services.

The National Advisory Committee has been instrumental in shaping Molina's commitment to the development of Peer Support Services. Molina Healthcare National Advisory Committee's newest member, Larry Fricks of the Appalachian Consulting Group also oversees Peer Support Services and service development for the Depression and Bipolar Support Alliance. Mr. Fricks was invited to serve on the National Advisory Committee to specifically help Molina's efforts to develop these community based services. These are consumer led services that have been repeatedly shown to carry great success in helping to engage members and enhance treatment adherence, particularly among the seriously mentally ill. Molina will work closely with the local community mental health centers to recruit consumers interested and capable in providing these auxiliary services. Molina will assist these identified consumers in gaining Peer Support credentialing. Once credentialed, Molina will work with the community mental health centers to incorporate their services into the member care plans. While peer support has been demonstrated to enhance member treatment adherence and lead to improved treatment response, peer counselors will also serve as liaisons to the Molina case management teams in communicating the satisfactions and dissatisfactions of members. Moreover, they will serve an important role in working with the Molina team to find appropriate issue resolutions for the member.

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Input and Feedback from Providers

Molina administers an annual provider satisfaction survey to evaluate the strength of the provider-plan partnership and how well Molina supports providers in delivering care. To assess how satisfied providers are compared with other Medicaid plans, Molina trends satisfaction rates and compares performance to available benchmarks. Molina Healthcare has contracted an NCQA-certified survey vendor, The Myers Group (TMG), which supplies an appropriate Medicaid benchmark generated from all providers surveyed at a national level. As an example, key attributes of the 2007-2010 Provider Satisfaction Survey for Molina Healthcare of Ohio are presented below. The Overall Rating and Loyalty, "recommend Plan to other patients," and "recommend Plan to other physicians" satisfaction rates are statistically significant and above benchmark, indicating that providers are highly satisfied with Molina Healthcare of Ohio's services.

Table 33-1: Annual Provider Satisfaction Survey Results 2007-2010

Molina Healthcare of Ohio	2007	2008	2009	2010	2010 National TMG Medicaid Benchmark
Overall Satisfaction and Loyalty	47.7%	62.8%	74.6%	83.0%	76.9%
Definitely or probably recommend to other patients	51.1%	68.3%	77.2%	86.1%	81.0%
Definitely or probably recommend to other physicians	51.4%	64.5%	76.0%	85.8%	79.9%

Following the 2007 annual survey, a review of provider satisfaction results revealed the need to develop an action plan and address opportunities for improvement. A few of the initiatives Molina Healthcare of Ohio implemented include the following:

- Re-organized and re-trained staff during 2008 into two dedicated functions. One internal unit was established to manage provider needs, which enabled Molina Healthcare of Ohio to develop in-house expertise. A separate dedicated field staff was trained to address unique issues associated with the delivery of care in rural and country settings in addition to urban service areas. The transition from "generalists" to experts has resulted in stronger provider partnerships and improved member and provider satisfaction.
- In late 2008, Molina Healthcare of Ohio launched a dynamic and interactive provider feedback program called "*It Matters to Molina.*" The feedback program includes several mechanisms such as postage-paid postcards and a dedicated e-mail address and telephone line which give providers the opportunity to offer recommendations anonymously. All comments, concerns or issues are addressed according to established turn-around-time standards that are tracked and monitored. Each submission is trended to ensure systematic issues are acted upon.

34. Describe the process that will be utilized by the Offeror to monitor services and service sites of members that reside in their own home. Describe what steps will be utilized if non-compliance is identified.

Members receiving services in their own homes may be isolated which can present additional challenges to accessing reliable, high quality care essential to achieving member satisfaction. Molina will monitor the delivery of services and service sites of members that reside in their own homes through an inter-departmental process. Molina's inter-departmental oversight of monitoring services in the member's home will include participation by the Case Manager and the Provider Services, Member Services and Quality Improvement departments.

Molina is committed to quality care and expects the same performance from its network providers. Long-term care services are essential to the ALTCS population and it is critical that

these services are provided reliably and with the highest quality. To ensure quality and safety, the Case Manager will consistently and frequently monitor long-term care providers' performance and service level. Random calls will be made to the home to check on the provider's attendance. Through the Quality Visit Survey, 10 percent of members will be randomly called on a quarterly basis to ensure the quality of the visit, timeliness of services and professionalism of the caregiver to meet the needs of the member. Regular on-site visits to the residence will be conducted at least every 90 days. Case Managers will conduct more frequent case monitoring when an urgent need or change of condition is identified and will make immediate emergency visits if there is any reason to believe that the member's well being is endangered.

Feedback from members is critical for early identification of quality and consistency of service issues. If a complaint is received by phone and the concern cannot be immediately remedied, the Case Manager will review the situation with the Case Management Supervisor to determine the priority. Based on severity, the Case Manager will schedule an appointment with the member for an on-site visit. Resolution must occur immediately for all complaints regarding member safety. The Case Manager and/or Supervisor will notify ALTCS and AHCCCS of mandatory report situations and any other concerns as appropriate.

The Case Manager will notify the Provider Services, Quality Improvement and Member Services departments of all complaints. Provider Services representatives may be involved in the interventions to monitor the provider's performance. If resolution of the issue is unattainable, the contract with the provider may be terminated. The Case Manager will keep the member and ALTCS informed throughout the process. Ongoing feedback from members will be a necessity.

Molina will monitor the quality of care of the provider types listed as follows:

- Adult Day Health Facilities
  Quality of care will be monitored through inpatient claims data of members attending Adult Day Health Facilities. Molina will set utilization benchmarks, and those facilities with higher than established utilization will be subject to closer scrutiny. Review of this data will occur quarterly. The Quality Improvement Committee will monitor utilization and benchmarks to track and trend areas for improvement.
- Personal Assistance Services
  Quality of care will be monitored through review of member and/or family complaints. All complaints will be investigated, documented and resolved within state standards. The Quality Improvement Committee will monitor complaints to track and trend areas for improvement.
- Home and Community Support Services Agencies and Providers
  Quality of care will be monitored through the review of member and/or family complaints, utilization of services and outcomes data to track and trend areas for improvement.

The Molina Case Manager will create a comprehensive contingency plan for gaps in services. Should this plan need to be utilized, the Case Manager will immediately contact the agency or provider causing the service gap. The discrepancy will be discussed, the contingency plan reviewed and the Case Manager will document the outcome. Molina Provider Services staff will be notified of these incidences and will participate in follow-up interventions with the provider as needed. The Molina Case Manager will document the information and follow-up with the member on a weekly basis for a period of four weeks. Should any additional disruption of

service occur, the Case Manager will coordinate an on-site visit with the member and provider to discuss concerns and other options with the member.

Molina will immediately report any complaint or self-reported incident alleging abuse, neglect or exploitation to AHCCCS, ALTCS and the Department of Family and Protective Services. In addition, Molina will monitor the following available data:

- Medicare and Medicaid Sanctions
  The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. This report is reviewed within 30 calendar days of its release. If a participating provider is identified on the exclusion report, the provider's contract with Molina is immediately terminated.
- Sanctions or Limitations on Licensure
  All reported sanctions or limitations against licensure by the appropriate licensing agencies are reviewed within 30 days of their release. Molina contracted providers identified on the report will be reviewed immediately by the Medical Director. The Medical Director will determine if the issue needs immediate action or can be reviewed at the next scheduled monthly Credentialing Committee meeting.
- Member Complaints/Appeals
  Member complaints/appeals about care are forwarded to the Quality Improvement department. The Quality Improvement Nurse reviews each complaint to determine if there is a potential quality of care issue. If it is determined that there is a potential concern, the case is sent to the Medical Director for review and determination. Network service complaints are forwarded to the Provider Services department for follow-up.

  The Credentialing Committee reviews the entire credentials file and the complaint information and makes a determination. If the Credentialing Committee identifies instances of poor quality that could affect the health and safety of Molina members, an appropriate intervention will be initiated. If there are patterns of poor service, the issues may be brought before the Quality Improvement Committee for recommendations.

  This data is also reviewed at the time of re-credentialing as part of the provider's profile. The Quality Improvement department may request the Credentialing Committee to review a practitioner or a group of practitioners' performance related to opportunities identified for improvement at any time.

Molina is committed to ensuring members receive consistent, quality services that promote choice, dignity, independence, privacy and self-determination. Monitoring these services is an integral part of Molina's Case Management program.

35. Oral Presentation
Responsive Offerors shall participate in a scheduled oral presentation, to last approximately two hours. All presentations will be scheduled to occur during the weeks of April 11 and 18. Presentations will be audio-taped by AHCCCS solely for the Agency's use in the evaluation process. AHCCCS shall notify each Offeror of their scheduled presentation no later than 5:00 pm on April 1.

The Offeror shall bring no more than five individuals to the meeting. Among these five individuals, the Offeror shall include persons with expertise in:

- **clinical integration of acute, behavioral health, and long-term care services;**
- **case management;**
- **quality management; and**
- **network development**

The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. MST on April 8. The Offeror shall indicate if a participant is a contractor/consultant not employed by the Offeror, and what role each individual will play during the implementation phase and the first year of the contract.

During the meeting, the Offeror will present solutions, and respond to oral questions, to two scenarios posed by AHCCCS. Offerors will be allotted time to privately discuss each scenario and to prepare a timed oral presentation. AHCCCS will:

- **select a single scenario from submission requirement 24, A through D. All Offerors will be provided with new information about the selected scenario at the oral presentation.**

- **present to all Offerors a new quality management case for the second scenario. This scenario will be provided at the oral presentation.**

Molina Healthcare of Arizona will be represented at the Oral Presentation by the following five individuals:

1) **Lynn Allen**, Plan President, Molina Healthcare of New Mexico and appointed Plan President (CEO) of Molina Healthcare of Arizona.
2) **Eugene Sun, M.D.,** Chief Medical Officer, Molina Healthcare of New Mexico.
3) **Barbara Johansson**, Vice President Care Coordination, Molina Healthcare, Inc.
4) **Debra Horowski, Ph.D.,** Director Behavioral Health Care, Molina Healthcare, Inc.
5) **Michelle Purrington**, Associate Vice President Implementation, Molina Healthcare, Inc.

The names and resumes of the above participating individuals will be uploaded to the EFT/SFTP server by 3 p.m. MST on April 8.

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E. Provider Network

Table of Contents

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E. PROVIDER NETWORK

Provider Network Submissions

36. The Offeror must submit a Network Development and Management Plan. The submission may exceed the three page maximum.

Molina has developed and will continue to refine and maintain a provider Network Development and Management Plan designed to ensure the provision of covered services that meet designated access and all other AHCCCS contract requirements to adequately serve Molina's assigned membership. The Network Development and Management Plan incorporates Molina's strategic approach to network composition as a living document that will evolve as the needs of Molina's membership change and will be annually evaluated, updated and submitted to AHCCCS within 45 days from the start of each contract year.

See Attachment 36-1 for Molina Healthcare of Arizona's Network Development and Management Plan.

37. Any Offeror who is new to a GSA must submit a description of how it will launch a network capable of supporting its membership by October 1, 2011. Incumbent Contractors that are not new to a GSA are exempt from this requirement.

Molina will establish all resources necessary to launch a network fully capable of supporting Molina's assigned membership, in advance of the October 1, 2011 effective date. Molina's ability to establish an effective network of providers is exceptional in three regards. First, Molina has taken a very proactive approach to the network build for ALTCS by investing considerable resources into building a robust provider network that meets AHCCCS contract requirements. Second, Molina has and will continue to build resources specific to Arizona for network development. And third, Molina is a large company with the flexibility to apply additional contracting resources on a temporary or longer term basis to ensure timely completion of network development. Additionally, Molina will establish adequate Medicare networks in the proposed GSAs. Molina has already applied for Medicare MASNP approval for GSAs 42 and 52 and anticipates an effective date of January 1, 2012. Molina plans to expand into GSA 44 with an effective date of January 1, 2013.

Throughout the past year, Molina has devoted extensive resources to manage the work involved with establishing a network of providers who will meet Molina's contracting requirements and the needs of ALTCS enrollees. Molina recognizes that network development needs for the ALTCS population are great and proactively decided to initiate contracting a network specifically for ALTCS members while awaiting award of a contract from AHCCCS. To ensure early resources were devoted to developing a contracted network for ALTCS beneficiaries, Molina utilized resources from Molina Healthcare of New Mexico and Molina Healthcare's network contracting departments. Molina Healthcare's strong market presence in Arizona's bordering states (California, Utah and New Mexico) provided subsidiary health plan resources that Molina leveraged to aid in the development of the Arizona network. Molina Healthcare of Utah and Molina Healthcare of New Mexico will also offer existing contracted providers to the network in their respective border communities, including Gallup, New Mexico; Kanab, Utah; and St. George, Utah. Molina Healthcare's Provider Services staff with significant experience building similar networks in other states have also been available to assist in the Arizona network development project.

Resources in Arizona

Molina has also engaged the services of three individual network development consultants who reside in the Phoenix metropolitan area and have extensive experience working with AHCCCS plan providers. These consultants would remain available on an as needed basis, after contract award. To further support network development, in January 2011, Molina hired a full-time employee, Penny Garrity, to lead Molina's Network Operations department. Ms. Garrity resides in Phoenix and brings with her more than 29 years' experience working in the Phoenix managed care market. Molina anticipates hiring significant additional network development and provider services staff upon contract award, sufficient to meet all network requirements prior to the October 1, 2010 effective date. To fulfill this objective, Molina has already been in contact with several in-market individuals with extensive networking experience that have expressed an interest in joining the Molina Healthcare of Arizona team as soon as possible.

Executive leadership to direct Arizona network development efforts is provided by Lynn Allen, the appointed Plan President of Molina Healthcare of Arizona and the current Plan President of Molina Healthcare New Mexico. Upon contract award, Mr. Allen will relocate to Arizona to transition from leading New Mexico operations to assume the leadership responsibility for Molina Healthcare of Arizona. Mr. Allen has specific experience building and maintaining networks for ALTCS plans. Because Mr. Allen has spent much of his career in the network development and management areas, AHCCCS can be assured that network contracting and maintenance will be a priority at Molina. Molina will engage and maintain a strong network contracting and service presence in Arizona.

Flexible Resourcing for Network Contracting and Configuration

As previously noted, Molina has initiated the use of specific contracting resources from both Molina Healthcare and Molina Healthcare of New Mexico, to provide a large contingent of experienced network building resources during the critical pre-operational phase of network development. Molina will continue to draw upon these resources and if indicated may utilize additional enterprise resources to ensure that the network is built promptly, completely and thoughtfully. Molina will also rely upon highly experienced resources in the area of systems configuration to ensure that the contracts established are properly configured into the claims system.

Molina Healthcare grew from a single provider practice and continues to be directed by physician leadership. Dr. Mario Molina's dedication to building successful provider networks ensures that the entire organization recognizes the impact each contracted provider has on Molina's operations and membership. To meet its own stringent network development requirements and to ensure ALTCS members have access to a provider network that meets all AHCCCS requirements, Molina is building a network fully capable of supporting over 8,000 GSA 52 members in Maricopa County, over 1,700 GSA 44 members in Apache, Coconino, Mohave, and Navajo Counties, and over 1,000 GSA 42 members in LaPaz and Yuma Counties. Molina is developing its Arizona network to ensure members' satisfaction with network composition and access, and will continue to strengthen the network in anticipation of ever-increasing membership.

Early provider alliances established by the network development team include:

- Arizona State Physicians Association (ASPA);
- Banner Health Systems;
- Banner PHO;
- Covenant Health Network;

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- Foundation for Senior Living;
- District Medical Group;
- IASIS Hospitals;
- John C. Lincoln Health Network;
- Kingman Regional Medical Center and physician group;
- Maricopa Integrated Health Systems;
- Northern Arizona Healthcare;
- Yuma Regional Medical Center; and
- Yuma Unified Medical Association (Yuma IPA).

Additional Sub-Contracted Networks
To ensure Molina's ALTCS members have network access to outstanding dental, vision, pharmacy and transportation services, Molina has contracted with the following vendors:

- DentaQuest will provide the statewide dental services network;
- March Vision Services will provide a statewide network of retail vision providers;
- CVS Caremark will provide an extensive retail pharmacy network featuring more than 1,000 retail locations applicable to Arizona; and
- SafeRide, Inc. will provide a statewide transportation solution and call-tracking center for transportation services.

Molina will seek AHCCCS approval of contract templates immediately following a contact award announcement to make full use of the limited time available to maximize execution of provider agreements. In the meantime, Molina will dedicate the necessary resources to ensure a network that meets all requirements is available on October 1, 2011.

38. Describe how the Offeror will communicate with its provider network in explaining the standards for the program, changes in laws and regulations, and changes in subcontract requirements.

Molina will establish processes and procedures to communicate and explain to its network providers the standards for the ALTCS program, changes in laws and regulations, and changes in subcontract requirements. Through frequent and effective communications with the provider network, Molina will keep providers up-to-date on program standards and regulatory changes to reduce their administrative burden, improve operational efficiencies, reduce unnecessary calls to Provider Services and minimize claims rework. Molina will keep providers informed of all changes following the timing specified in Molina provider agreements and ALTCS contract requirements, including providing the proposed communications to AHCCCS 60 days in advance and providers 30 days in advance of material changes to health plan operations. Updates to AHCCCS Subcontract Provisions, as amendments to the contract, will be distributed via direct mail. General updates on health plan operations will be delivered using multiple methods, as listed below, to ensure providers are receiving information as it is available.

- Provider Manual
  The Molina Provider Manual will contain all ALTCS program information and regulatory requirements necessary for participation in the Molina provider network. Molina will distribute the Provider Manual to all new practitioners when they enter into a network provider contract and will use the Provider Manual as the primary source of provider training. The Provider Manual is available in hard copy, on CD and on Molina's provider ePortal Web site. Updates to the Molina Provider Manual are distributed throughout the year via direct mailing, facsimile distribution, electronic mail, and on the ePortal Web site.

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- Provider Web Site
  The Molina ePortal Provider Web site is another venue Molina utilizes to communicate with providers when program changes or laws and regulations take effect. Molina will post program changes on the Provider Web site to alert providers of changes that impact services or requirements; these postings will also include copies of recently distributed documents.

- Direct Mail Communications
  Molina will mail notifications to providers to inform them of regulatory, subcontract or program changes at least 30 days in advance of changes taking effect, unless regulatory or Arizona Department of Health Services' timing requires shorter timeframes.

- Facsimile Communications
  Molina will establish a database of secure provider facsimile telephone numbers to facilitate transmission of general updates and will use "Just the Fax" software to facilitate automated facsimile distribution. This is a very cost effective means of communication within the network.

- Electronic Mail
  Molina will establish a database of provider electronic mail addresses to facilitate electronic submission of real-time information to its provider network.

- Provider Newsletters
  Molina will publish and mail a Provider Newsletter on a routine basis. The newsletter will note recent changes impacting providers, general information regarding the plan and updates on quality and compliance initiatives.

- Remittance Advices
  Molina will create special messaging on Remittance Advices when changes will be made that will affect provider reimbursement. Additionally, we may insert notices within Remittance Advice envelopes to provide additional information.

- Provider Meetings
  Molina will update providers on the latest changes that affect the provider network during Molina provider meetings. During these routine training sessions Molina will include reminders to providers to access the Molina ePortal Web site on a regular basis for access to current information.

- Physician Advisory Committee Meetings
  Molina will establish Physician Advisory Committee meetings in each assigned Geographic Service Area that will meet no less than biannually. The intent of these meetings is to facilitate a two-way communications venue with key physicians in each community. These meetings keep Molina aware of emerging issues within the network specific to a given Geographic Service Area. These meetings also give network providers a voice in the operation of the plan and a mechanism for continuous operational improvement.

- Provider Service Representative Interaction
  Molina Provider Service Representatives conduct routine face-to-face visits with providers. Molina emphasizes the importance of routine meetings with providers when hiring and training Provider Service Representatives. Provider Service Representatives annual evaluation criteria is heavily weighted by frequency of provider meetings and timeliness of new provider in-person orientations.

39. Describe how data and information obtained from throughout the organization are used to manage the network and identify how provider issues are communicated within the organization. Provide an example of how this process has been used in your organization.

Molina considers network operations a core competency of its health plans, and identifying and implementing process improvements within the provider network is integral to success. To ensure quality improvements within its provider network, Molina has established a solid infrastructure to monitor, evaluate and implement changes within the Molina provider network. This infrastructure offers Molina a consistent and methodical approach to the art of network management which emphasizes provider participation in the process of operational improvement. As a very large health plan which grew from a very small group practice, Molina fully understands the importance of a dynamic network that is capable of continuous operational improvement. Molina has identified a number of sources for data regarding the operation of the provider network.

The Network Operations Committee

Molina will establish a multi-disciplinary committee to review, analyze and act upon data and information obtained from network monitoring. This multidisciplinary approach will ensure that inter-related issues are communicated effectively throughout the organization, analyzed from multiple perspectives, and integrated solutions developed. The Network Operations Committee will be comprised of members from Provider Services, Network Management, Utilization Management, Compliance, Finance, Quality Improvement, as well as the Chief Operating Officer or Chief Executive Officer and the Chief Medical Officer.

The Network Operations Committee will meet on a monthly basis to address issues that emerge from collected data and reports throughout the previous month. Trends that have been identified will be discussed. These may include:

- Gaps in network coverage;
- Physician profiling;
- Quality of care issues (if significant may be referred to the Professional Review Committee for protected deliberations);
- Provider grievance and appeals;
- Provider accessibility issues;
- Provider service issues (such as immunization compliance);
- Review of the annual non-contracted services report (non-contracted providers utilized more than 25 times in a year); and
- Review of the use of Letters of Agreement to secure non-contracted provider services.

The Network Operations Committee will analyze issues and discuss appropriate courses of action to intervene or take corrective measures. The Network Operations Committee will receive direction from higher level committees such as the Quality Improvement Committee, to analyze and if appropriate, affect change. The Network Operations Committee is fully charged with affecting operational changes in the provider network. This might include targeting providers for additional training, a telephone call or a visit to a provider's office, admitting new providers to the network, or termination of a provider contract. The Network Operations Committee will track deliverables and report outcomes. Molina recognizes that all of these provider issues impact the health plan as a whole, and therefore must be addressed in a cohesive and cooperative manner. Strategies for network growth and improvement will emerge from these monthly meetings to enable efficient network management and provide clear and measurable goals.

The Network Operations Committee will also track the progress of prior program or procedural changes that were implemented to determine if they are successful and meeting program goals. If measurable outcomes are falling short of goals, the issues and programs will be analyzed again to determine further improvements needed to satisfy requirements. Molina's commitment to establish and maintain a sound network will be evident in this continuing pursuit of network improvement.

Medical Management/Utilization Management Committee
The Medical Management/Utilization Management Committee is comprised of a multidisciplinary team of health plan leaders who meet to evaluate health plan utilization trends and outliers. This forum would identify anomalies in utilization and initiate actions to address perceived issues. Information from the Medical Management/Utilization Management Committee is routinely reported in the Network Operations Committee. The Medical Management/Utilization Management Committee is a subcommittee of the Quality Improvement Committee. Provider profiling information is reviewed in the Medical Management/Utilization Management Committee, the Professional Review Committee, and the Clinical Quality Improvement Committee, as appropriate.

Quality Improvement Committee
The Quality Improvement Committee, established in accordance with AHCCCS AMPM 900, is the governing health plan quality committee. This committee routinely receives reports from the Network Operations Committee, Clinical Quality Improvement Committee, Professional Review Committee, and the Utilization Management Committee. Data and initiatives from the Quality Improvement Committee are routinely administered in the Network Operations Committee.

Member and Provider Committee
The Member and Provider Committee is a multidisciplinary committee comprised of representatives from various health plan functional areas, network providers, and Molina members. This committee reviews various health plan statistics and surveys and initiates action intended to improve member and provider satisfaction. In addition to the Network Operations Committee, the Member and Provider Committee reviews the following provider network reports:

- Annual provider access survey;
- Annual provider appointment time survey; and
- Annual provider satisfaction survey.

Physician Advisory Committee
A Physician Advisory Committee will be established with key physicians within the service area to obtain input into member and provider outreach programs and education initiatives. Regular Physician Advisory Committee meetings will allow Molina to monitor deficient areas and improve upon educational tools.

Provider "Post Card" Input Program
Based on positive experiences in multiple Molina Healthcare state health plans, it has identified a post card provider input program as a best practice to be implemented in all new health plans. Provider Service representatives distribute post card feedback forms to all offices during routine office visits. They emphasize the various means of communicating feedback to Molina and offer the post card and a dedicated e-mail address specific to the program as an additional mode of communication. One Provider Services staff member is responsible for logging all feedback received via the post cards and associated e-mail address. The Manager of Provider Services

reviews the information regularly and facilitates direct responses to providers when contact information is provided. On a quarterly basis, Molina sends out a "We Heard You" mailing to its contracted provider network to summarize feedback received and actions taken or planned by Molina as a result of the feedback. In Ohio, a contracted provider communicated surprise about the program to Molina Healthcare of Ohio's Director of Provider Services. The provider was impressed not only that Molina had asked for input, but that it followed through by responding to the concern submitted with an operational change.

All of these communication venues will be used to ensure strong network provider knowledge of health plan initiatives and requirements. These communication venues will also be used to obtain information for inclusion in Network Operations Committee and Utilization Management Committee meetings. Molina will also utilize regular communication via automated facsimile, automated electronic mail and direct mailing to ensure that providers are aware of health plan changes and operational improvements. Routine newsletters will inform providers of topics generated from the Quality Improvement Committee, Network Operations Committee and other committees.

Network Provider Participation
Molina's operating model encourages network providers to participate in various health plan committees. Rural providers are especially encouraged to participate, to encourage an adequate voice for these providers. Network providers are encouraged to participate in the following health plan committees:

- Pharmacy and Therapeutics Committee;
- Member and Provider Committee;
- Clinical Quality Improvement Committee;
- Credentialing Committee; and
- Quality Improvement Committee.

Network Development and Management Plan
The annual Network Development and Management report tracks the network build strategies, progress and initiative results. This report will provide information about the general status of the network, identify issues associated with network adequacy and describe the success of implemented network interventions. The comprehensive report is presented to the Network Operations Committee and Quality Improvement Committee for approval.

40. Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the claims dispute process.

Efficient health care delivery is dependent upon a network of providers who are treated as valued members of the health care team. Appreciating and utilizing the feedback of providers enables Molina to improve the processes that serve its members. A provider's satisfaction with a health plan is closely aligned with their ability to have their concerns and questions addressed promptly and effectively. Input from providers can enter through a variety of channels to address episodic and longer-term suggestions, inquiries, complaints, or requests. Molina monitors input and takes appropriate action based on the data received.

Episodic (Rapid Response) Issue Resolution
Molina will offer a first level of provider appeals by assisting providers with any issues related to its members and/or services, and make every reasonable effort to resolve issues during the informal review process. Informal appeals may come to Molina's attention by telephone, e-mail, fax, Provider Service Representatives or meetings. All provider informal appeals will be entered

into Molina's computerized call-tracking system to aggregate and trend issues to enable prompt, appropriate action that will reduce or eliminate future occurrences. Once an informal appeal has been received, it will remain open in the call tracking system until the provider has been notified of the outcome. Routine reporting from this unit is reviewed in the Network Operations Committee and, as appropriate, health plan quality committees.

Member Services
Inquiries that are received by Member Services are generally answered and resolved by Member Services Representatives. On occasion, the Member Services Representative will require inter-departmental assistance to resolve an inquiry. In such cases, the Member Services phone tracking system is used to engage assistance from Provider Services, Provider Contracting, Utilization Management or other operational areas. Use of the call tracking system within QNXT allows Molina to track and trend such issues and thus address provider needs in a proactive manner.

Physician Advisory Committee
The Physician Advisory Committee is one of the channels that Molina will use to solicit feedback from providers. Physician Advisory Committees are comprised of network physicians that are established in each applicable Geographic Service Area. The main objective of the Physician Advisory Committee is to assist Molina in becoming the premier managed care organization in Arizona. The panel reviews and provides input about new or enhanced programs and may suggest approaches to communications. The panel members are closely in touch with consumers (members) at times that can be considered the best teachable moments. This unique perspective presents both opportunities and challenges to providers; understanding that perspective is an essential element in ensuring that providers know that Molina supports their efforts to provide high quality care to members and develops or enhances programs to meet those needs. Molina, as an organization, is keenly aware that many innovative ideas for improving health care delivery will come from the providers; therefore, Molina solicits suggestions from its provider partners, to establish operational best practices. The Physician Advisory Committees function as a two-way vehicle for intake of provider suggestions and concerns, and as a means to communicate information regarding Molina operations to providers. Information from the Physician Advisory Committee is reviewed by the Network Operations Committee, which is charged with the general operation of the Molina Provider Network. As appropriate, the Network Operations Committee will bring certain issues to the following health plan committees: Utilization Management Committee and Quality Improvement Committee.

Provider Office Manager Meetings
Molina will offer large regional provider meetings known as Provider Office Manager Meetings. These meetings, held on a routine basis throughout Molina's network territory, are designed to communicate Molina program requirements to providers and intake general provider issues. Generally, Provider Office Manager Meetings are attended by office managers and other provider office staff members, so the input received in these meetings offer a different point of view than the Physician Advisory Committee. At the end of each Provider Office Manager Meeting, providers are encouraged to meet with the Provider Office Manager team to address provider-specific issues. Issues identified in the Provider Office Manager Meetings are communicated back to the Network Operations Committee, and as appropriate, the Utilization Management Committee and Quality Improvement Committee.

Provider Services Representatives

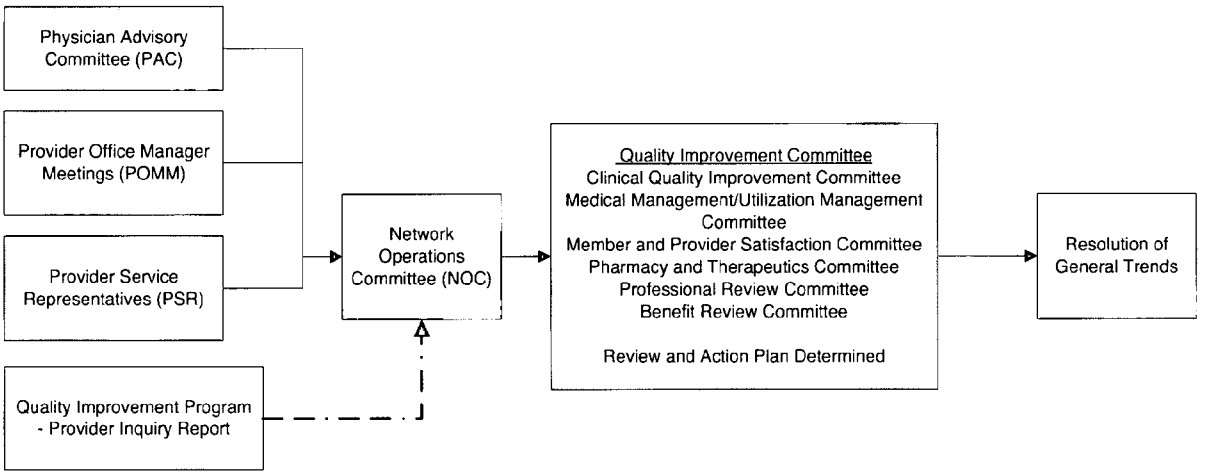
The Provider Services Representatives are Molina's daily eyes and ears in the provider community, and serve as an additional channel for providers to communicate issues to Molina or to request additional information. Provider Services Representatives are assigned to a given geographic territory and will retain full responsibility for the service of their assigned providers. Provider Service Representatives will be located within Molina's Geographic Service Area. Molina believes that a Provider Services Representative who lives and works in a given territory will have a greater knowledge of issues that impact that community. Molina will take into consideration the geographic distribution and number of providers within its service area to determine the appropriate number of staff required to meet Molina's service expectations.

The Provider Services Representative will visit their assigned providers routinely to ensure that the provider understands plan requirements and to ensure that Molina is adequately addressing any issues the provider may have. Provider Service Representatives will be aware of any network inadequacies in their assigned service areas via GeoAccess reports and associated goal tracking documentation. They will also be aware of any complaints, concerns or requests related to providers in their areas before visiting with providers through call tracking review.

Provider Service Representatives will pay particular attention to ensure that non-traditional service providers such as community based service providers and Alternative Residential Setting providers receive and understand provider communications. Molina will use the traditional modes of communication described herein and closely monitor the responsiveness of these providers, adjusting and tailoring communication strategies as may be needed to most effectively partner with these providers. Additionally, the Provider Service Representatives will be available to meet with Homeless Clinics and a plan for routine visits and support of the clinics will be developed. The Provider Services Representative will respond to all provider inquiries within two working days or less following the receipt of the provider complaint. Provider Services Representatives will report issues and trends to Provider Services Management via their formal office visit reports and Molina's call tracking system. Provider Services leaders communicate these trends to the Network Operations Committee. Individual issues are tracked and addressed by the Provider Services Representative and entered into the Molina call tracking system. The provider will always have access to their Provider Services Representative and various levels of management above that Provider Services Representative, as a protocol for resolving issues. In addition, providers always have access to the Medical Director.

Quality Improvement Program

Molina's Quality Improvement program will analyze the reports generated from provider inquiries on a monthly basis to ensure that interventions are implemented if negative trends are evident. After analysis and review, the Member and Provider Satisfaction Committee will develop and utilize an action plan to resolve issues, prevent future occurrences, and improve general operations. The program and activities will reflect the requirements of Chapter 900 of the AHCCCS Policy Manual.



A Coordinated Approach

The Molina operating model emphasizes the importance of close coordination between departments within the health plan. Routinely, Provider Service Representatives, contracts negotiators, utilization management staff members, member services staff members and executive staff members will interact to affect prompt and efficient resolution of issues.

Issue Tracking

The Molina call tracking system is utilized by various health plan departments (Provider Services, Customer Service, Utilization Management) to track and trend provider issues and also to ensure closure of provider issues. Policies and procedures are in place to ensure appropriate and timely resolution of provider issues and appropriate analysis of trends. Interventions are routinely established to respond to general trends identified from the various channels of input.

Provider inquiries, trends and questions come to Molina from a variety of sources. All inquiries, trends and questions receive an appropriate, timely response and are tracked and trended for quality improvement purposes. Regardless of the functional area receiving the communication, all Molina employees have proper access to the proper resources to help the employee resolve and/or respond to the inquiry. Physicians can always speak to a Molina Medical Director when they have a problem. Molina employees understand the importance of communication from its customers and will take responsibility for the appropriate resolution of the inquiry.

41. Describe the process for ensuring that provider services staff receive adequate training.

Molina commits to training its Provider Services staff to fully prepare them to work with contracted network providers. Training is performed upon joining the organization and when changes to state regulations, contract requirements, network composition or other provider-related changes occur. Molina Healthcare has recently revised its Provider Services training program that begins with a general overview about Molina Healthcare, function specific training segments and state-specific operations and regulations. Throughout training, examples of exemplary provider service performance are highlighted. Components of the Provider Services training program will include the following:

- Overview of Molina Healthcare history, goals and mission;
- Overall expectations of the Provider Services department;
- Available resources at Molina Healthcare and Molina Healthcare of Arizona;

** Unless otherwise stated, references to "Molina" are specific to the Molina Healthcare of Arizona health plan. "Molina Healthcare" refers to the corporate parent company Molina Healthcare, Inc.*

- Review of Provider Services impact on Molina's performance;
- Value-added Services Molina will offer to ALTCS members;
- Overview of Molina's provider network and key provider group arrangements;
- Overview of the Geographic Service Areas covered by Molina and any unique attributes of particular areas such as network adequacy challenges and key community partners;
- Member benefit plans specific to the ALTCS program;
- Expectations of each role, including how to perform provider orientations, visits, etc.;
- Molina's provider appeals process;
- Molina Healthcare's claims and data management systems;
- Resources and tools available to the provider network such as HEDIS reference guides, member education materials, Molina sponsored free Continuing Medical Education programs;
- Provider Services' role in meeting HEDIS and NCQA requirements;
- Training specific to HCBS and institutional care; and
- Training provided by the Case Management team to ensure Molina Provider Services staff understands the general characteristics and needs of the population and specific benefits and tools to support specific population groups.

42. Describe the process for evaluating provider services staffing levels based on the needs of the provider community.

Precise provider services staffing levels are based on ratios of the number of physician offices/groups that are the focus of the intervention. Molina will also take into consideration its service goals. For example, provider services staffing levels will be sufficient to support at least quarterly office visits to Primary Care Provider offices and to offer needed Provider Services assistance to Long-term Care providers who are less familiar with managed care. Molina staffing ratios will also take into consideration the geographic distribution of the awarded service area to ensure sufficient external Provider Service staff to visit the offices of all providers.

Molina will base its Provider Services staffing model on the understanding that provider issues are most effectively addressed when providers have regular opportunities to discuss their concerns and challenges in person with their assigned local Provider Services Representative. This ongoing communication will enable Molina to identify and address provider concerns before they escalate into significant issues. Local Provider Service Representatives are grouped to work in the field or in the office. Those working in the field will be supported by office staff who will supply phone call support and claims system research.

Responsibilities of local Provider Services Representatives in the field include:

- Reviewing the network and determining adequacy concerns;
- Making initial contact with providers identified as needed to build/enhance the network;
- Performing new provider training;
- Continuing relationships with contracted providers through regular office visits;
- Responding to complaints received in the Quality Improvement Department for assigned providers;
- Attending health fairs with providers;
- Conducting Joint Operations Committee meetings with provider groups;
- Training providers on Molina procedures and ePortal;
- Meeting with Molina Internal Representative and Contracting Representative to resolve provider issues;

- Reviewing Call Tracking Reports to determine trends in assigned region; and
- Supporting provider offices on continued ePortal usage.

Responsibilities of local Provider Service Representatives in the office include:

- Taking phone calls directly from assigned providers;
- Researching provider questions and concerns;
- Attending external provider meetings as needed;
- Meeting weekly with Provider Services Representatives working in the field to review issues; and
- Referring Provider Services Representatives working in the field to provider offices calling with issues.

Molina expects each local Provider Services Representative in the field to make approximately 120 provider office visits each month. Given this assumption, Molina currently anticipates hiring a Provider Services Manager, two Provider Services Representatives to work in the field and two Provider Services Representatives to work in the office to service GSA 42, 44 and 52; however final provider services staffing levels will be determined upon contract awarded. At that time, Molina will review the service areas awarded and the geographic distribution of contracted providers to determine a reasonable number of visits that a representative can make in an average month. Molina will determine travel distances between the Molina office and its providers to determine the number of Provider Services Representatives required to meet access needs.

43. The Offeror must describe how their organization will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a nursing facility and b) an assisted living facility.

Molina understands that ALTCS services are provided to potentially vulnerable enrollees with complex health and social needs. As such, Molina is committed to maintaining an up-to-date and effective plan for caring for its members in the event that Molina experience the loss of a major provider, this would include nursing facilities and assisted living facilities. At a higher level, Molina will establish a health plan culture which reinforces each staff member's responsibility to manage to the needs of Molina's enrollees and to the contract between Molina and AHCCCS. Molina will establish cross departmental teams to support this culture of responsibility throughout the organization. This cross-departmental approach will eliminate departmental silos and improve early identification of issues with providers and promote more effective recovery in the event of a network loss. Molina's Director of Compliance will hold ultimate responsibility for Molina's Network Recovery Plan. The Network Recovery Plan will feature three key functional areas: Early Intervention and Monitoring; Recovery Action; and Post Recovery Evaluation. Following are key features of each of these functional areas as they relate to nursing facilities and assisted living facilities:

- Early Intervention and Monitoring – Molina considers Case Management, Member Services, and Provider Services staff members to be the eyes and ears of the organization. These staff members are trained to indentify early indications of future issues with Molina facilities. Early indications of potential network loss will be monitored in Molina's Professional Review Committee on a continual basis, to identify network issues and resolve them efficiently. In the case of nursing and assisted living facilities areas of review will include:

- Complaints or concerns as raised by enrollees; enrollee family members; facility staff members; outside providers; or Molina staff members including issues involving: quality of care, availability of care, facility payment of staff and other debts;
- Issues with credentialing, including state licensure issues; insurance issues, governmental sanctions; and
- Requests from the facility for advance payments to cover operating expenses.

The Professional Review Committee is empowered to take immediate actions to address identified early indicators. These actions include:

- Increased communication with the provider, including on-site;
- Suspension of further placements in the facilities;
- Ordering a corrective action plan from the provider; and
- Termination of the provider contract.

- Recovery Action – In the event of the loss of a nursing or assisted living facility, any member of the established Molina Business Recovery team may initiate an immediate meeting of this multidisciplinary team. The team will include the leaders of the Case Management, Medical Services, and Provider Services departments, as well as the Plan President and Medical Director. The team will always approach recovery in such a way so as to promote the best quality of care for the member; minimize disruption to the member and to providers; and affect the outcome that will minimize future disruption to the provider and the member. The team will implement the following actions in the case of the loss of one of these facilities:
  - Notify AHCCCS of the initiation of the action;
  - Establish a list of members who will require relocation, as well as any special needs of these members;
  - Prioritize members based upon their medical, social and behavioral health needs; Establish a specific plan of action to place the members' alternative sites;
  - Document all actions of the recovery team, including when and where the enrollees were transferred. Notify AHCCCS of specific actions taken;
  - Ensure that all medications, medical equipment, and medical charts are transferred to the receiving facility; and
  - Establish on-site monitoring of the receiving facility to ensure the appropriate quality of care is provided in the new facility.
- Post Recovery Evaluation – The recovery team will convene a follow-up meeting to assess the effectiveness of their recent actions and to identify areas for improvement. The recovery team will assess if any early indicators of facility loss were present and if they were properly identified, and incorporate all lessons learned into the recovery plan.

General Considerations: Molina will incorporate the following general considerations into the operation of the health plan:

- Network will be adequate to ensure the availability of alternative contracted providers;
- Where Molina offers no alternative contracted provider, non-contracted providers will be utilized; and
- Molina Healthcare is a multistate operation, and as such features contracted providers in adjoining states. This may prove especially helpful in rural areas of Arizona.

Certain losses are caused by specific events; as such following are some considerations regarding those loss events:

- Contract Termination – In the event of a contract termination with a nursing or assisted living facility, after any immediate concerns regarding member care are first addressed, Molina will follow the terms of the contract with the provider. Contracts with these facilities feature specific provisions concerning the transition of member care following termination of the contract. Molina will first consider the needs of the member in developing the plan for transition. These types of transitions generally require a less emergent approach. The transition would still be initiated by the Business Recovery team, following the same process. The following additional considerations shall be included in the plan established by the recovery team:
  - A more formal approach to notification of stakeholders, both internal and external will be followed;
  - Case Managers will facilitate meetings with members, their families, and their care givers;
  - If a member is placed in a facility that is not their first choice, track availability of other facilities that better reflect the member's wishes;
  - Review all member trust fund accounts for proper transfer of funds; and
  - Ensure Case Manager conducts on-site visits within the first week of transfer.

In addition to the actions identified above, in the case of a natural disaster, Molina will comply with state and federal emergency response regulations. If applicable, Molina would activate its Continuity of Operations Plan that will be tailored to the potential disasters facing Arizona. This plan, developed in accordance with a Molina Continuity of Operations Plan template, delineates activation procedures, identifies a recovery team, and defines procedures to recover critical functions and vital records. Some key considerations of facility closures due to natural disasters:

- Alternate accommodations may not be available in the immediate geographic area. Molina will evaluate the situation and determine the most appropriate, safe accommodations for its members. When indicated, Molina will make arrangements for accommodations in other communities or even in bordering states if necessary, to ensure the safety of its members. Molina's sub-contracted transportation vendor will work closely with the recovery team to provide applicable transportation.

44. Describe the process for addressing provider performance issues, up to and including contract termination.

Molina has established a structure of health care delivery services and program performance monitoring to ensure that members access the most appropriate health care source for their needs. Molina provides feedback through reports to providers on their performance related to care received by members associated with them. The report results are useful when compared to providers' prior performance, other similar providers' performances, and to established goals and benchmarks. The purpose of this reporting is to monitor and educate providers and improve health care quality for members.

Molina sets specific goals to ensure provider performance issues are appropriately addressed. First, provider monitoring must measure provider activities that are important to member health and wellness. Measurement is the first step to management and provider monitoring reports are a powerful performance management tool. Another goal is to support providers in the care and services rendered to members by furnishing sufficient information for them to take meaningful action that addresses individual member issues. These activities support members receiving the

health care services they need in the appropriate setting at the right time in order to optimize their long-term health.

Molina monitors all PCPs and includes selective high volume specialties (e.g., orthopedics and cardiology) where there are substantial numbers of members impacted by the specialty. To ensure a sufficient membership to produce valid results, Molina will explore aggregating performances of PCPs in the same geographic region and monitoring groups of PCPs who individually would not have the minimum membership required for monitoring. This may be a viable option in non-urban areas in particular.

The metrics that Molina selects for inclusion are assessed against the following criteria:

- Relevance to quality of care and population;
- Performance attributable to provider;
- Measureable data available:
  - accurately reflects provider performance, or
  - demonstrates provider data deficiencies;
- Evidence-based, valid, reliable, verifiable, consistent with established metrics;
- Providers' performance distribution allows room for meaningful improvement;
- Balanced program coverage – primary care, prevention/EPSDT services, chronic care, managed care with focus on accountability, patient safety, quality and efficiency – inclusive of performance and process;
- Alignment – AHCCCS; Provider Community; Specific Provider;
- Linkage to Quality Improvement Efforts – HEDIS®, NCQA; and
- Reporting efficiency – existing data systems support measurement, no added administrative burden to provider.

Molina calculates performances as frequently as monthly, and reports annually to providers. Reports may be delivered electronically, by mail, or in person to providers. All providers (including HCBS providers and institutional facilities) who do not meet performance goals will be contacted by Provider Service Representatives who will reinforce performance objectives and the importance of partnering with Molina to deliver preventive and appropriate clinical care to members according to best practice guidelines. Discussions among providers, their administrators, and Molina network and medical management staff will support providers to learn more about best practices and improve performance. Supportive information regarding improving the data submitted including the correct use of diagnosis codes used in the metrics is given to providers to ensure that they get credit for services they actually rendered. Molina recognizes providers in various ways who improve their performance, meet a goal, or whose performance becomes a benchmark for the network.

Communication with the provider may indicate other issues that impact provider performance, such as missed appointments or member failure to comply with treatment programs. Molina will generate and submit lists of members with Missed Services to the relevant provider. The Missed Services report will also be provided to Molina staff for outreach efforts to contact members remind them of the need for obtaining services, and provide assistance with scheduling appointments. Identified issues such as transportation needs or non-compliance with the treatment plan may indicate an opportunity for interventions to assist the member. In those cases, the Provider Service Representative would request that a Case Manager contact the member to provide needed assistance. Alerts will also be activated in the QNXT Member Management System to flag members who have missed services and prompt Member Services

Representatives to remind the member to obtain those services during incoming and outbound member calls. This education and collaboration assists providers in improving the quality of the care and services that members receive and supports prevention and wellness. Such provider outreach also encourages establishment of a medical home and promotes the members' relationship to the provider and partnership in managing their healthcare. Molina will provide the support necessary to enable providers to meet performance objectives.

Lists of providers who fall short of the established threshold will be submitted to the Professional Review and Quality Improvement Committees to determine if there is evident improvement in performance or if there is a need for a corrective action plan and recommendations that target the specific areas of non-compliance. Outcomes data supplied in these reports will:

- Identify any need to intervene with a specific provider;
- Identify results that may be indicative of a systemic problem/need;
- Identify solutions to address the problem/need; and
- Identify opportunities for further improvements and enhancements to quality of care practices.

If providers fail to show improvement when re-audited within 180 days, and it is evident that recommended actions have not been implemented, the Professional Review Committee will review the audit findings and make recommendations to the Quality Improvement Committee. Molina will utilize a multi-disciplinary committee process to review, analyze and act upon the results of network and provider monitoring. The results of the Quality Improvement Committee's analysis will determine if the provider's panel should be frozen, or in extreme cases, if the provider should be terminated from the network, depending on the nature and duration of the unacceptable performance and non-compliance. This multi-disciplinary approach also ensures that inter-related issues are communicated effectively throughout the organization and analyzed from multiple perspectives to develop integrated solutions. All monitoring, outcomes analysis and follow-up is overseen operationally by the Chief Medical Officer and Quality Management Coordinator.

This reporting and monitoring is viewed as a first step rather than as a definitive step in identifying aberrant practice patterns. No conclusions will be made or actions taken without thorough evaluation of the data and the practice context.

The Quality Improvement department will prepare and submit all reports to AHCCCS on provider compliance with quality improvement goals related to provider monitoring as required.

45. Offerors shall develop and maintain a provider network, supported by written agreements, which is sufficient to provide all covered services to ALTCS members [42 CFR 438.206]. The ACOM *ALTCS Network Standards Policy* specifies the network standards that have been established for most services (institutional, HCBS, acute, alternative residential, non-emergency transportation, etc.) by county and GSA. The Offeror's network will be evaluated by service and by site in each GSA bid by the Offeror.

The Offeror must provide a listing of its provider network using the Network Summary template as described in ACOM 420 *Network Summary Policy*. Offerors shall have contracts with providers or signed Letters of Intent (LOIs) in order to complete the Network Summary template. The Sample LOI is the only format permitted. A signed LOI will receive the same weight and consideration as a signed contract. LOIs and contracts must be available for review by AHCCCS, when requested, as evidence of an understanding between the Offeror and provider. LOIs and contracts should NOT be included with the Offeror's proposal. AHCCCS may verify any or all referenced LOIs or contracts. New Offerors should not complete Column 2, AHCCCS Contractor Identification Number, of the Network Template. Incumbent Contractors should use their assigned Contractor number as defined in the *Network Summary Policy*.

All Offerors must sign the Network Attestation Statement. Any network gap must be noted on the Attestation Statement.

The LOI and Network Summary templates, and the Network Attestation Statement, are available in the Bidder's Library. The template(s) and the Network Attestation Statement must be submitted to AHCCCS via the EFT/SFTP server by 3 p.m. on the Proposal Due Date in Section A. There is no hard copy requirement for this submission. Instructions for access to the EFT/SFTP are included in Section A of the Data Supplement. The Offeror should upload to its designated folder using the names "Network Summary" and "Network Attestation Statement" for the two documents.

Molina will submit the Network Summary of its provider listings for GSA 42, 44 and 52, and the signed Network Attestation Statement via the EFT/SFTP server by 3 p.m. on April 1, 2011. Also included in this RFP response is a hard copy of the Network Attestation Statement in the Certificates and Other Required Forms section.

Certifications and Other Required Forms

Section G-
Representations and
Certifications of Offeror Form

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR

The Offeror must complete all information requested below.

1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED

By signing this offer the Offeror certifies, under penalty of law, that the information provided herein is true, correct and complete to the best of Offeror's knowledge and belief. Offeror also acknowledges that should investigation at any time disclose any misrepresentation or falsification, any subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS.

2. CERTIFICATION OF NON-COERCION

By signing this offer the Offeror certifies, under penalty of law, that it has not made to any provider any requests or inducements not to contract with another potential Contractor in relation to this solicitation.

3. CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING

By signing this offer, the Offeror certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the "Stark I" and "Stark II" laws governing related-entity and compensation there-from. If the Offeror provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneous copies of the information required to be sent to the Centers for Medicare and Medicaid Services. (See 42 USC §1320a-7b, PL 101-239, PL 101-432, and 42 CFR §411.361.)

4. AUTHORIZED SIGNATORY

Authorized Signatory for Molina Healthcare of Arizona, Inc.
[OFFEROR'S Name]

Lynn Allen — President
[INDIVIDUAL'S Name] [Title]
is the person authorized to sign this contract on behalf of Offeror.

5. OFFEROR'S MAILING ADDRESS

AHCCCS should address all notices relative to this offer to the attention of:

Lynn Allen		President
Name		Title
8801 Horizon Blvd. NE, Ste 400		800-377-9594 x180270
Address		Telephone Number
Albuquerque	NM	87113
City	State	ZIP

6. OFFEROR GENERAL INFORMATION

a. If other than a government agency, when was your organization formed? January 29, 2008

b. License/Certification: Attach a list of all licenses and certification (e.g. federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates.

Have any licenses been denied, revoked or suspended within the past 10 years? Yes _☐_ No _☒_

If yes, please explain.

c. Civil Rights Compliance Data: Has any federal or state agency ever made a finding of noncompliance with any civil rights requirements with respect to your program? Yes _☐_ No _☒_ If yes, please explain.

d. Accessibility Assurance: Does your organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Offeror's facilities (including subcontractors) are inaccessible to or unusable by persons with disabilities? (Note: Check local zoning ordinances for accessibility requirements). Yes_☒_ No _☐_ If yes, describe how such assurance is provided or how your organization is taking affirmative steps to provide assurance.
Molina Healthcare of Arizona will lease office space and other facilities and enact policies and procedures to ensure that persons with disabilities are not unnecessarily excluded from participation in programs or activities or denied benefits because of architectural, transportation, communication, procedural, or attitudinal barriers.

e. Prior Convictions: List all felony convictions within the past 15 years of any key personnel (i.e., Administrator, Medical Director, financial officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal.
No Molina Healthcare of Arizona key personnel has any felony convictions.

f. Federal Government Suspension/Exclusion: Has Offeror been suspended or excluded from any federal government programs for any reason? Yes_☐_ No _☒_ If yes, please explain.

g. Provide the name(s) of the in-house or independent actuary, or actuarial firm used to assist in developing capitation rates and / or reviewing published capitation rate information.
Brian Goebel
Name

200 Oceangate, Suite 100	Long Beach	CA
Address	City	State

h. Did any other firm or organization provide the Offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)? Yes_☐_ No _☒_ If yes, what is the name of this firm or organization?

Name

Address	City	State

i. Has the Offeror contracted or arranged for Management Information Systems, software or hardware, for the term of the contract? Yes_☒_ No _☐_ If yes, is the Management Information System being obtained from a vendor? Yes _☒_ No _☐_ If yes, please provide the vendor's name, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with other Medicaid programs.
Molina Healthcare of Arizona will enter into a Service Level Agreement with Molina Healthcare, Inc. to arrange for Management Information Systems, software or hardware for the term of the contract. Molina Healthcare, Inc. is the parent company of the wholly owned subsidiary Molina Healthcare of Arizona.

Molina Healthcare, Inc. is a managed care company administering government programs serving approximately 1.6 million members in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin.

7. FINANCIAL DISCLOSURE STATEMENT

The Offeror must provide the following information as required by 42 CFR 455.103. This Financial Disclosure Statement shall be prepared as of December 31, 2010. However, continuing Offerors who have filed the required Financial Disclosure Statement to AHCCCS within the last 12 months need not complete this section if no significant changes have occurred since the last filing.

a. Ownership: List the name and address of each person with an ownership or controlling interest, as defined by 42 CFR 455.101, in the entity submitting this offer:

Name	Address	Percent of Ownership or Control
Molina Healthcare, Inc.	200 Oceangate, Suite 100, Long Beach, CA 90802	100%
Robert Gordon (Director)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
Steve O'Dell (Director)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
George Figueroa (Director)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
John C. Molina (Director)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
Donald (Lynn) Allen (Director and Vice President)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
Joseph M. Molina, MD (President)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
John C. Molina (Treasurer)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
Terry Bayer (Vice President)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%
Jeff Barlow (Secretary)	200 Oceangate, Suite 100, Long Beach, CA 90802	0%

b. Subcontractor Ownership: List the name and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more:

Name	Address	Percent of Ownership or Control
None		

Names of above persons who are related to one another as spouse, parent, child or sibling:
None

c. Ownership in Other Entities: List the name of any other entity in which a person with an ownership or control interest in the Offeror entity also has an ownership or control interest:

Molina Healthcare, Inc. also owns 100% of the outstanding capital stock/membership interest in the following subsidiaries:

Molina Healthcare of California	Alliance for Community Health, LLC, dba Molina Healthcare of Missouri
Molina Healthcare of California Partner Plan, Inc.	Molina Healthcare of Missouri, Inc.
Molina Healthcare of Michigan, Inc.	Molina Healthcare of Georgia, Inc.

Molina Healthcare of Washington, Inc.	Molina Healthcare of Nevada, Inc.
Molina Healthcare of Utah, Inc.	Molina Healthcare of Arizona, Inc.
Molina Healthcare of New Mexico, Inc.	Molina Healthcare of Virginia, Inc.
Molina Healthcare of Ohio, Inc.	Molina Healthcare of Mississippi, Inc.
Molina Healthcare of Texas, Inc.*	Florida NetPASS, LLC
Molina Healthcare Insurance Company, Inc.	Molina Healthcare of Illinois, Inc.
Abri Health Plan, Inc.	Molina Information Systems, LLC
Molina Healthcare of Florida, Inc.	

*Molina Healthcare of Texas, Inc. owns 100% of the outstanding Common Stock of Molina Healthcare of Texas Insurance Company, a Texas corporation.

d. Long-Term Business Transactions: List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end:

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
None		

e. Criminal Offenses: List the name of any person who has ownership or control interest in the Offeror, or is an agent or managing employee of the Offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs:

Name	Address	Title
None		

f. Creditors: List name and address of each creditor whose loans or mortgages exceed 5% of total Offeror equity and are secured by assets of the Offeror's company.

Name	Address	Description of Debt	Amount of Security
None			

g. Outstanding Legal Actions:

1. Are there any lawsuits, judgments, tax deficiencies or claims pending against your organization? Yes _☐_ No _☒_ If yes, provide details including the dollar amount.

2. Has your organization ever gone through bankruptcy? Yes _☐_ No _☒_ If yes, provide the year.

8. RELATED PARTY TRANSACTIONS

a. Board of Directors: List the names and addresses of the Board of Directors of the Offeror.

Name/Title	Address
Robert Gordon	200 Oceangate, Suite 100, Long Beach, CA 90802
Steve O'Dell	200 Oceangate, Suite 100, Long Beach, CA 90802
George Figueroa	200 Oceangate, Suite 100, Long Beach, CA 90802
John C. Molina	200 Oceangate, Suite 100, Long Beach, CA 90802
Donald (Lynn) Allen	200 Oceangate, Suite 100, Long Beach, CA 90802

b. Related Party Transactions: Describe transactions between the Offeror and any related party in which a transaction or series of transactions during any one fiscal year exceeds 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:

i) Describe all transactions between Offeror and any related party which includes the lending of money, extensions of credit or any investment in a related party. This type of transaction requires review and approval in advance by the Office of the Director:

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period
None		

Justification:

ii) List the name and address of any individual who owns or controls more than 10% of stock or that has a controlling interest (i.e. formulates, determines or vetoes business policy decisions):

None – The Offeror is a wholly-owned subsidiary of Molina Healthcare, Inc., a Delaware corporation.

Name	Address	Owner Or Controller	Has Controlling Interest? Yes / No

9. OFFEROR'S OFFSHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers. **Offerors shall declare all anticipated offshore services in the proposal.**

Molina Healthcare of Arizona does not anticipate conducting any offshore work that directly serves the State of Arizona or its clients that may involve access to secure or sensitive data or personal client data or development or modification of software for the State, unless such services are indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract.

END OF SECTION

Actuarial Certification

ACTUARIAL CERTIFICATION

Molina Healthcare of Arizona, Inc. (MHA)
Price Bid for FY 2012 Arizona Long Term Care Services (ALTCS) Operated Under
Arizona Health Care Cost Containment System Administration (AHCCCS)

I, Brian F. Goebel, am chief actuary of Molina Healthcare, Inc. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. I have performed an actuarial certification of MHA's capitation pricing bid for the FY 2012 ALTCS RFP operated under AHCCCS which covers the period from October 1, 2011 to September 30, 2012. This certification applies to the rates in GSA 42, 44 and 52 only.

The capitation rates provided with this certification are considered "actuarially sound" for the purposes of 42 CFR 438.6(c), according to the following criteria:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices,
- the capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42, CFR 438.6 (c).

I have examined the both the financial data provided by the State of Arizona and the additional information provided by the state regarding the estimated impact of fee schedule changes on the projected experience.

In my opinion, MHA's capitation pricing bid rates for the period October 1, 2011 to September 30, 2012 are actuarially sound based on a review of the financial information, have been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I have relied upon both the accuracy of the underlying records, data summaries, and other calculations provided by the State of Arizona., with respect to the relevant factors related to the development of a price bid. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find any material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion. It should be emphasized that the capitation rates are based on a projection of future costs based on a set of assumptions. Actual costs will vary from the experience assumed in the rates.

The Opinion is intended for the management of MHA and Molina Healthcare, Inc, and the State of Arizona and should not be relied on by other parties.

Brian F. Goebel

3-22-2011

Brian F. Goebel, FSA, MAAA
Chief Actuary
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
562-951-8356

Date

Network Attestation

Attachment A

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

MOLINA HEALTHCARE OF ARIZONA, INC.

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

☑ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county(ies):

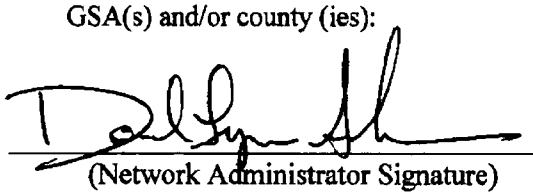
ALTCS LOB: GSA 42 – Yuma County: Nursing Facility (have 3 of 4).

ALTCS LOB: GSA 44 –Coconino County: Nursing Facility: Flagstaff , Sedona
Mohave County: Nursing Facility Lake Havasu City (have 1 of 2); Assisted Living Facility (have 17 of 28). Navajo County: Assisted Living Facility (have 3 of 5).

NOTE: there are not 28 available assisted living facilities in Mohave County actively in business and accepting ALTCS members.

ALTCS LOB: GSA 52 – Maricopa County: Nursing Facility Zone 5 (have 2 of 3); Assisted Living Center Zone 7 (have 3 of 4).

☑ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):



(Network Administrator Signature) 3/23/2011 Date

Attachments

Attachment 7-1 -
Remittance Advice

MOLINA HEALTHCARE OF ARIZONA
PO BOX 1234
TEMPE, AZ 12345

emporary Return Service Requested

MOLINA HEALTHCARE

DATE: 12/14/2010
NPI: 1437272689
TAX ID: 381359517
Check or EFT Trace # 01165448

Tempe St. Luke's Hospital
1500 S. Mill Avenue
Tempe, AZ 85281

EXPLANATION OF PAYMENT

SUMMARY OF PAYMENT

Billed Amount:	$4,598.60	Refunds:	$0.00
Contract/Allowed Amt:	$2,389.67	Interest:	$0.00
Disallow Amount::	$2,208.93	Coinsurance:	$0.00
Gross Plan Payable:	$2,389.67	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	$2,389.67

Payment Amount: $2,389.67

Confidential Protected Health Information

s document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Exciting COB Enhancement: Molina can now accept COB claims through the standard 837 EDI file format.

MOLINA HEALTHCARE

MOLINA HEALTHCARE OF ARIZONA
PO BOX 1234
TEMPE, AZ 12345

USBank
Havre, MT
usbank.com
93-455/929

01165448

12/14/2010

VOID AFTER 90 DAYS

PAY Two Thousand Three Hundred Eighty-Nine and 67/100 **$2,389.67

TO THE ORDER OF
Tempe St. Luke's Hospital
1500 S. Mill Avenue
Tempe, AZ 85281

VOID

Authorized Signature 1060CK01

FILING A PROVIDER CLAIM DISPUTE/RECONSIDERATION

Claim disputes must be submitted in writing within the following timelines:

- Within twelve months after the date of service;
- Within twelve months after the date that eligibility is posted; or
- Within sixty days after the date of the denial of a timely claim submission, whichever is later.

Dispute/Reconsideration Procedures

The claim dispute should include factual and legal details and any documents which support the facts of the case (e.g., payment, specific claim denial, quick pay discount). If Molina receives a claim dispute lacking in details, it may be denied. All provider claim disputes should be sent to:

MOLINA HEALTHCARE OF ARIZONA

PO BOX 1234

TEMPE, AZ 12345

Upon receipt of the claim dispute will be reviewed by the appropriate personnel of the claims department for review and resolution. After the review has been completed a Notice of Decision will be issued. If you are not satisfied with the resolution, you can request a state fair hearing within 30 days from receipt of the notice.

MOLINA HEALTHCARE

Remittance Ac for .

Tempe St. Luke's Hospital
1500 S. Mill Avenue, Tempe, AZ 85281

Molina Healthcare of Arizona

Paid Date: 12/14/2010

Check # 01165448

Claim Line	Date of Service	Rev Code	CPT/ HCPC	Units	Modifier	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Other Disc/Int	Coinsurance	Deductible	FFS Withhold	Net Plan Payable	FFS/ CAP	Line Status	Expl Code
Patient Name: Member ID#: Claim #: 1034180454 Patient Account #: 00244494 Rendering Provider Name: NPI#:																				
1	10/26/2010	59400		1		$2,164.00	$1,180.74	$983.26	$1,180.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,180.74	FFS	PAID	
TOTAL AMOUNT:						$2,164.00	$1,180.74	$983.26	$1,180.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,180.74			
Patient Name: Member ID#: Claim #: 1034480499 Patient Account #: 002444151 Rendering Provider Name: NPI#:																				
1	12/03/2010	99213		1		$79.80	$28.19	$51.61	$28.19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$28.19	FFS	PAID	
TOTAL AMOUNT:						$79.80	$28.19	$51.61	$28.19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$28.19			
Patient Name: Member ID#: Claim #: 1034280556 Patient Account #: 00244550 Rendering Provider Name: NPI#:																				
1	11/14/2010	59400		1		$2,164.00	$1,180.74	$983.26	$1,180.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,180.74	FFS	PAID	
TOTAL AMOUNT:						$2,164.00	$1,180.74	$983.26	$1,180.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,180.74			

196

Attachment 7-1 Remittance Advice

Attachment 17-1 -
2008 Audited Financial Report

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2008

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐ Yes ☑ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☑ No

The aggregate market value of Common Stock held by non-affiliates of the Registrant as of June 30, 2008, the last business day of our most recently completed second fiscal quarter, was approximately $300 million (based upon the closing price for shares of the Registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2008).

As of March 13, 2009, approximately 26,066,000 shares of the Registrant's Common Stock, $0.001 par value per share, were tstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Proxy Statement for the 2009 Annual Meeting of Stockholders to be held on April 28, 2009 are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

Table of Contents
Form 10-K

PART I

Item 1: *Business*

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. We conduct our business primarily through 10 licensed health plans in the states of California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those 10 states, each of which is licensed as a health maintenance organization. Our revenues are derived primarily from premium revenues paid to our health plans by the relevant state Medicaid authority, which revenues are jointly financed by the federal government and the states. Increasingly, we also derive revenues from the federal Centers for Medicare and Medicaid Services, or CMS, in connection with our Medicare services.

The payments made to our health plans generally represent an agreed upon amount per member per month, or a "capitation" amount, which is paid regardless of whether the member utilizes any medical services in that month or whether the member utilizes medical services in excess of the capitation amount. Each of our health plans (with the exception of our Utah plan whose Medicaid business was not capitated in 2008) is thus financially "at risk" for the medical care of its members. Each health plan arranges for health care services for its members by contracting with health care providers in the relevant communities or states, including contracting with primary care physicians, specialist physicians, physician groups, hospitals, and other medical care providers. Our California health plan also operates 17 of its own primary care community clinics. Various core administrative functions of our health plans — primarily claims processing, information systems, and finance — are centralized at our corporate parent in Long Beach, California. As of December 31, 2008, approximately 1,256,000 members were enrolled in our ten health plans.

Dr. C. David Molina founded our company in 1980 under the name "Molina Medical Centers" as a provider organization serving the Medicaid population in Southern California through a network of primary care clinics. Since then, we have increased our membership through the start-up development of new health plan operations, the acquisition of existing health plans, and internal or organic growth. In 1997, we established our Utah health plan as a start-up operation. In 1999, we incorporated in California as the parent company of our California and Utah health plan subsidiaries under the name "American Family Care, Inc." In late 1999, we acquired our Michigan and Washington health plans. In March 2000, we changed our name to Molina Healthcare, Inc. In June 2003, we reincorporated from California to Delaware, and in July 2003 we completed our initial public offering of common stock and listed our shares for trading on the New York Stock Exchange under the trading symbol, MOH. In July 2004, we acquired our New Mexico health plan. Our start-up health plan in Ohio began operations in December 2005. On January 1, 2006, our health plans in California, Michigan, Utah, and Washington began operating Medicare Advantage Special Needs Plans in their respective states. In May 2006, we acquired Cape Health Plan in Michigan, merging it into our Michigan health plan effective December 31, 2006. Our start-up health plan in Texas began operations in September 2006. On January 1, 2007, our health plans in California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington began enrolling members in Medicare Advantage plans with prescription drug coverage, or MA-PD plans. In June 2007, we organized a health plan in Nevada that serves only Medicare members. In November 2007, we acquired Alliance For Community Health LLC, doing business as Mercy CarePlus, a licensed health plan in Missouri. In January 2008, our health plans in New Mexico and Texas also began operating Medicare Advantage Special Needs Plans. In late December 2008, we began enrolling members in our Florida health plan.

Our members have distinct social and medical needs and come from diverse cultural, ethnic, and linguistic backgrounds. From our inception, we have focused exclusively on serving financially vulnerable individuals enrolled in government-sponsored health care programs. Our success has resulted from our extensive experience with meeting the needs of our members, including over 28 years of experience in operating community-based primary care clinics, our cultural and linguistic expertise, our education and outreach programs, our expertise in working with government agencies, and our focus on operational and administrative efficiencies.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is *www.molinahealthcare.com.*

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to "Molina Healthcare," the "Company," "we," "our," and "us" herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge on our website, *www.molinahealthcare.com,* as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, and Corporate Governance and Nominating Committee Charters, are also available on our website. Such information is also available in print upon the request of any stockholder to our Investor Relations Department at the address of our executive offices set forth above. In accordance with New York Stock Exchange ("NYSE") rules, on June 9, 2008, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Our Industry

The Medicaid and CHIP Programs. Established in 1965, the Medicaid program is an entitlement program funded jointly by the federal and state governments and administered by the states. The Medicaid program provides health care benefits to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced "TAN-if"). TANF is the successor to the Aid to Families with Dependent Children program, or AFDC, and most enrolled members are mothers and their children. Another common state-administered Medicaid program is for the aged, blind, or disabled, or ABD Medicaid members, who do not qualify under other Medicaid coverage categories. Although state programs must meet minimum federal standards, states have significant flexibility in determining eligibility thresholds, the amount of covered services, and payment rates for providers.

In addition, the Children's Health Insurance Program, known widely by the acronym, CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage, but not enough to afford commercial health insurance. States have the option of administering CHIP through their Medicaid programs.

The federal government pays a portion of the costs that states incur to provide services to Medicaid enrollees. The proportion of states' costs that the federal government pays is based on the "federal medical assistance percentage," or FMAP. The percentage for each state is determined through a formula that assigns a higher federal reimbursement rate to states that have lower income per capita (and vice versa) relative to the national average. The average matching rate that the federal government pays is 57 percent nationwide; states contribute the remaining 43 percent. The federal matching rates have both a floor (50 percent) and a ceiling (83 percent). The matching rates for CHIP are approximately one-third higher than those under Medicaid. Generally, states have more programmatic flexibility in CHIP than in Medicaid.

As part of the American Recovery and Reinvestment Act of 2009 enacted on February 17, 2009, states will receive approximately $87 billion in assistance for their Medicaid programs through a temporary increase in the FMAP match rate. The funding is effective retroactively from October 1, 2008 to December 31, 2010. Under the American Recovery and Reinvestment Act of 2009, every state will receive a minimum FMAP increase of 6.2 percent. The balance of funding is based on unemployment rates in the states. In order to receive this additional FMAP increase, states may not reduce Medicaid eligibility levels below the eligibility levels that were in place on July 1, 2008. Medicaid is classified as an entitlement, and therefore there is no limit on the federal funds that may be expended. Federal payments for Medicaid are limited only by the amount states are willing and able to spend. Nevertheless, budgetary constraints at both the federal and state levels may limit the benefits paid and the number of members served by Medicaid. CHIP, however, is a capped allotment. Pursuant to the Children's Health Insurance

Program Reauthorization Act of 2009 enacted on February 4, 2009, CHIP was reauthorized and expanded to cover up to a total of 11 million children by 2011. The legislation also provides an additional $32.8 billion in funding over the next four and a half years, and allows states to expand coverage up to 300 percent of the federal poverty level. CHIP will continue to be funded at an enhanced match, with the minimum federal amount being 65 percent.

Medicaid Managed Care. Under traditional fee-for-service Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These beneficiaries typically have minimal access to preventive care such as immunizations, and access to primary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, because providers are paid on a fee-for-service basis where additional services rendered result in additional revenues, they lack incentives to monitor utilization and control costs.

In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives a predetermined payment per enrollee or member (commonly referred to as "capitation") for the covered health care services. The health plan is thus financially "at risk" for its members' medical services. The health plan, in turn, arranges for the provision of the covered health care services by contracting with a network of providers, including both physicians and hospitals, who agree to provide the covered services to the health plan's members. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore and, in many cases, to mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have mandatory Medicaid managed care programs.

Medicare Advantage Plans. During 2008, each of our health plans in California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name, Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name, Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicaid plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operate a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans at December 31, 2008 was approximately 8,000 members. Our 2008 premium revenues from Medicare across all health plans represented approximately 3.1% of our total premium revenues.

Other Government Programs for Low Income Individuals. In certain instances, states have elected to provide medical benefits to individuals and families who do not qualify for Medicaid. Such programs are often administered in a manner similar to Medicaid and CHIP, but without federal matching funds. At December 31, 2008, our Washington health plan served approximately 26,000 such members under one such program, that state's "Basic Health Plan."

Our Approach

We focus on serving financially vulnerable families and individuals who receive health care benefits through government-sponsored programs within a managed care model. These families and individuals generally represent diverse cultures and ethnicities. Many have had limited educational opportunities and do not speak English as their first language. Lack of adequate transportation is common. We believe we are well-positioned to capitalize on the growth opportunities in serving these members. Our approach to managed care is based on the following key attributes:

Experience. For over 28 years we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. We have developed and forged strong relationships with the constituents whom we serve — members, providers, and government agencies. Our ability to deliver quality care and to establish and maintain provider networks, as well as our administrative efficiency, has allowed us to compete successfully for government contracts. We have a strong record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The successful integration of our New Mexico and Missouri health plans demonstrated our ability to expand into states in which we had not previously had any presence. The establishment of our health plans in Utah, Ohio, and Texas reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We arrange health care services through contracts with providers that include independent physicians and medical groups, hospitals, ancillary providers and, in California, our own clinics. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates, and diagnostic related groups, or DRGs. Our provider network strategy is to contract with providers that are best-suited, based on expertise, proximity, cultural sensitivity, and experience, to provide services to the members we serve.

Our California health plan operates 17 company-owned primary care clinics in California. In addition, on July 1, 2008, our unlicensed subsidiary in Virginia began to manage the Fairfax County Community Health Care Network. This network consists of three county-owned clinics, providing comprehensive medical services to over 12,000 of Fairfax County's uninsured residents. We believe that our clinics serve a useful role in providing certain communities with access to primary care and providing us with insights into physician practice patterns, first-hand knowledge of the needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. We have over 28 years of experience developing targeted health care programs for culturally diverse Medicaid members, and believe we are well-qualified to successfully serve these populations. We contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. We educate employees and providers about the differing needs among our members. We develop member education materials in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

Medical Management. We believe that our experience as a health care provider has helped us to improve medical outcomes for our members while at the same time enhancing the cost-effectiveness of care. We carefully monitor day-to-day medical management to provide appropriate care to our members, contain costs, and ensure an efficient delivery network. We have developed disease management and health education programs that address the

particular health care needs of our members. We have established pharmacy management programs and policies that have allowed us to manage our pharmaceutical costs effectively. For example, our staff pharmacists educate our providers on the use of generic drugs rather than brand drugs.

Our Strategy

Our objective is to be an innovative health care leader providing quality care and accessible services in an efficient and caring manner to Medicaid, CHIP, Medicare, and other financially vulnerable members. To achieve this objective, we intend to:

Focus On Serving Financially Vulnerable Families And Individuals. We believe that the Medicaid and low-income Medicare population, which is characterized by significant ethnic diversity, requires unique services to meet its health care needs. Our more than 28 years of experience in serving this population has provided us significant expertise in meeting the unique needs of our members.

Increase Our Membership. We have grown our membership through a combination of acquisitions, start-up health plans, serving new populations, and internal or organic growth. Increasing our membership provides the opportunity to grow and diversify our revenues, increase profits, enhance economies of scale, and strengthen our relationships with providers and government agencies. We will continue to seek to grow our membership by expanding within existing markets and entering new strategic markets.

- *Expand within existing markets.* We expect to grow in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, extending our services to new populations, maintaining positive provider relationships, and integrating members from other health plans.
- *Enter new strategic markets.* We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size and, where possible, mandated Medicaid managed care enrollment.

Provide quality cost-effective care. We will use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the quality of care, these programs also facilitate the cost-effective delivery of that care. To document our commitment to quality, each Molina Healthcare health plan has adopted goals: (1) to achieve or continue accreditation by the National Committee for Quality Assurance, or NCQA, and (2) to achieve scores under the Healthcare Effectiveness Data and Information Set (HEDIS) at the 75th percentile for Medicaid plans. It is our goal to be the health plan of choice, recognized for the quality and accessibility of our services. Financially vulnerable families and individuals covered by government programs have traditionally faced long-standing barriers to accessing care that include language, culture, and literacy. We want to be known for our ability to help others overcome these barriers. Among physicians, hospitals, and other providers, we want to be known for prompt and accurate payment of claims and sound medical decisions.

Leverage operational efficiencies. Our centralized administrative infrastructure, flexible information systems, and dedication to controlling administrative costs provide economies of scale. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and entry into new markets.

Our Health Plans

As of December 31, 2008, our health plans were located in California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. Additionally, we operate three county primary care clinics in Virginia. An overview of our health plans and their principal governmental program contracts with the relevant state authority as of December 31, 2008 is provided below:

State	Expiration Date	Contract Description or Covered Program
California....	3-31-10	Subcontract with Health Net for services to Medi-Cal members under Health Net's Los Angeles County Two-Plan Model Medi-Cal contract with the California Department of Health Services (DHS).
California....	12-31-12	Medi-Cal contract for Sacramento Geographic Managed Care Program with California Department of Health Services (DHS).
California....	3-31-11	Two Plan Model Medi-Cal contract for Riverside and San Bernardino Counties (Inland Empire) with California Department of Health Services (DHS).
California....	6-30-09	Medi-Cal contract for San Diego Geographic Managed Care Program with California Department of Health Services (DHS).
California....	6-30-09	Healthy Families contract (California's CHIP program) with California Managed Risk Medical Insurance Board (MRMIB).
Florida.....	8-31-09	Medicaid contract with the Florida Agency for Health Care Administration.
Michigan	9-30-09	Medicaid contract with State of Michigan.
Missouri.....	9-30-09	Medicaid contract with the Missouri Department of Social Services.
Nevada.....	12-31-09	Medicare Advantage contract with CMS.
New Mexico..	6-30-09	Salud! Medicaid Managed Care Program contract (including CHIP) with New Mexico Human Services Department (HSD).
Ohio	6-30-09	Medicaid contract with Ohio Department of Job and Family Services (ODJFS).
Texas.....	8-31-10	Medicaid contract with Texas Health and Human Services Commission (HHSC).
Utah	6-30-09	Medicaid contract with Utah Department of Health.
Washington ..	12-31-09	Basic Health Plan and Basic Health Plus Programs contract with Washington State Health Care Authority (HCA).
Washington ..	12-31-09	Healthy Options Program (including Medicaid and CHIP) contract with State of Washington Department of Social and Health Services.

In addition to the foregoing, our health plans in California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington have entered into a standardized form of contract with CMS with respect to their operation of a MA SNP, and our health plans in California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington have also entered into a standardized form of contract with CMS with respect to their operations of an MA-PD plan. These contracts are renewed annually and were most recently renewed as of January 1, 2009.

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. For example, our Indiana plan's contract with the state of Indiana expired without being renewed effective December 31, 2006.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. We are usually paid a negotiated amount per member per month, with the amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also paid an additional amount for each newborn delivery in Michigan, Missouri, New Mexico, Ohio, Texas and Washington. Since July 2002, our Utah health plan has been reimbursed by the state for all medical costs incurred by its Medicaid members plus a 9%

administrative fee. Effective as of January 1, 2009, that administrative fee was reduced to 8%. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. As of December 31, 2008, our California health plan served 322,000 members. We arrange health care services for our members either as a direct contractor to the state or through subcontracts with other health plans. Our plan serves the counties of Los Angeles, Riverside, San Bernardino, San Diego, Sacramento, and Yolo. Our Medi-Cal members in Los Angeles County are served pursuant to a subcontract we have entered into with Health Net, with Health Net in turn contracting with the state. Our California health plan also operates 17 of its own primary care community clinics.

Florida. In August 2008, we announced our intention to acquire Florida NetPASS, LLC ("NetPASS"), a provider of care management and administrative services at that time to approximately 55,000 Florida MediPass members in South and Central Florida. In October 2008, we announced that our wholly owned subsidiary, Molina Healthcare of Florida, Inc., was awarded a Medicaid managed care contract by the state of Florida. The term of the contract commenced on December 1, 2008, at which time Molina Healthcare of Florida began its initial enrollment of NetPASS Medicaid members, with the full transition of NetPASS members expected to be completed by the third quarter of 2009. As of March 1, 2009, our Florida plan served approximately 17,000 members.

Michigan. As of December 31, 2008, our Michigan health plan served 206,000 members, and operated in 42 of the state's 83 counties, including the Detroit metropolitan area.

Missouri. As of December 31, 2008, our Missouri health plan served 77,000 members, and operated in 57 of the state's 114 counties. Our Missouri health plan was acquired effective November 1, 2007.

Nevada. As of December 31, 2008, our Nevada health plan served approximately 700 Medicare members, and had no Medicaid enrollment. Our Nevada health plan became operational on June 1, 2007.

New Mexico. As of December 31, 2008, our New Mexico health plan served 84,000 members, and operated in all of New Mexico's 33 counties.

Ohio. As of December 31, 2008, our Ohio health plan served 176,000 members, and operated in 50 of the state's 88 counties.

Texas. As of December 31, 2008, our Texas health plan served 31,000 members, serving STAR and CHIP members in 6 counties and STAR PLUS members in 13 counties. STAR stands for State of Texas Access Reform, and is Texas' Medicaid managed care program. STAR PLUS is the Texas Medicaid managed care program serving the aged, blind or disabled and includes a long-term care component.

Utah. As of December 31, 2008, our Utah health plan served 61,000 members (including 2,400 Medicare Advantage SNP members). Our Utah health plan serves Medicaid members in 26 of the state's 29 counties, including the Salt Lake City metropolitan area, and CHIP members in all 29 counties.

Virginia. On July 1, 2008, Molina Healthcare of Virginia, Inc. began to operate the Fairfax County Community Health Care Network. This network consists of three county clinics, providing comprehensive medical services to over 12,000 of the county's uninsured residents.

Washington. As of December 31, 2008, our Washington health plan served 299,000 members, and operated in 32 of the state's 39 counties.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

The following table shows the total approximate number of primary care physicians, specialists, and hospitals participating in our network as of December 31, 2008:

	Primary Care Physicians	Specialists	Hospitals
California	2,833	7,162	81
Florida	226	85	8
Michigan	2,103	4,319	66
Missouri	1,828	4,282	97
Nevada	706	2,091	27
New Mexico	1,511	5,799	60
Ohio	1,682	10,585	123
Texas	1,329	3,939	58
Utah	1,101	3,178	35
Washington	2,710	5,815	87
Total	16,029	47,255	642

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California health plan operates 17 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a non-licensed subsidiary in Virginia which manages three health care clinics for Fairfax County.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert

data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*[sm] is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*[sm] is a multi-disciplinary disease management program that provides intensive health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*[sm] is a diabetes disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/Submit Authorizations.

- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/PCP.

- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (HIPAA or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the Health Employer Data and Information Set (HEDIS) and accreditation by the National Committee on Quality Assurance, or NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. At December 31, 2008, six of our ten health plans were accredited by the NCQA. In January 2009, our Ohio health plan received its NCQA accreditation. Our Texas health plan expects to apply for NCQA accreditation review in 2009. Our Missouri plan will undergo NCQA review in 2010, and our Nevada plan expects to apply for NCQA review as soon as it is eligible.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 3.4 system), with the exception of our Missouri plan which we expect will be migrated to the Molina standard platform in the fourth quarter of 2009.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented and currently subject to significant changes as a result of business consolidations, new strategic alliances entered into by other managed care organizations, and the entry into the industry of large commercial health plans. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.

- *Medicaid HMOs* — National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.

- *Prepaid Health Plans* — Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.

- *Primary Care Case Management Programs* — Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Regulation

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our 10 operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Each of our health plans is required to report quarterly on its operating results to the appropriate state regulatory agencies, and to undergo periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. Any acquisition of another plan's members must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state governments jointly fund it, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states, such as Washington, award contracts to any applicant demonstrating that it meets the state's requirements. Other states, such as California, engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that

we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Once awarded, our contracts generally have terms of one to four years, with renewal options at the discretion of the states. Our contracts generally set forth the requirements for operating in the Medicaid sector, and include provisions relating to: eligibility; enrollment and disenrollment processes; covered services; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education and wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by the insurance department of the jurisdiction that licenses the health plan, and must submit periodic utilization reports and other information to state or county Medicaid authorities. Health plans are not permitted to enroll members directly, and are permitted to market only in accordance with strict guidelines. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

Our health plans have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. The Medicaid managed care contracts of our Michigan and Missouri health plans are each the subject of a new Request for Proposal, or RFP, during 2009.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- Afford privacy to patient health information, and
- Protect the privacy of patient health information through physical and electronic security measures.

The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations.

Fraud and Abuse Laws. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2008, we had approximately 2,500 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Item 1A: ***Risk Factors***

RISK FACTORS

This annual report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. We cannot guarantee that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial may also become important factors that may materially affect us. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For

example, if our overall medical care ratio for 2008 of 84.8% had been one percentage point higher, or 85.8%, our earnings for 2008 would have been $1.60 per diluted share rather than our actual 2008 earnings of $2.25 per diluted share, a 29% reduction in our earnings.

Factors that may affect our medical care costs include the level of utilization of health care services, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, unexpected patterns in the annual flu season, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations. For additional information regarding this risk, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations — Critical Accounting Policies."

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid," or IBNP medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer health plans in Florida and Missouri is impacted by the more limited claims payment history of those health plans. Likewise, our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to Medicare Advantage or aged, blind or disabled Medicaid members, is impacted by the more limited experience we have had with those populations. Finally, with regard to the new Medicaid and CHIP members we expect to enroll in 2009 through organic growth due primarily to the recession, new members may be disproportionately costly due to high utilization in their first several months of Medicaid or CHIP membership as a result of their previously having been uninsured and therefore not seeking or deferring medical treatment.

The IBNR estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results. For additional information regarding this risk, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations — Critical Accounting Policies."

The 2008-'09 recession and resulting pressures on state budgets may result in funding for Medicaid or CHIP that does not keep pace with the growth in member enrollment.

As a result of the current recession and rising unemployment levels, overall Medicaid enrollment and Medicaid costs are projected to increase in 2009. In addition, the federal government recently approved a significant expansion of the CHIP program, which should lead to increased CHIP enrollment and costs.

However, most state governments are currently facing significant budget shortfalls for their 2009 and 2010 fiscal years. These budget pressures have already caused many states to cut their spending, to tap into their budget reserves, and to seek to raise revenues in order to balance their budgets. Because governmental health care programs account for such a large portion of state budgets, efforts to contain overall government spending and to achieve a balanced budget often result in significant political pressure being directed at the funding for these health care programs. With the exception of the relatively small portion of our revenues which come from Medicare, nearly all of our premium revenues are derived from the joint federal and state funding of the Medicaid and CHIP programs. Thus, the completeness of the funding under our various state contracts, or the rate increases we expect to receive during the course of a year, can be jeopardized during times of state budget crises. All of the states in which we currently operate our health plans — with the sole exception of Texas — are currently facing significant budgetary pressures.

In recognition of this problem and to help ease the pressure caused by shortfalls in state budgets, the federal government enacted on February 17, 2009 the American Recovery and Reinvestment Act of 2009. As part of this legislation, the federal government increased the amount of funding for federal Medicaid matching by approximately $87 billion for the period between October 1, 2008 and December 31, 2010. The actual matching percentage is computed from a formula that takes into account the average per capita income for each state relative to the national average, and a state's unemployment rate. As a result of the passage of this legislation, the share of Medicaid costs that are paid for by the federal government will go up, and the share of costs that are paid for by the states will go down.

However, in order for states to receive these increased federal matching funds, they must first budget for and actually spend their own state dollars to cover their additional Medicaid and CHIP members. Medicaid spending will therefore be driven by states' available revenues. State governments may have insufficient funds in order to fully fund these programs or provide for expanded enrollment. As a result, states may seek to cut or revise health care programs, optional benefits, eligibility criteria, or provider rates, causing the funding of one or more of our state contracts to be curtailed or cut off. In addition, the timing of payments we receive may be impacted by state budget shortfalls. As an example, during 2008 some monthly payments made by the state of California to our California health plan were several months late, which may occur again during 2009. Any of these events could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

There are numerous risks associated with the growth and operation of our Ohio health plan.

Membership at our Ohio health plan has grown rapidly, and the medical care ratio of our Ohio health plan has been substantially higher than that historically experienced by the Company as a whole. At the beginning of 2008, we had projected that the medical care ratio of our Ohio plan would be 88% for the full year. The actual medical care ratio of our Ohio health plan for full year 2008 was 91.1%. For full year 2009, as the result of risk adjustment payments we expect to receive with respect to our Ohio ABD members, the expected benefits from our in-sourcing of behavioral health, and the expected savings derived from our provider re-contracting efforts, we have projected that we can lower the medical care ratio of our Ohio health plan to approximately 87%. In the event these efforts are unsuccessful, the predicted savings are not realized, or we are otherwise unable to lower the medical care ratio of our Ohio health plan, the higher-than-expected medical care ratio of that plan could negatively impact the financial performance of the Company as a whole.

In addition, the lower amount of experience of our Ohio Medicaid and ABD members in accessing managed care and of our local providers in coordinating managed care services for their patients may also contribute to a higher than average medical care ratio. Further, as our Ohio plan continues to grow, we will be required to increase the amount of regulatory capital we contribute to it. In 2008, we were required to contribute $18.4 million in additional regulatory capital to our Ohio plan. If we are required to contribute additional capital in the future, our

existing cash balances or cash from operations may not be sufficient to cover such payments, in which case we would be required to draw down on our credit facility or obtain additional financing from another source and thereby incur additional indebtedness. In the event we are unable to lower our medical care ratio in Ohio, or if the Ohio plan requires a disproportionate investment of corporate resources or is otherwise unsuccessful, the poor performance of that health plan could detrimentally impact the financial performance of the Company as a whole.

If our government contracts are not renewed or are terminated, or if the responsive bids of our health plans for new Medicaid contracts are not successful, including the 2009 bids of our Michigan and Missouri health plans, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts generally run for periods of one year to four years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. There is no guarantee that any of our government contracts will be renewed or extended. Moreover, our contracts may be subject to periodic competitive bidding. As an example, the Medicaid contracts of our Michigan and Missouri health plans both expire on September 30, 2009. These health plans will be required to submit bids in response to the requests for proposals of the Medicaid authorities in each of Michigan and Missouri. In the event the responsive bids of our health plans are not successful, we will lose our Medicaid contract in the applicable state, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, they may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or had previously been the case.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. In addition, most contracts are terminable without cause. We may face increased competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the contracting process. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from ten state health plans. If we were unable to continue to operate in any of those ten states — and in particular in the plans we operate in the states of Washington, Ohio, Michigan, California, or New Mexico — or if our current operations in any portion of the states we are in were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

Portions of our premium revenue are subject to accounting estimates or retroactive adjustment.

Certain elements of the premium revenue earned by our New Mexico, Ohio, Texas, and Utah health plans, and by our Medicare Advantage plans, are subject to accounting estimates. Such estimates may subsequently prove to be inaccurate or may require adjustment based upon factual developments. If our accounting estimates with respect to our anticipated premiums are inaccurate or previously recognized premiums require retroactive adjustment, the change in our revenues could have a material adverse effect on our business, financial condition, cash flows, or results of operations. For additional information regarding this risk, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations — Revenue."

Our business may be negatively affected by major governmental health care reform proposals.

In response to dramatically escalating health care costs and the large and growing number of uninsured Americans, legislative proposals that would reform the health care system have been advanced by Congress and state legislatures and are currently pending at the federal and state levels. These changes include policy changes that would fundamentally change the dynamics of the health care industry, such as having the federal government assume a larger role in the health care industry, or effecting a fundamental restructuring of the Medicare or Medicaid programs. These proposals may also affect certain aspects of our business, including contracting with providers, provider reimbursement methods and payment rates, coverage determinations, mandated benefits, minimum medical expenditures, claims payment and processing, drug utilization and patient safety efforts, collection, use, disclosure, maintenance, and disposal of individually identifiable health information or personal health records.

We cannot predict if any of these initiatives will ultimately become law, or, if enacted, what their terms or the regulations promulgated pursuant to such laws will be, but their enactment could increase our costs, expose us to expanded liability and require us to revise the ways in which we conduct business or put us at risk for loss of business. In addition, our operating results could be adversely affected by such changes even if we correctly predict their occurrence.

In the event the grandfathering of the Medicaid managed care organization provider tax in the states of California, Missouri, and Ohio is not extended past September 30, 2009 or replacement state programs are not enacted, the Medicaid funds available for managed care organization in those states, including for our health plans, could be materially reduced.

Section 1903(w) of the Social Security Act permits states to receive federal matching Medicaid funds for revenues collected through health care-related taxes. Some states use these taxes to fund increased payment rates to providers, thereby effectively increasing the state's federal matching rates. The statute defines the term "tax" to include any licensing fee, assessment, or other payment mandated by the state. Prior to the enactment of the Deficit Reduction Act of 2005 (the "Deficit Reduction Act"), the law had permitted a state to define the class of items provided by managed care organizations to mean only revenues received for Medicaid services. However, the Deficit Reduction Act effectively eliminated the future use of such a tax by requiring states to apply the tax broadly to revenue received by health plans for all services provided, including services provided by commercial health plans to commercial health plan members. But for eight states that previously had had managed care organization provider taxes in place targeting only Medicaid health plan services, the Deficit Reduction Act delayed the effective date of this change to October 1, 2009. Included among those eight grandfathered states were four states in which we currently operate health plans: California, Michigan, Missouri, and Ohio. Since the adoption of the Deficit Reduction Act, those four states have continued to collect a provider tax on Medicaid managed care organizations, which has resulted in additional federal Medicaid matching funds being available in those states for distribution to Medicaid managed care organizations. These states depend upon revenues raised through their Medicaid managed care organization provider tax to help them fund their Medicaid programs.

The affected states are now considering how to comply with the expiration of the Deficit Reduction Act grandfather clause on September 30, 2009. One option would be for them to eliminate the managed care organization provider tax and replace the lost funds with increases in other Medicaid provider taxes. Another option would be to modify the existing managed care organization provider tax to meet the requirements for a "broad-based" tax that is imposed on both Medicaid and non-Medicaid covered services. One of the affected states — Michigan — has recently enacted a law which, effective as of April 1, 2009, repeals the existing managed care organization provider tax and introduces a new use tax on entities that have a contract to provide Medicaid services, thus effectively resolving the issue in that state. In the event Congress does not further grandfather the Medicaid managed care organization provider tax in the states of California, Missouri, and Ohio to support their Medicaid programs, or if local state programs are not adopted in its place, the loss of state and federal matching Medicaid funds in those states starting in October 2009 could materially reduce the revenues of our California, Missouri, and Ohio health plans, thereby negatively affecting our business, financial condition, cash flows, or results of operations.

A sustained drop in the rate of interest earned on our invested balances could adversely affect our revenues.

Our revenues from invested balances in 2008 were $21.1 million, whereas our revenues from invested balances in 2007 were $30.1 million. If the rate of return on our invested balances in 2008 had matched the rate of return experienced in 2007, our year-over-year earnings would have increased by 23% rather than the 10% increase actually experienced. Thus, prevailing interest rates during the year can have a significant impact on our revenues and earnings. We have projected that, on average in fiscal year 2009, our invested balances will earn interest at the rate of at least 2%. Our invested balances earned an average of 3.0% in 2008. In the event the interest earned on our invested balances throughout 2009 averages less than 2% per annum, our business, financial condition, cash flows, or results of operations could be adversely affected.

If we are unable to achieve our projected growth in Medicare members or our projected medical care ratio with respect to our Medicare program, our results of operations could be adversely affected.

Our business strategy includes increasing enrollment for our members who are dually eligible under both the Medicaid and Medicare programs, as well as increasing the number of our members eligible under Medicare alone. Our experience with the Medicare program and with Medicare members is much more limited than our experience with Medicaid. The administrative processes, programmatic requirements, and regulations pertaining to the Medicare program differ significantly from those of the Medicaid program. Likewise, the Medicare population has many characteristics and behavior patterns which differ from the Medicaid population with which we are familiar. Finally, Medicare providers, provider networks, and provider relations also differ from those of Medicaid.

During 2009, we intend to continue to invest in the infrastructure necessary to grow our Medicare program. We have projected that we will have enrolled 12,000 Medicare members by the end of 2009. In the event we are unable to enroll as many Medicare members as we project or if we are unable to quickly develop our Medicare expertise and adapt to the differing requirements and needs of the Medicare program and Medicare members, our business strategy may be unsuccessful and our business, financial condition, cash flows, or results of operations could be adversely affected.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we were unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also create increased net worth requirements. In such circumstances we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have a significant adverse impact on our business, financial condition, cash flows, or results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets

— particularly operators of large commercial health plans — have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or comply with these regulatory requirements in a timely manner, if at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions or reduce our liquidity and capital resources.

To provide liquidity, we have a $200 million senior secured credit facility that matures in May 2012. As of December 31, 2008, we had no outstanding indebtedness under our credit facility. Our credit facility imposes numerous restrictions and covenants, including prescribed consolidated leverage and fixed charge coverage ratios, net worth requirements, and acquisition limitations that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends without lender approval. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to act with complete flexibility, or our inability to use our credit facility in the manner intended.

If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, we may be unable to use the credit facility in the manner intended. In addition, if we were to draw down on our credit facility, or incur other additional debt in the future, it could have an adverse effect on our business and future operations. For example, it could:

- require us to dedicate a substantial portion of cash flow from operations to pay principal and interest on our debt, which would reduce funds available to fund future working capital, capital expenditures, and other general operating requirements;
- increase our vulnerability to general adverse economic and industry conditions or a downturn in our business; or
- place us at a competitive disadvantage compared to our competitors that have less debt.

In addition, the financial institutions which form the lending syndicate under our credit facility have recently experienced significant losses. As a result, such financial institutions may be unable to fund a loan under our credit facility. In the event we default under our credit facility or our lenders are unable to fund a loan request under our credit facility, our operations, liquidity, and capital resources could be materially adversely affected.

Adverse credit market conditions may have a material adverse affect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past year. The availability of credit, from virtually all types of lenders, has been severely restricted. Such conditions may persist throughout 2009 and beyond. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all. While we have not attempted to access the credit markets recently, we believe that if credit could be obtained, the terms and costs of such credit would be significantly less favorable to us than what was obtained in our most recent financings.

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In fiscal year 2005, we had total premium revenue of $1.6 billion. In fiscal year 2008, we had total premium revenue of $3.0 billion, an increase of 88% over a four-year span. Continued rapid growth could place a significant strain on our management and on other Company resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Funding under our contracts is subject to regulatory and programmatic adjustments and reforms for which we may not be appropriately compensated.

The federal government and the governments of the states in which we operate frequently consider legislative and regulatory proposals regarding Medicaid reform and programmatic changes. Such proposals involve, among other things, changes in reimbursement or payment levels based on certain parameters or member characteristics, changes in eligibility for Medicaid, and changes in benefits covered such as pharmacy, behavioral health, or vision. Any of these changes could be made effective retroactively. If our cost increases resulting from these changes are not matched by commensurate increases in our revenue, we would be unable to make offsetting adjustments, such as supplemental premiums or changes in our benefit plans, as would a commercial health plan. Any such regulatory or programmatic reforms at either the federal or state level could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. For instance, CMS announced in 2008 that it will perform audits of selected Medicare health plans each year to validate the coding practices of and supporting documentation maintained by care providers. These audits involve a review of medical records maintained by providers, including those in and out of network, and may result in retrospective or prospective adjustments to payments made to health plans pursuant to CMS Medicare contracts. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems, or to successfully migrate our main data processing facility to the new facility we are constructing in New Mexico, could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. Our policy is to upgrade and expand our information systems capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

We are currently constructing a new health information technology center in Albuquerque, New Mexico. During 2009, we anticipate migrating our main data processing functions from our current facility in Long Beach,

California to that new facility. In the event that transition to New Mexico is disrupted for any reason, or if the information technology equipment in our new facility malfunctions, our claims processing, utilization management, or other data processing functions could be disrupted which would adversely affect all of our business operations. In addition, we intend during 2009 to migrate the claims processing functions of our Missouri health plan to our centralized platform. In the event that migration is unsuccessful, the business operations of our Missouri health plan could be adversely affected.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if they are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, until our centralized claims processing and information technology support functions are migrated to New Mexico, those facilities will remain in Long Beach, California. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the country. If a major earthquake were to strike the Los Angeles and Long Beach area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

If we are unable to maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to assure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our

plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial position, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which the Company does not participate. Because of the limited number of health care companies competing in our market space, these actions and the resulting negative publicity could become associated with or imputed to the Company, regardless of the Company's actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which the Company does participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. Providers at the 17 primary care clinics we operate in California are employees of our California health plan. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our California plan is subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of its employees. We maintain medical malpractice insurance for our clinics in the amount of $1 million per occurrence, and an annual aggregate limit of $3 million, errors and omissions insurance in the amount of $10 million per occurrence and in aggregate for each policy year, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Also, Congress and several state legislatures have considered legislation that would permit managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. If this or similar legislation were enacted, claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, cash flows, or results of operations, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is currently subject to significant changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct and indirect subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2008, 2007, and 2006 without approval of the regulatory authorities were approximately $7.6 million, $18.7 million, and $6.9 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our credit facility and/or our senior convertible notes.

Unforeseen changes in regulations or pharmaceutical market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our

pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $16.12 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- state and federal budget decreases,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in government payment levels,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies in the health care industry,
- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change, and
- general economic conditions, including unemployment rates, inflation, and interest rates.

Our stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our stock does not continue to develop, securities analysts may not initiate or maintain research coverage of our company and our shares, and this could depress the market for our shares.

Members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate own or are entitled to receive upon certain events approximately 56% of our capital stock. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of our Company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

It may be difficult for a third party to acquire our company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

We do not anticipate paying any cash dividends in the foreseeable future.

We have not declared or paid any dividends since our initial public offering in July 2003. While we have in the past and may again use our available cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles ("GAAP") and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, the adoption of new pronouncements or the application of existing pronouncements to our business could significantly affect our results of operations.

In October 2007, we completed our offering of $200 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014. In May 2008, the Financial Accounting Standards Board ("FASB") issued FASB Staff Position APB 14-1, *Accounting for Convertible Debt Instruments That May Be Settled in Cash upon Conversion (Including Partial Cash Settlement)* (the "FSP"). The FSP requires the proceeds from the issuance of such convertible debt instruments to be allocated between a liability component and an equity component. The resulting debt discount is amortized over the period the convertible debt is expected to be outstanding, as additional non-cash

interest expense. The change in accounting treatment is effective for fiscal years beginning after December 15, 2008, and shall be applied retrospectively to prior periods. The FSP changes the accounting treatment for our 3.75% Convertible Senior Notes. The impact of this new accounting treatment will result in an increase to non-cash interest expense beginning in fiscal year 2009 for financial statements covering past and future periods. The incremental impact of the FSP to our results of operations in 2009 will be approximately $3.1 million, or $0.12 per diluted share, net of tax. This estimate does not include the impact of our repurchase of $13 million face amount of the 3.75% Convertible Senior Notes in February 2009. We estimate the retroactive adjustment for prior periods will be approximately $627,000, or $0.02 per diluted share, net of tax, for 2007, and $2.9 million, or $0.11 per diluted share, net of tax, for 2008.

Our investments in auction rate securities are subject to risks that may cause losses and have a material adverse effect on our liquidity.

As of December 31, 2008, $70.5 million par value (fair value of $58.2 million) of our investments consisted of auction rate securities, all of which were securities collateralized by student loan portfolios, guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2008. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008. We used pricing models to estimate the fair value of these securities. These pricing models included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would be expected to have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of December 31, 2008.

As of December 31, 2008, we held $42.5 million par value (fair value of $34.9 million) auction rate securities with a certain investment securities firm. In November 2008, we entered into a rights agreement with this firm that (1) allows us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gives the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we receive the par value.

We have accounted for the Rights as a freestanding financial instrument and have elected to record the value of the Rights under the fair value option of SFAS 159, *The Fair Value Option for Financial Assets and Financial Liabilities*. In the fourth quarter of 2008, this resulted in the recognition of a $6.9 million non-current asset, with a corresponding increase to pretax income for the value of the Rights. To determine the fair value estimate of the Rights, we used a discounted cash-flow model that was based on the expectation that the auction rate securities will be put back to the investment securities firm at par on June 30, 2010, as permitted by the Rights agreement.

Simultaneous to the recognition of the $6.9 million rights agreement, we recorded an other-than-temporary impairment of the underlying auction rate securities, and prior unrealized losses on the auction rate securities that had been recorded to other comprehensive loss through November 2008 were charged to income, totaling $7.2 million. Also, at the time of the execution of the Rights agreement and pursuant to SFAS 115, we elected to transfer the underlying auction rate securities from available-for-sale to trading securities. For the month of December 2008, we recorded additional losses of $399,000 on these auction rate securities. We expect that the future changes in the fair value of the Rights will be substantially offset by the fair value movements in the underlying auction rate securities.

As of December 31, 2008, the remainder of our auction rate securities, which are still designated as available-for-sale, amounted to $28.0 million par value (fair value of $23.3 million). As a result of the decline in fair value of these auction rate securities, we recorded unrealized losses of $4.7 million to accumulated other comprehensive (loss) income for the year ended December 31, 2008. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive (loss) income. If we

determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated primarily as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. Trading securities are carried at fair value and any realized gains or losses are included as a component of earnings. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. During the year ended December 31, 2008, we recorded an other-than-temporary impairment of certain auction rate securities as described above, totaling $7.2 million. Over time, the economic and market environment may further deteriorate or provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines or losses related to our trading securities to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments or trading security losses may result in realized losses in future periods which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel which could negatively impact our operations.

A pandemic, such as a worldwide outbreak of a new influenza virus, could materially and adversely affect our ability to control health care costs.

An outbreak of a pandemic disease, such as the H5N1 avian flu, could materially and adversely affect our business and operating results. The impact of a flu pandemic on the United States would likely be substantial. Estimates of the contagion and mortality rate of any mutated avian flu virus that can be transmitted from human to human are highly speculative. A significant global outbreak of avian flu among humans could have a material adverse effect on our results of operations and financial condition as a result of increased inpatient and outpatient hospital costs and the cost of anti-viral medication to treat the virus.

Conversion of our senior convertible notes may dilute the ownership interest of existing stockholders.

Our convertible notes are convertible into cash and, under certain circumstances, shares of our common stock. The conversion of some or all of our convertible notes may dilute the ownership interests of existing stockholders. Any sales in the public market of our common stock issuable upon such conversion could adversely affect prevailing market prices of our common stock. In addition, the anticipated conversion of the convertible notes into cash and shares of our common stock could depress the price of our common stock.

Item 1B: ***Unresolved Staff Comments***

We have not received any comments from the staff of the Securities and Exchange Commission which remain unresolved.

Item 2: ***Properties***

We lease a total of 51 facilities, including our corporate headquarters at 200 Oceangate in Long Beach, California, and 16 of our 17 California medical clinics. We also own a 32,000 square-foot office building in Long Beach, California, the 26,000 square-foot data center nearing completion of construction in Albuquerque, New Mexico, and one of our medical clinics in Pomona, California. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3: ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 4: ***Submission of Matters to a Vote of Security Holders***

None.

Executive Officers of the Registrant

J. Mario Molina, M.D., 50, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 44, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 28 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Mark L. Andrews, Esq., 51, has served as Chief Legal Officer and General Counsel since 1998. He also has served as a member of the Executive Committee of our company since 1998. Before joining our company, Mr. Andrews was a partner at Wilke, Fleury, Hoffelt, Gould & Birney of Sacramento, California, where he chaired that firm's health care and employment law departments and represented Molina as outside counsel from 1994 through 1997. Mr. Andrews holds a Juris Doctorate degree from Hastings College of the Law.

Terry P. Bayer, 58, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has 25 years of health care management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University.

James W. Howatt, 62, has served as our Chief Medical Officer since May 2008. Dr. Howatt formerly served as the chief medical officer of Molina Healthcare of Washington. Prior to joining Molina Healthcare in February 2006, Dr. Howatt was Western Regional Medical Director for Humana, where he was responsible for the coordination and oversight of quality, utilization management, credentialing, and accreditation for Humana's activities west of Kansas City. Previously, he was Vice President and CMO of Humana Arizona, where he was responsible for leading a variety of medical management functions and worked closely with the company's sales division to develop customer-focused benefit structures. Dr. Howatt also served as CMO for Humana TRICARE, where he oversaw a $2.5 billion health care operation that served three million beneficiaries and comprised a professional network of 40,000 providers, 800 institutions, and 13 medical directors. Dr. Howatt received B.S. and M.D. degrees from the University of California, San Francisco, and also holds a Master of Business Administration degree with an emphasis in Health Management from the University of Phoenix. He interned and completed his residency program in family practice at Ventura County Hospital in Ventura, California. Dr. Howatt is a board-certified family physician and a member of the American College of Managed Care Medicine.

PART II

Item 5: ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2008		
First Quarter	$44.94	$23.46
Second Quarter	$30.50	$22.68
Third Quarter	$42.61	$24.08
Fourth Quarter	$32.45	$16.12
2007		
First Quarter	$34.76	$28.88
Second Quarter	$34.92	$28.72
Third Quarter	$38.41	$28.15
Fourth Quarter	$41.21	$34.01

As of March 10, 2009, there were approximately 112 holders of record of our common stock.

We did not declare or pay any dividends in 2008, 2007, or 2006. While we have in the past and may again in the future use our cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Moreover, our ability to pay dividends to stockholders is dependent on cash dividends being paid to us by our subsidiaries. Laws of the states in which we operate or may operate our health plans, as well as requirements of the government sponsored health programs in which we participate, limit the ability of our health plan subsidiaries to pay dividends to us. In addition, the terms of our credit facility limit our ability to pay dividends.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2008)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	665,339(1)	$30.29	3,887,414(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and Incentive Plan have been suspended.

(2) Includes only shares remaining available to issue under the 2002 Equity Incentive Plan (the "2002 Incentive Plan") and the 2002 Employee Stock Purchase Plan (the "ESPP"). The 2002 Incentive Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares available for issuance under the 2002 Incentive Plan automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. The 400,000 share increase on January 1, 2008 increased the total number of shares reserved for issuance under the 2002 Incentive Plan to 3,600,000 shares. The ESPP initially allowed for the issuance of 600,000 shares of common stock. Beginning December 31, 2003, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance is reached, shares reserved for issuance under the ESPP automatically increase by 1% of total outstanding capital stock. Through the automatic increase effective

December 31, 2008, the total number of shares reserved for issuance under the ESPP has increased to 2.2 million shares.

Purchases of Equity Securities by the Issuer

As publicly announced on July 23, 2008, our board of directors authorized the repurchase of up to one million shares of our common stock. The repurchase plan terminated on December 31, 2008. Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2008 are set forth below:

	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs
Oct. 1 - Oct. 31, 2008	721,561	$23.9222	721,561	$—
Nov. 1 - Nov. 30, 2008	—	—	—	—
Dec. 1 - Dec. 31, 2008	—	—	—	—
Total	721,561	$23.9222	721,561	$—

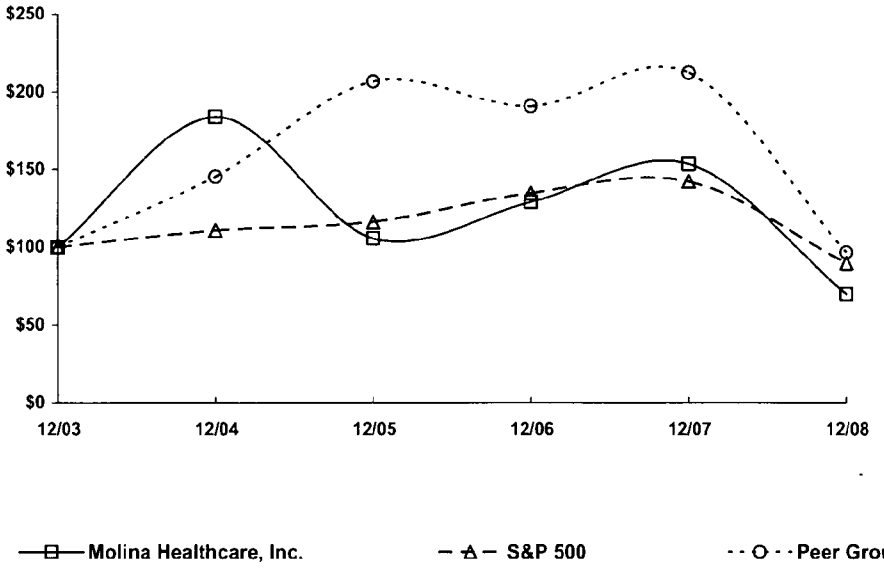
STOCK PERFORMANCE GRAPH

The following discussion shall not be deemed to be "soliciting material" or to be "filed" with the SEC nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500") and a peer group index for the five-year period from December 31, 2003 to December 31, 2008. The graph assumes an initial investment of $100 in Molina Healthcare, Inc. common stock and in each of the indices.

The peer group index consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

COMPARISON OF FIVE-YEAR CUMULATIVE TOTAL RETURN
Among Molina Healthcare, Inc, The S&P 500 Index
And A Peer Group



* $100 invested on 12/31/03 in stock & index-including reinvestment of dividends. Fiscal year ending December 31.

Item 6. ***Selected Financial Data***

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics") for the five years ended December 31, 2008 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data. The data under the caption "Operating Statistics" has not been audited.

	Year Ended December 31,				
	2008	2007(1)	2006(2)	2005	2004(3)
Statements of Income Data:					
Revenue:					
Premium revenue	$ 3,091,240	$ 2,462,369	$ 1,985,109	$ 1,639,884	$ 1,171,038
Investment income	21,126	30,085	19,886	10,174	4,230
Total revenue	3,112,366	2,492,454	2,004,995	1,650,058	1,175,268
Expenses:					
Medical care costs	2,621,312	2,080,083	1,678,652	1,424,872	984,686
General and administrative expenses	344,761	285,295	229,057	163,342	94,150
Loss contract charge	—	—	—	939	—
Impairment charge on purchased software(4)	—	782	—	—	—
Depreciation and amortization	33,688	27,967	21,475	15,125	8,869
Total expenses	2,999,761	2,394,127	1,929,184	1,604,278	1,087,705
Operating income	112,605	98,327	75,811	45,780	87,563
Total other income (expense), net	(8,714)	(4,631)	(2,353)	(1,929)	122
Income before income taxes	103,891	93,696	73,458	43,851	87,685
Provision for income taxes	41,493	35,366	27,731	16,255	31,912
Net income	$ 62,398	$ 58,330	$ 45,727	$ 27,596	$ 55,773
Net income per share:					
Basic	$ 2.25	$ 2.06	$ 1.64	$ 1.00	$ 2.07
Diluted	$ 2.25	$ 2.05	$ 1.62	$ 0.98	$ 2.04
Weighted average number of common shares outstanding	27,676,000	28,275,000	27,966,000	27,711,000	26,965,000
Weighted average number of common shares and potential dilutive common shares outstanding	27,772,000	28,419,000	28,164,000	28,023,000	27,342,000
Operating Statistics:					
Medical care ratio(5)	84.8%	84.5%	84.6%	86.9%	84.1%
General and administrative expense ratio(6)	11.1%	11.5%	11.4%	9.9%	8.0%
General and administrative expense ratio, excluding premium taxes	8.0%	8.2%	8.4%	7.1%	5.9%
Members(7)	1,256,000	1,149,000	1,077,000	893,000	788,000

	As of December 31,				
	2008	2007(1)	2006(2)	2005	2004(3)
Balance Sheet Data:					
Cash and cash equivalents	$ 387,162	$ 459,064	$403,650	$249,203	$228,071
Total assets	1,149,186	1,171,305	864,475	659,927	533,859
Long-term debt (including current maturities)	200,000	200,000	45,000	—	1,894
Total liabilities	638,522	680,827	444,309	297,077	203,237
Stockholders' equity	510,664	490,478	420,166	362,850	330,622

(1) The balance sheet and operating results of the MCP (Mercy CarePlus) acquisition have been included since November 1, 2007, the effective date of the acquisition.

(2) The balance sheet and operating results of the HCLB (Cape Health Plan) acquisition have been included since May 15, 2006, the effective date of the acquisition.

(3) The balance sheet and operating results of the New Mexico HMO have been included since July 1, 2004, the effective date of the acquisition.

(4) Amount represents an impairment charge related to commercial software no longer used for operations.

(5) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See *Management's Discussion and Analysis of Financial Condition and Results of Operations* for further discussion.

(6) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(7) Number of members at end of period.

Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Overview

Molina Healthcare, Inc. is a multi-state managed care organization participating exclusively in government-sponsored health care programs for low-income persons, such as the Medicaid program and the Children's Health Insurance Program, or CHIP. We also serve a small number of low-income Medicare members. We conduct our business primarily through 10 licensed health plans in the states of California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our financial performance for 2008, 2007 and 2006 is briefly summarized below (dollars in thousands, except per- share data):

	Year Ended December 31,		
	2008	2007	2006
Earnings per diluted share	$ 2.25	$ 2.05	$ 1.62
Premium revenue	$3,091,240	$2,462,369	$1,985,109
Operating income	$ 112,605	$ 98,327	$ 75,811
Net income	$ 62,398	$ 58,330	$ 45,727
Medical care ratio	84.8%	84.5%	84.6%
G&A expenses as a percentage of total revenue	11.1%	11.5%	11.4%
Total ending membership	1,256,000	1,149,000	1,077,000

Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2008, we received approximately 92% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services (CMS), and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for members of the Children's Health Insurance Program (CHIP) are generally among our lowest, with rates as low as approximately $80 PMPM in California and Utah. Premium revenues for Medicaid members are generally higher. Among the Temporary Aid for Needy Families (TANF) Medicaid population — the Medicaid group that includes most mothers and children — PMPM premiums range between approximately $100 in California to $300 in New Mexico. Among our Medicaid Aged, Blind or Disabled (ABD) membership, PMPM premiums range from approximately $450 in California and Texas to over $1,000 in New Mexico and Ohio. Medicare premiums are approximately $1,100 PMPM, with Medicare revenue totaling $95.1 million, $49.3 million and $27.2 million for the years ended December 31, 2008, 2007 and 2006, respectively.

Approximately 3% of our premium revenue for the year ended December 31, 2008 was realized under a Medicaid cost-plus reimbursement agreement that our Utah plan has with that state. For the year ended December 31, 2008, we also received approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in Michigan, Missouri, Ohio, Texas, and Washington. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates. Chief among these are (1) that portion of premium revenue paid to our New Mexico health plan by the state of New Mexico that may be refunded to the state if certain minimum amounts are not expended on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts, (2) that portion of the revenue of our Ohio health plan that is at risk if certain performance measures are not met, (3) the additional premium revenue our Utah health plan is entitled to receive from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid, (4) the profit-sharing agreement between our Texas health plan and the state of Texas, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income above a certain specified percentage, according to a tiered rebate schedule, and (5) that portion of our Medicare revenue that is subject to retroactive adjustment for member risk adjustment and recoupment of pharmacy related revenue.

Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. During the six months ended June 30, 2008, we recorded adjustments totaling $12.9 million to increase premium revenue associated with this requirement. The revenue resulted from a reversal of previously recorded amounts due the state of New Mexico when we were below the minimum percentage, because we exceeded the minimum percentage for the six months ended June 30, 2008.

Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (1) expend on administrative costs; and (2) retain as profit. At December 31, 2008, there was no liability recorded under the terms of these contract provisions. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may trigger a change in the amounts owed. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required.

Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. At December 31, 2008, we had recorded a liability of approximately $1.6 million under the terms of this contract provision.

In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to work with the state to assure an appropriate determination of amounts due to us under the savings share agreement. When additional information is known, or agreement is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement.

As of December 31, 2008, we had a liability of approximately $619,000 accrued pursuant to our profit-sharing agreement with the state of Texas for the 2008 contract year (ending August 31, 2008) and the 2009 contract year (ending August 31, 2009). During 2008, we paid the state of Texas $10.1 million relating to the 2007 and 2008 contract years, and the 2007 contract year is now closed. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.

Medicare revenue paid to us is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience. Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare revenue is subject to adjustment for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that our membership (measured on an

individual by individual basis) requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that our membership requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

Historically, membership growth has been the primary reason for our increasing revenues, although more recently our revenues have also grown due to the more care intensive benefits associated with our ABD and Medicare members. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2008	2007	2006
Total Ending Membership by Health Plan:			
California	322,000	296,000	300,000
Michigan	206,000	209,000	228,000
Missouri(1)	77,000	68,000	—
Nevada(2)	—	—	—
New Mexico	84,000	73,000	65,000
Ohio	176,000	136,000	76,000
Texas(3)	31,000	29,000	19,000
Utah	61,000	55,000	52,000
Washington	299,000	283,000	281,000
Subtotal	1,256,000	1,149,000	1,021,000
Indiana(4)	—	—	56,000
Total	1,256,000	1,149,000	1,077,000
Total Ending Membership by State for our Medicare Advantage Special Needs Plans:			
California	1,500	1,100	500
Michigan	1,700	1,100	200
Nevada	700	500	—
New Mexico	300	—	—
Texas(3)	400	—	—
Utah	2,400	1,900	1,500
Washington	1,000	500	200
Total	8,000	5,100	2,400
Total Ending Membership by State for our Aged, Blind and Disabled ("ABD") Population:			
California	12,700	11,800	10,700
Michigan	30,300	31,400	33,200
New Mexico	6,300	6,800	6,700
Ohio	19,000	14,900	—
Texas(3)	16,200	16,000	—
Utah	7,300	6,800	6,900
Washington	3,000	2,800	2,700
Total	94,800	90,500	60,200

(1) Our Missouri health plan was acquired effective November 1, 2007.

(2) Less than one thousand members. Our Nevada plan serves only Medicare members and commenced operations in June 2007.

(3) Our Texas health plan commenced operations in September 2006.

(4) Our Indiana health plan ceased serving members effective January 1, 2007.

The following table provides details of member months (defined as the aggregation of each month's membership for the period) by state for the years ended December 31, 2008, 2007, and 2006:

	2008	2007	2006
Total Member Months by Health Plan:			
California	3,721,000	3,500,000	3,694,000
Michigan	2,526,000	2,597,000	2,365,000
Missouri(1)	910,000	136,000	—
Nevada(2)	7,000	1,000	—
New Mexico	970,000	803,000	726,000
Ohio	1,998,000	1,567,000	442,000
Texas(3)	348,000	335,000	34,000
Utah	659,000	593,000	689,000
Washington	3,514,000	3,419,000	3,410,000
Subtotal	14,653,000	12,951,000	11,360,000
Indiana(4)	—	—	499,000
Total	14,653,000	12,951,000	11,859,000

(1) Our Missouri health plan was acquired effective November 1, 2007.

(2) Our Nevada plan serves only Medicare members and commenced operations in June 2007.

(3) Our Texas health plan commenced operations in September 2006.

(4) Our Indiana health plan ceased serving members effective January 1, 2007.

Expenses

Our operating expenses include expenses related to the provision of medical care services and general and administrative, or G&A, expenses. Our results of operations are impacted by our ability to effectively manage expenses related to health care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups, or DRGs, percent of billed charges, and case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract; under certain circumstances, we pay escalated charges in connection with these stop-loss agreements. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated

contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2008, 2007 and 2006, medically related administrative costs were approximately $75.9 million, $65.4 million and $52.6 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,								
	2008			2007			2006		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service . .	$1,709,806	$116.69	65.2%	$1,343,911	$103.77	64.6%	$1,125,031	$ 94.86	67.0%
Capitation	450,440	30.74	17.2	375,206	28.97	18.0	261,476	22.05	15.6
Pharmacy	356,184	24.31	13.6	270,363	20.88	13.0	209,366	17.65	12.5
Other	104,882	7.16	4.0	90,603	7.00	4.4	82,779	6.98	4.9
Total	$2,621,312	$178.90	100.0%	$2,080,083	$160.62	100.0%	$1,678,652	$141.54	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities. The following table provides the details of our medical claims and benefits payable as of the dates indicated (in thousands):

	December 31,	
	2008	2007
Fee-for-service claims incurred but not paid (IBNP)	$236,492	$264,385
Capitation payable	28,111	27,840
Pharmacy	18,837	14,676
Other	9,002	4,705
Total	$292,442	$311,606

G&A expenses largely consist of wage and benefit costs for our employees, premium taxes, and other administrative expenses. Some G&A services are provided locally, while others are delivered to our health plans from a centralized location. The primary centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally provided functions include member services, plan administration, and provider relations. G&A expenses include premium taxes for each of our health plans in California, Michigan, New Mexico, Ohio, Texas, and Washington.

Results of Operations

The following table sets forth selected consolidated operating ratios. All ratios, with the exception of the medical care ratio, are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium revenue earned and the cost of health care.

	Year Ended December 31,		
	2008	2007	2006
Premium revenue	99.3%	98.8%	99.0%
Investment income	0.7	1.2	1.0
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	84.8%	84.5%	84.6%
General and administrative expense ratio, excluding premium taxes	8.0%	8.2%	8.4%
Premium taxes included in general and administrative expenses	3.1	3.3	3.0
Total general and administrative expense ratio	11.1%	11.5%	11.4%
Depreciation and amortization expense ratio	1.1%	1.1%	1.1%
Effective tax rate	39.9%	37.8%	37.8%
Operating income	3.6%	3.9%	3.8%
Net income	2.0%	2.3%	2.3%

Year Ended December 31, 2008 Compared with the Year Ended December 31, 2007

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2008					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 417,027	$ 112.06	$ 363,776	$ 97.75	87.2%	$12,503
Michigan	509,782	201.86	405,683	160.64	79.6	26,710
Missouri	225,280	247.62	184,298	202.58	81.8	—
Nevada	8,037	1,106.45	9,099	1,252.61	113.2	—
New Mexico	348,576	359.45	286,004	294.92	82.1	11,713
Ohio	602,826	301.76	549,182	274.91	91.1	30,505
Texas	110,178	316.32	84,324	242.09	76.5	1,995
Utah	155,991	236.75	139,011	210.98	89.1	—
Washington	709,943	202.02	575,085	163.64	81.0	11,668
Other	3,600	—	24,850	—	—	21
	$3,091,240	$ 210.97	$2,621,312	$ 178.90	84.8%	$95,115

	Year Ended December 31, 2007					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 378,934	$ 108.29	$ 310,226	$ 88.66	81.9%	$11,338
Michigan	487,032	187.55	409,230	157.59	84.0	28,493
Missouri	30,730	226.65	26,396	194.69	85.9	—
Nevada	2,438	1,440.73	2,069	1,222.76	84.9	—
New Mexico	268,115	333.94	221,567	275.97	82.6	9,088
Ohio	436,238	278.39	394,451	251.72	90.4	19,631
Texas	88,453	263.90	68,173	203.40	77.1	1,598
Utah	116,907	197.19	109,895	185.36	94.0	—
Washington	652,970	190.96	519,763	152.00	79.6	10,844
Other	552	—	18,313	—	—	28
	$2,462,369	$ 190.13	$2,080,083	$ 160.62	84.5%	$81,020

Net Income

For the year ended December 31, 2008, net income increased to $62.4 million, or $2.25 per diluted share, from $58.3 million, or $2.05 per diluted share, for the year ended December 31, 2007.

Premium Revenue

Premium revenue for the year ended December 31, 2008 was $3,091.2 million, an increase of $628.8 million, or 26%, over the $2,462.4 million of premium revenue for the year ended December 31, 2007. Medicare premium revenue for 2008 was $95.1 million, compared with $49.3 million for 2007.

Significant contributors to the $628.8 million increase in annual premium revenue included the following:

- A $194.6 million increase in Medicaid premium revenue at the Missouri health plan, primarily a result of our acquisition of this plan on November 1, 2007.
- A $166.6 million increase in Medicaid premium revenue at the Ohio health plan due to higher enrollment, particularly in the Covered Families and Children (CFC) population.
- A $78.7 million increase in Medicaid premium revenue at the New Mexico health plan, primarily due to higher enrollment.
- A $51.4 million increase in Medicaid premium revenue at the Washington health plan, primarily due to higher rates.
- A $45.8 million increase in Medicare premium revenue across all health plans that serve Medicare enrollees, primarily due to increased enrollment.
- A $34.3 million increase in Medicaid premium revenue at the California health plan, primarily due to increased enrollment.

Investment income

Investment income for 2008 decreased $9.0 million to $21.1 million, from $30.1 million earned in 2007. This 30% decline was due to declining interest rates in 2008.

Medical care costs

Medical care costs as a percentage of premium revenue (the medical care ratio) increased to 84.8% in 2008 from 84.5% in 2007. Excluding Medicare, our medical care ratio was 84.8% in 2008, compared with 84.7% in 2007.

- The medical care ratio of the California health plan was 87.2% for 2008, up from 81.9% in 2007. The increase in the plan's medical care ratio was caused primarily by increased fee-for-service and pharmacy costs that proportionally exceeded the increased revenue from premium rate increases.
- The medical care ratio of the Michigan health plan was 79.6% for 2008, down from 84.0% in 2007. This decrease was caused primarily by premium rate increases that proportionally exceeded the plan's increased medical costs.
- The medical care ratio of the Missouri health plan was 81.8% for 2008, down from 85.9% in 2007. Premium increases were proportionally greater than PMPM medical costs due to revised provider contracts and a fee schedule increase effective July 1, 2008.
- The medical care ratio of the New Mexico health plan was 82.1% in 2008, down from 82.6% in 2007. Between July 1, 2008 and December 31, 2008, the New Mexico health plan received a blended rate decrease of approximately 3% under the plan's Medicaid Salud! contract and two separate contracts serving membership under the state's coverage initiative for the uninsured. The impact of this blended rate decrease was exceeded by the reversal of a $12.9 million accrual established as of December 31, 2007, pursuant to a minimum medical care ratio contract provision. In 2007, the New Mexico health plan had recorded a charge of $6.0 million related to this contract provision. Absent the impact of the minimum medical care ratio contract provision, the New Mexico health plan's MCR would have been 85.2% in 2008, compared with 80.8% in 2007, due to higher fee-for-service and capitation costs and lower PMPM premium revenue.
- The medical care ratio of the Ohio health plan increased to 91.1% in the 2008 from 90.4% in the 2007, primarily due to higher pharmacy cost as a parentage of premium revenue. The medical care ratio of the Ohio health plan, by line of business, was as follows:

	Dec. 31, 2008	Dec. 31, 2007
Covered Families and Children (CFC)	89.7%	88.6%
Aged, Blind or Disabled (ABD)	93.7	94.7
Aggregate	91.1%	90.4%

- The medical care ratio of the Texas health plan was 76.5% in 2008, down from 77.1% in 2007. Increased premiums more than offset higher medical costs.
- The medical care ratio of the Utah health plan was 89.1% in 2008, down from 94.0% in 2007. In 2007, the Utah health plan had recorded a $4.2 million reduction of revenue as a result of a reconciliation of amounts due the state of Utah under a savings sharing arrangement. Absent the savings sharing adjustment, the medical care ratio in 2007 would have been 90.7%.
- The medical care ratio of the Washington health plan was 81.0% in 2008, up from 79.6% in 2007, primarily due to higher fee-for-service specialist and hospital costs.

General and administrative expenses

General and administrative expenses were $344.8 million, or 11.1% of total revenue, for 2008, compared with $285.3 million, or 11.5% of total revenue, for 2007. Included in G&A expenses were premium taxes totaling $95.1 million in 2008 and $81.0 million in 2007. Premium taxes increased in 2008 due to increased revenues in the states where premium taxes are assessed.

Core G&A expenses (defined as G&A expenses less premium taxes) were 8.0% of revenue in 2008, compared with 8.2% in 2007. The decrease in core G&A compared with 2007 was primarily due to lower administrative payroll as a percentage of revenue, as indicated in the table below.

	Year Ended December 31,			
	2008		2007	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 18,451	0.6%	$ 9,778	0.4%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	190,932	6.1	163,420	6.6
Florida health plan start up expenses	2,495	0.1	—	—
All other administrative expense	37,768	1.2	31,077	1.2
Core G&A expenses	$249,646	8.0%	$204,275	8.2%

Depreciation and Amortization

Depreciation and amortization expense increased $5.7 million for the year ended December 31, 2008 compared to 2007, primarily due to depreciation expense associated with investments in infrastructure. Of the total increase, amortization expense contributed $2.1 million, primarily due to the Mercy CarePlus acquisition in Missouri in 2007. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2008	2007
Depreciation expense	$20,718	$17,118
Amortization expense on intangible assets	12,970	10,849
Total depreciation and amortization expense	$33,688	$27,967

Impairment Charge on Purchased Software

During the second quarter of 2007, we recorded an impairment charge of $782,000, related to purchased software no longer used for operations. No such charge was recorded in 2008.

Interest Expense

Interest expense increased to $8.7 million in 2008 from $4.6 million in 2007 primarily due to the issuance of our $200.0 million convertible senior notes in the fourth quarter of 2007.

Income Taxes

Income taxes were recorded at an effective rate of 39.9% for the year ended December 31, 2008, compared with 37.8% in the prior year. The increase in our effective tax rate was primarily the result of an increase in Michigan state taxes attributable to tax law changes that took effect on January 1, 2008. The increase in Michigan taxes was partially offset by prior years' tax benefits recorded during 2008 relating to California enterprise zone credits. Absent the enterprise zone credit tax benefits, our effective tax rate for the year ended December 31, 2008 would have been approximately 41%.

Year Ended December 31, 2007 Compared with the Year Ended December 31, 2006

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2007					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 378,934	$ 108.29	$ 310,226	$ 88.66	81.9%	$11,338
Michigan	487,032	187.55	409,230	157.59	84.0	28,493
Missouri	30,730	226.65	26,396	194.69	85.9	—
Nevada	2,438	1,440.73	2,069	1,222.76	84.9	—
New Mexico	268,115	333.94	221,567	275.97	82.6	9,088
Ohio	436,238	278.39	394,451	251.72	90.4	19,631
Texas	88,453	263.90	68,173	203.40	77.1	1,598
Utah	116,907	197.19	109,895	185.36	94.0	—
Washington	652,970	190.96	519,763	152.00	79.6	10,844
Other	552	—	18,313	—	—	28
	$2,462,369	$ 190.13	$2,080,083	$ 160.62	84.5%	$81,020

	Year Ended December 31, 2006					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 372,071	$100.74	$ 328,532	$ 88.95	88.3%	$11,738
Indiana	82,946	166.29	79,411	159.20	95.7%	—
Michigan	429,835	181.73	335,696	141.93	78.1%	25,982
New Mexico	221,597	305.07	187,460	258.08	84.6%	8,203
Ohio	94,751	214.25	86,249	195.03	91.0%	4,265
Texas	4,508	133.37	4,688	138.70	104.0%	79
Utah	165,507	240.10	151,417	219.66	91.5%	—
Washington	613,750	179.98	484,435	142.06	78.9%	10,506
Other	144	—	20,764	—	—	4
	$1,985,109	$167.39	$1,678,652	$141.55	84.6%	$60,777

Net Income

For the year ended December 31, 2007, net income increased to $58.3 million, or $2.05 per diluted share, from $45.7 million, or $1.62 per diluted share, for the year ended December 31, 2006.

Premium Revenue

For the year ended December 31, 2007, premium revenue was $2,462.4 million, an increase of $477.3 million, or 24.0%, over $1,985.1 million for the year ended December 31, 2006. Medicare premium revenue for 2007 was $49.3 million compared with $27.2 million in 2006. Contributing to the $477.3 million increase in annual premium revenues were the following:

- A $341.5 million increase at the Ohio health plan principally due to higher enrollment;
- An $83.9 million increase at the Texas health plan due to higher enrollment. During 2007, the Texas health plan reduced revenue by $3.1 million to record amounts due back to the state under a profit sharing agreement;

- A $57.2 million increase at our Michigan health plan principally due to a full year of operations which had included the revenue of the Cape Health Plan, compared to only eight months of operations including Cape Health Plan revenues in 2006 (the acquisition of Cape Health Plan was effective May 1, 2006);
- A $46.5 million increase at our New Mexico health plan due to higher enrollment and higher premium rates. The New Mexico health plan reduced revenue by $6.0 million and $6.9 million in 2007 and 2006, respectively, to meet a contractually required minimum medical care ratio;
- A $39.2 million increase at our Washington health plan due to higher premium rates and slightly higher membership;
- A $30.7 million increase as a result of our acquisition of Mercy CarePlus in Missouri effective November 1, 2007; and
- A $6.9 million increase at our California health plan as increased premium rates offset lower enrollment.

These increases in premium revenues during 2007 were partially offset by:

- An $82.9 million decrease due to the termination of operations of our Indiana health plan effective January 1, 2007; and
- A $48.6 million decrease at our Utah health plan due to reduced membership (on a member-month basis), and the write-off of $4.7 million in savings share receivables.

Investment Income

Investment income for 2007 increased $10.2 million to $30.1 million, from $19.9 million for 2006, as a result of higher invested balances, due in part to the investment of proceeds from our offering of convertible senior notes in the fourth quarter of 2007, and higher investment yields.

Medical Care Costs

Medical care costs as a percentage of premium revenue (the medical care ratio), decreased to 84.5% in the year ended December 31, 2007, from 84.6% in 2006. Contributing to this change were the following:

- The medical care ratio of the California health plan decreased to 81.9% in 2007 from 88.3% in 2006 as a result of the premium increases received during 2007 in San Bernardino/Riverside, San Diego, and Sacramento counties, while PMPM medical costs were essentially flat;
- The medical care ratio of the Michigan health plan increased to 84.0% in 2007 from 78.1% in 2006 due to higher capitation and pharmacy and specialty fee-for-service costs partially offset by lower hospital fee-for-service costs;
- The medical care ratio of the New Mexico health plan decreased to 82.6% in 2007 from 84.6% in 2006. The decrease was the result of higher premium rates and a reduction in the minimum medical care ratio premium adjustment, partially offset by the impact of Medicaid fee schedule increases. Absent the adjustments made to premium revenue in 2007 and 2006, the medical care ratio in New Mexico would have been 80.8% in 2007 and 82.0% in 2006;
- The medical care ratio of the Ohio health plan decreased to 90.4% for 2007 from 91.0% in 2006. During 2007, the Ohio health plan began serving the ABD population for the first time. The medical care ratio of the Ohio health plan, by line of business, was as follows:

	Dec. 31, 2007	Dec. 31, 2006
Covered Families and Children (CFC)	88.6%	91.0%
Aged, Blind or Disabled (ABD)	94.7	—
Aggregate	90.4%	91.0%

- The medical care ratio of the Texas health plan decreased in 2007 primarily due to very low medical costs for the Star Plus membership. As noted above, we recorded a $3.1 million reduction to revenue in Texas during 2007 to reflect estimated amounts due back to the state under a profit sharing arrangement;
- The medical care ratio of the Utah health plan increased due to the write-off of $4.2 million in savings share receivables in the second half of 2007. Medical care costs in Utah decreased on a PMPM basis in 2007 when compared to 2006. Absent the write-off of $4.2 million in savings share receivable in the second half of 2007 ($4.0 million of which was accrued as of December 31, 2006), the Utah health plan's medical care ratio would have been 90.7%, a decrease compared with the 91.5% reported for 2006. During 2007 our Utah health plan served the majority of its membership under a cost-plus contract with the state of Utah;
- The medical care ratio reported at the Washington health plan increased to 79.6% in 2007 from 78.9% in 2006, principally due to higher fee-for-service costs; and
- The termination of our operations in Indiana resulted in a 10 basis-point decrease in our medical care ratio, to 84.5%, in 2007. Absent the impact of the Indiana plan in both years, the medical care ratio in 2007 would have increased 50 basis points to 84.6% from 84.1% in 2006.

General and Administrative Expenses

G&A expenses were $285.3 million, or 11.5% of total revenue, for the year ended December 31, 2007, compared to $229.1 million, or 11.4% of total revenue, for 2006. Included in G&A expenses were premium taxes totaling $81.0 million in 2007 and $60.8 million in 2006. Premium taxes increased in 2007 due to increased revenues in the states where premium taxes are assessed.

Core G&A expenses decreased to 8.2% of total revenue for the year ended December 31, 2007, compared with 8.4% for 2006. Although Core G&A expenses declined slightly in 2007 as a percentage of total revenue, certain categories of expenses increased. These increases included employee incentive compensation, recruitment costs, and our continued investment in the administrative infrastructure necessary to support the Medicare product line. The following table provides details regarding the impact of these increases (dollars in thousands):

	Year Ended December 31,			
	2007		2006	
	Amount	% of Total Revenue	Amount	% of Total Revenue
Medicare-related administrative costs	$ 9,778	0.4%	$ 3,237	0.2%
Non Medicare-related administrative costs:				
Employee recruitment expense	2,568	0.1	1,769	0.1
Employee incentive compensation	9,976	0.4	5,102	0.2
All other administrative expense	182,735	7.3	158,172	7.9
Core G&A expenses	$205,057	8.2%	$168,280	8.4%

Depreciation and Amortization

Depreciation and amortization expense increased $6.5 million for the year ended December 31, 2007 compared to 2006, primarily due to depreciation expense associated with investments in infrastructure. Of the total increase, amortization expense contributed $1.3 million, primarily due to the Cape Health Plan acquisition in Michigan in 2006. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2007	2006
Depreciation expense	$17,118	$11,936
Amortization expense on intangible assets	10,849	9,539
Total depreciation and amortization expense	$27,967	$21,475

Impairment Charge on Purchased Software

During the second quarter of 2007, we recorded an impairment charge of $782,000 related to purchased software no longer used for operations. No such charge occurred during the year ended December 31, 2006.

Interest Expense

Interest expense increased to $4.6 million in 2007 from $2.4 million in 2006 primarily due to increased borrowings, including the issuance of our convertible senior notes in the fourth quarter of 2007.

Income Taxes

We recognized income tax expense for the year ended December 31, 2007 using an effective tax rate of 37.8%, consistent with the rate used for the year ended December 31, 2006.

Acquisitions

In August 2008, we announced our intention to acquire Florida NetPASS, LLC ("NetPASS"), a provider of care management and administrative services to approximately 55,000 Florida MediPass members in South and Central Florida. We expect the closing of the transaction to occur by the third quarter of 2009, at a purchase price of approximately $42 million, subject to adjustments. On October 1, 2008, we completed the initial closing of the transaction, under which we acquired one percent of the ownership interests of NetPASS for $9.0 million. Additionally, we deposited $9.0 million to an escrow account that will be used for the purpose of reimbursing the state of Florida for any sums due under a final settlement agreement with the state.

On October 7, 2008, we announced that our wholly owned subsidiary, Molina Healthcare of Florida, Inc., was awarded a Medicaid managed care contract by the state of Florida. The term of the contract commenced on December 1, 2008, at which time Molina Healthcare of Florida began its initial enrollment of NetPASS Medicaid members, with the full transition of NetPASS members expected to be completed by the third quarter of 2009.

On June 30, 2008, we paid $1 million and issued a total of 48,186 shares of our common stock in connection with our acquisition of the assets of The Game of Work, LLC. The purchase price consideration totaled $2.3 million. The Game of Work, LLC is a company specializing in productivity measurement and improvement and will be used internally to increase operational efficiency.

Effective November 1, 2007, we acquired Mercy CarePlus, a licensed Medicaid managed care plan based in St. Louis, Missouri, to expand our market share within our core Medicaid managed care business. The results of operations for Mercy CarePlus are included in the consolidated financial statements from periods following November 1, 2007. The purchase price for the acquisition was $80.0 million, and was funded with available cash and proceeds from our issuance of convertible senior notes in October 2007. The purchase price was subject to the following post-closing adjustments: (1) a reconciliation with respect to incurred but not reported medical costs; (2) a settlement of income taxes; and (3) the payment of an additional $5.0 million to the sellers if the earnings of the health plan (as defined in the purchase agreement) exceeded $22.0 million for the twelve months ended June 30, 2008. Upon evaluation, we have preliminarily determined that: (1) the sellers owe us approximately $650,000 in connection with the reconciliation of incurred but not reported medical costs; (2) we owe the sellers approximately $400,000 in connection with the settlement of income taxes; and (3) the earnings condition was not met, so we believe that we do not owe the sellers the additional $5.0 million payment. However, the sellers have objected to our first and third determinations as listed above, and the dispute resolution process provided for under the parties' stock purchase agreement has commenced. During the post-acquisition period in 2008, we reduced goodwill relating to the Mercy CarePlus acquisition by approximately $6.2 million, primarily due to the establishment of a deferred tax asset relating to the carryover tax basis in certain identifiable intangibles.

In May 2006, we acquired HCLB, Inc. ("HCLB"). HCLB is the parent company of Cape Health Plan, Inc. ("Cape"), a Michigan corporation based in Southfield, Michigan. The Cape acquisition expanded our geographic presence within Michigan. The purchase price was $44.0 million in cash and the acquisition was deemed effective May 15, 2006 for accounting purposes. Accordingly, the results of operations for Cape have been included in the

consolidated financial statements for the periods following May 15, 2006. Effective December 31, 2006, we merged Cape into Molina Healthcare of Michigan, Inc., our Michigan health plan.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of ten years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be four years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2008, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. For a comprehensive discussion of our auction rate securities, see "Fair Value Measurements," below. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. The average annualized portfolio yields for the years ended December 31, 2008, 2007, and 2006 were approximately 3.0%, 5.2%, and 4.8%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the year ended December 31, 2008 was $40.4 million, compared with $158.6 million for 2007, a decrease of $118.2 million. The significant components of the 2008 decrease in cash provided by operating activities included the following:

- *Receivables:* year-over-year increase in 2008 due primarily to higher birth income receivables as a result of increased enrollment in Ohio and Missouri, combined with the addition of receivables from the acquisition of our Missouri health plan in the fourth quarter of 2007;
- *Medical claims and benefits payable:* year-over-year decrease due primarily to the ramp up of membership and medical claims at the Texas and Ohio health plans in 2007 compared with less significant changes for those plans in 2008;
- *Deferred revenue:* year-over-year decrease due primarily to the timing of the Ohio health plan's receipts of premium payments from the state of Ohio;
- *Income taxes:* the 2008 increase in income taxes receivable, combined with the 2007 decrease in income taxes payable, due to timing of receipts and payments.

Cash used in investing activities was $64.5 million for the year ended December 31, 2008, compared with $256.3 million for 2007. The much greater amount invested in 2007 relates to the $193.4 million in proceeds from our issuance of $200 million senior convertible notes and our $70.2 million purchase of our Missouri health plan, Mercy CarePlus, both of which occurred in the fourth quarter of 2007, with no comparable activity in 2008.

Cash used in financing activities totaled $47.8 million for the year ended December 31, 2008, compared with $153.1 million provided by financing activities for 2007. The primary use of cash in 2008 was $49.9 million in repurchases of our common stock, compared with cash provided by, in 2007, the $193.4 million net proceeds from the issuance of convertible senior notes, offset by the reduction in borrowings and the repayment of amounts owed under our credit facility.

The securities and credit markets have been experiencing extreme volatility and disruption over the past year, and as a result the availability of credit has been severely restricted. Such conditions may persist throughout 2009. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility. While we have not attempted to access the credit markets recently, we believe that if credit could be obtained, the terms and costs of such credit would be significantly less favorable to us than what was obtained in our most recent financings.

Repurchase Programs. Under our board of directors' authorization, we undertook two common stock share repurchase programs in 2008. During 2008, we repurchased approximately 1.9 million shares at an aggregate cost of approximately $50 million. In January 2009, our board of directors authorized the repurchase of up to $25 million in aggregate of either our common stock or our convertible senior notes. In February 2009, we paid approximately $10 million to repurchase $13 million face amount of our convertible senior notes. In February and March 2009, we repurchased approximately 724,000 shares of our common stock for an aggregate purchase price of approximately $13.3 million.

Shelf Registration Statement. In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Capital Resources

At December 31, 2008, we had working capital of $340.8 million compared with $407.7 million at December 31, 2007. At December 31, 2008 and December 31, 2007, cash and cash equivalents were $387.2 million and $459.1 million, respectively. At December 31, 2008 and December 31, 2007, investments were $248.0 million and $242.9 million, respectively. In 2008, this total included $58.2 million in auction rate securities classified as non-current assets. In 2007, all investments were classified as current assets. At December 31, 2008, the parent company (Molina Healthcare, Inc.) had cash and investments of approximately $68.9 million. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

EBITDA(1)

	Three Months Ended December 31,		Year Ended December 31,	
	2008	2007	2008	2007
	(In thousands)			
Operating income	$27,467	$30,633	$112,605	$ 98,327
Add back:				
Depreciation and amortization expense	8,691	7,693	33,688	27,967
EBITDA	$36,158	$38,326	$146,293	$126,294

(1) We calculate EBITDA by adding back depreciation and amortization expense to operating income. Operating income included interest income of $21.1 million and $29.2 million for the years ended December 31, 2008,

and 2007, respectively. EBITDA is not prepared in conformity with GAAP since it excludes depreciation and amortization expense, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to net income, operating income, operating margin, or cash provided by operating activities. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Fair Value Measurements

Effective January 1, 2008, we adopted SFAS 157, *Fair Value Measurements*, for financial assets and liabilities. The statement defines fair value, provides guidance for measuring fair value and requires certain disclosures. SFAS 157 discusses valuation techniques, such as the market approach (comparable market prices), the income approach (present value of future income or cash flow) and the cost approach (cost to replace the service capacity of an asset or replacement cost). The statement establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three broad levels. The following is a brief description of those three levels:

- *Level 1:* Observable inputs such as quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities.
- *Level 2:* Inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets and quoted prices for identical or similar assets or liabilities in markets that are not active.
- *Level 3:* Unobservable inputs that reflect the reporting entity's own assumptions.

As of December 31, 2008, we held certain assets that are required to be measured at fair value on a recurring basis. These included cash and cash equivalents, investments and restricted investments as follows:

Balance Sheet Classification	Description
Current assets:	
Cash and cash equivalents	Cash and highly liquid securities with original or purchase date remaining maturities of up to three months that are readily convertible into known amounts of cash; reported at fair value based on market prices that are readily available (Level 1).
Investments	Investment grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1).
Non-current assets:	
Investments	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
	Auction rate securities; designated as trading; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Other assets	Auction rate securities rights (the "Rights"); reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Restricted investments	Interest-bearing deposits and U.S. treasury securities required by the respective states in which we operate, or required by contractual arrangement with a third party such as a provider group; designated as held-to-maturity; reported at amortized cost which approximates market value and based on market prices that are readily available (Level 1).

As of December 31, 2008, $70.5 million par value (fair value of $58.2 million) of our investments consisted of auction rate securities, of which all were securities collateralized by student loan portfolios, guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2008. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008. We used pricing models to estimate the fair value of these securities. These pricing

models included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would be expected to have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of December 31, 2008.

As of December 31, 2008, we held $42.5 million par value (fair value of $34.9 million) auction rate securities with a certain investment securities firm. In November 2008, we entered into a rights agreement with this firm that (1) allows us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gives the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we receive the par value.

We have accounted for the Rights as a freestanding financial instrument and have elected to record the value of the Rights under the fair value option of SFAS 159, *The Fair Value Option for Financial Assets and Financial Liabilities*. In the fourth quarter of 2008, this resulted in the recognition of a $6.9 million non-current asset, with a corresponding increase to pretax income for the value of the Rights. To determine the fair value estimate of the Rights, we used a discounted cash-flow model that was based on the expectation that the auction rate securities will be put back to the investment securities firm at par on June 30, 2010, as permitted by the Rights Agreement.

Simultaneous to the recognition of the $6.9 million rights agreement, we recorded an other-than-temporary impairment of the underlying auction rate securities, and prior unrealized losses on the auction rate securities that had been recorded to other comprehensive loss through November 2008 were charged to income, totaling $7.2 million. Also, at the time of the execution of the Rights agreement and pursuant to SFAS 115, we elected to transfer the underlying auction rate securities from available-for-sale to trading securities. For the month of December 2008, we recorded additional losses of $399,000 on these auction rate securities. We expect that the future changes in the fair value of the Rights will be substantially offset by the fair value movements in the underlying auction rate securities.

As of December 31, 2008, the remainder of our auction rate securities, which are still designated as available-for-sale, amounted to $28.0 million par value (fair value of $23.3 million). As a result of the decline in fair value of these auction rate securities, we recorded unrealized losses of $4.7 million to accumulated other comprehensive (loss) income for the year ended December 31, 2008. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive (loss) income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Long-Term Debt

Convertible Senior Notes

In October 2008, we completed our offering of $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2008, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;

- During the five business day period immediately following any five consecutive trading day period in which the trading price per $1,000 principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or

- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and $50 (representing 1/20th of $1,000); and

- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above $50.

On February 18, 2009, we settled the repurchase of $13.0 million face amount of our convertible senior notes (see Note 11 of the notes to consolidated financial statements). We repurchased the notes at an average price of $74.25 per $100 principal amount, for a total of $9.6 million. Including accrued interest of approximately $186,000, our total payment was $9.8 million.

Credit Facility

In 2005, we entered into an Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2008, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for working capital and general corporate purposes, and subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the amount available under the Credit Facility to up to $250.0 million.

Interest rates on borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest expense, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2008, there were no borrowings outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2008, we were in compliance with all financial covenants in the Credit Facility.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our ten health plan subsidiaries operating in California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $355.0 million at December 31, 2008, and $332.2 million at December 31, 2007.

The National Association of Insurance Commissioners, or NAIC, has established model rules which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Florida, Michigan, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. California has not adopted RBC rules and has not given notice of any intention to do so. The RBC rules, if adopted by California, may increase the minimum capital required by that state.

At December 31, 2008, our health plans had aggregate statutory capital and surplus of approximately $362.5 million, compared to the required minimum aggregate statutory capital and surplus of approximately $211.1 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2008. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2009.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management. As a result, the determination of our liability for claims and medical benefits is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. Our estimated IBNP liability represented $236.5 million of our total medical claims and benefits payable of $292.4 million as of December 31, 2008. Excluding amounts related to our cost-plus Medicaid contract in Utah and amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at December 31, 2008 was $216.7 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these

factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2008 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2008, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Our Utah health plan is excluded from these calculations, because the majority of the Utah business is conducted under a cost-plus reimbursement contract. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 53,199
(4)%	35,466
(2)%	17,733
2%	(17,733)
4%	(35,466)
6%	(53,199)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2008, that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Our Utah health plan is excluded from these calculations, because the majority of the Utah business is conducted under a cost-plus reimbursement contract. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$(27,129)
(4)%	(18,086)
(2)%	(9,043)
2%	9,043
4%	18,086
6%	27,129

The following per-share amounts are based on a combined federal and state statutory tax rate of 38%, and 27.8 million diluted shares outstanding for the year ended December 31, 2008. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2008, net income for the year ended December 31, 2008 would increase or decrease by approximately $5.5 million, or $0.20 per diluted share, net of tax. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2008, net income for the year ended December 31, 2008 would increase or decrease by approximately $2.8 million, or $0.10 per diluted share, net of tax. The corresponding figures for a 5% change in completion

factors and PMPM cost estimates would be $27.5 million, or $0.99 per diluted share, net of tax, and $14.0 million, or $0.50 per diluted share, net of tax, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by an change in the estimate of the other component, and that an change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. For example, if completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $5.5 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, which also uses actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which much of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP liability and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10%

range, as shown by our results in 2008 and 2007 when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of those years by approximately 20% and 19%, respectively.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities recorded at both December 31, 2007 and 2006 were less than what we had expected when we established our reserves. While the specific reasons for the overestimation of our liabilities were different at each of the two reporting dates, in general the overestimations were tied to our assessment of specific circumstances at our various individual health plans which were unique to those reporting periods.

In 2008, overestimation of our claims liability, particularly at our Michigan and Washington health plans, at December 31, 2007 led to the recognition of a benefit from prior period claims development.

- In Michigan, we overestimated the extent to which both catastrophic claims and state-mandated changes to the methodology used to pay outpatient claims had increased our liability at December 31, 2007.
- In Washington, we overestimated the extent to which state-mandated changes to hospital fee schedules implemented in August 2007 had increased our liability at December 31, 2007.

In 2007, overestimation of the claims liability at our California, New Mexico, and Washington health plans at December 31, 2006, led to the recognition of a benefit from prior period claims development, which benefit was partially offset by the underestimation of our claims liability at December 31, 2006 at our Michigan health plan.

- In California, we underestimated the impact of changes to certain provider contracts implemented during the second half of 2006 which lowered medical costs further than we had anticipated, leading us to overestimate our claims liability at December 31, 2006.
- In Washington, we overestimated the impact of the upward trend in medical costs during the latter half of 2006. Additionally, we lowered claims inventory in December 2006 in anticipation of a claims system upgrade in early 2007. While we attempted to adjust our claims liability estimation procedures for the increased speed of claims payment, we were only partially successful in doing so. Both of these circumstances led us to overestimate our claims liability at December 31, 2006.
- In Michigan, we underestimated the upward trend in medical costs during the latter half of 2006. Additionally, we underestimated the costs associated with the membership we had added as a result of our acquisition of Cape Health Plan in May 2006.

We do not believe that the recognition of a benefit (or detriment) from prior period claims development had a material impact on our consolidated results of operations in either 2008 or 2007.

In estimating our claims liability at December 31, 2008, we adjusted our base calculation to take account of the impact of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Uncertainties regarding utilization trends in December at our California health plan.
- Delays in the receipt and processing of paper-formatted claims at our California health plan during the second half of 2008. Our California health plan receives a far higher percentage of its fee-for-service claims in paper format than do our other health plans.
- The impact of accruals for potential high dollar provider settlements at our New Mexico health plan that we expect to be resolved in 2009.
- The impact of major revisions to financially significant provider contracts at the Ohio health plan in the latter half of 2008.
- The impact of a significant increase to the Ohio health plan's aged, blind or disabled (ABD) membership in the latter half of 2008.
- The impact of the Ohio health plan's decision to transition responsibility for the management of behavioral health services from an independent provider to Company employees in the latter half of 2008.
- Decreases in claims inventory across all of our health plans throughout 2008.

Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability.

We seek to maintain a consistent claims reserving methodology across all periods. Accordingly, any prior period benefit from an un-utilized reserve for adverse claims development may be offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) in the current period, and thus the impact on earnings for the current period may be minimal.

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2008 and 2007. The negative amounts displayed for "*components of medical care costs related to prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The benefit of this prior period development may be offset by the addition of a reserve for adverse claims development when estimating the liability at the end of the period (captured as a "*component of medical care costs related to current year*").

	Year Ended December 31,	
	2008	2007
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of period	$ 311,606	$ 290,048
Medical claims and benefits payable from business acquired	—	14,876
Components of medical care costs related to:		
Current year	2,683,399	2,136,381
Prior years	(62,087)	(56,298)
Total medical care costs	2,621,312	2,080,083
Payments for medical care costs related to:		
Current year	2,413,128	1,851,035
Prior years	227,348	222,366
Total paid	2,640,476	2,073,401
Balances at end of period	$ 292,442	$ 311,606
Benefit from prior period as a percentage of:		
Balance at beginning of period	19.9%	19.4%
Premium revenue	2.0%	2.3%
Total medical care costs	2.4%	2.7%
Days in claims payable	41	52
Number of members at end of period	1,256,000	1,149,000
Fee-for-service claims processing and inventory information:		
Number of claims in inventory at end of period	87,300	161,400
Billed charges of claims in inventory at end of period	$ 115,400	$ 212,000
Claims in inventory per member at end of period	0.07	0.14
Billed charges of claims in inventory per member at end of period	$ 91.88	$ 184.51
Number of claims received during the period	11,095,100	9,578,900
Billed charges of claims received during the period	$ 7,794,900	$6,190,900

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2008, our lease obligations for the next five years and thereafter were as follows: $15.5 million in 2009, $15.3 million in 2010, $14.9 million in 2011, $13.8 million in 2012, $12.0 million in 2013, and an aggregate of $40.9 million thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 15 to the accompanying

audited consolidated financial statements for the year ended December 31, 2008. We have certain advances to related parties, which are discussed in Note 14 to the accompanying audited consolidated financial statements for the year ended December 31, 2008.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2008. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2009	2010-2011	2012-2013	2014 and Beyond
Medical claims and benefits payable	$292,442	$292,442	$ —	$ —	$ —
Long-term debt(1)	200,000	—	—	—	200,000
Operating leases	112,310	15,514	30,204	25,725	40,867
Interest on long-term debt(1)	43,125	7,500	15,000	15,000	5,625
Purchase commitments	28,086	15,528	9,028	3,515	15
Total contractual obligations	$675,963	$330,984	$54,232	$44,240	$246,507

(1) Amounts relate to our October 2007 offering of $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014.

In accordance with Financial Accounting Standards Board Interpretation No. 48, *Accounting for Uncertainty in Income Taxes*, we have recorded approximately $11.7 million of unrecognized tax benefits as liabilities. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 12 to the accompanying audited consolidated financial statements for the year ended December 31, 2008 for further information.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Cash Management Class, PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

Inflation

Although the general rate of inflation has remained relatively stable and health care cost inflation has stabilized in recent years, the national health care cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. While we currently believe our strategies will mitigate health care cost inflation, competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2008 and 2007, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2008. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2008 and 2007, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2008, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 4, the Company adopted the provisions of Statement of Financial Accounting Standards No. 159, "The Fair Value Option for Financial Assets and Liabilities," effective January 1, 2008, and elected to apply this Standard to a transaction completed in the fourth quarter of 2008.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2008, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 16, 2009 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2009

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31, 2008	December 31, 2007
	(In thousands, except per share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 387,162	$ 459,064
Investments	189,870	242,855
Receivables	128,562	111,537
Income tax refundable	4,019	—
Deferred income taxes	4,603	8,616
Prepaid expenses and other current assets	14,766	12,521
Total current assets	728,982	834,593
Property and equipment, net	65,058	49,555
Intangible assets, net	79,133	89,776
Goodwill and indefinite-lived intangible assets	113,466	117,447
Investments	58,169	—
Deferred income taxes	4,488	—
Restricted investments	38,202	29,019
Receivable for ceded life and annuity contracts	27,367	29,240
Other assets	34,321	21,675
Total assets	$1,149,186	$1,171,305
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 292,442	$ 311,606
Accounts payable and accrued liabilities	66,247	69,266
Deferred revenue	29,538	40,104
Income tax payable	—	5,946
Total current liabilities	388,227	426,922
Long-term debt	200,000	200,000
Liability for ceded life and annuity contracts	27,367	29,240
Deferred income taxes	—	10,136
Other long-term liabilities	22,928	14,529
Total liabilities	638,522	680,827
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 26,725 shares at December 31, 2008 and 28,444 shares at December 31, 2007	27	28
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	146,179	185,808
Accumulated other comprehensive (loss) income	(2,310)	272
Retained earnings	387,158	324,760
Treasury stock (1,201 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	510,664	490,478
Total liabilities and stockholders' equity	$1,149,186	$1,171,305

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2008	2007	2006
	(In thousands, except per share data)		
Revenue:			
Premium revenue	$3,091,240	$2,462,369	$1,985,109
Investment income	21,126	30,085	19,886
Total revenue	3,112,366	2,492,454	2,004,995
Expenses:			
Medical care costs	2,621,312	2,080,083	1,678,652
General and administrative expenses	344,761	285,295	229,057
Depreciation and amortization	33,688	27,967	21,475
Impairment charge on purchased software	—	782	—
Total expenses	2,999,761	2,394,127	1,929,184
Operating income	112,605	98,327	75,811
Interest expense	(8,714)	(4,631)	(2,353)
Income before income taxes	103,891	93,696	73,458
Provision for income taxes	41,493	35,366	27,731
Net income	$ 62,398	$ 58,330	$ 45,727
Net income per share(1):			
Basic	$ 2.25	$ 2.06	$ 1.64
Diluted	$ 2.25	$ 2.05	$ 1.62
Weighted average shares outstanding:			
Basic	27,676	28,275	27,966
Diluted	27,772	28,419	28,164

(1) Potentially dilutive shares issuable pursuant to the Company's 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2008 and 2007.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
	(In thousands)						
Balance at January 1, 2006	27,792	$28	$162,693	$ (629)	$221,148	$(20,390)	$362,850
Comprehensive income:							
Net income	—	—	—	—	45,727	—	45,727
Other comprehensive loss, net of tax:							
Unrealized gain on Investments	—	—	—	292	—	—	292
Total comprehensive income	—	—	—	292	45,727	—	46,019
Stock options exercised, employee stock grants and employee stock purchases	327	—	10,070	—	—	—	10,070
Tax benefit from employee stock compensation	—	—	1,227	—	—	—	1,227
Balance at December 31, 2006	28,119	$28	$173,990	$ (337)	$266,875	$(20,390)	$420,166
Comprehensive income:							
Net income	—	—	—	—	58,330	—	58,330
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	609	—	—	609
Total comprehensive income	—	—	—	609	58,330	—	58,939
Adjustment to initially apply FIN 48	—	—	—	—	(445)	—	(445)
Stock options exercised, employee stock grants and employee stock purchases	325	—	10,965	—	—	—	10,965
Tax benefit from employee stock compensation	—	—	853	—	—	—	853
Balance at December 31, 2007	28,444	$28	$185,808	$ 272	$324,760	$(20,390)	$490,478
Comprehensive income:							
Net income	—	—	—	—	62,398	—	62,398
Other comprehensive loss, net of tax:							
Unrealized loss on investments	—	—	—	(7,025)	—	—	(7,025)
Other-than-temporary impairment of available-for-sale securities	—	—	—	4,443	—	—	4,443
Total comprehensive income	—	—	—	(2,582)	62,398	—	59,816
Purchase of treasury stock	—	—	—	—	—	(49,940)	(49,940)
Retirement of treasury stock	(1,943)	(1)	(49,939)	—	—	49,940	—
Stock issued in business purchase transaction	48	—	1,262	—	—	—	1,262
Stock options exercised, employee stock grants and employee stock purchases	176	—	9,340	—	—	—	9,340
Tax deficiency from employee stock compensation	—	—	(292)	—	—	—	(292)
Balance at December 31, 2008	26,725	$27	$146,179	$(2,310)	$387,158	$(20,390)	$510,664

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Operating activities:			
Net income	$ 62,398	$ 58,330	$ 45,727
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	33,688	27,967	21,475
Other-than-temporary impairment on available-for-sale securities	7,166	—	—
Unrealized loss on trading securities	399	—	—
Gain on rights agreement	(6,907)	—	—
Deferred income taxes	(1,688)	(9,057)	(399)
Stock-based compensation	7,811	7,188	5,505
Amortization of deferred financing costs	1,626	1,042	885
Tax deficiency from employee stock compensation recorded as additional paid-in capital	(335)	—	—
Loss on disposal of property and equipment	142	—	—
Changes in operating assets and liabilities, net of effects of acquisitions:			
Receivables	(17,025)	15,007	(38,847)
Prepaid expenses and other current assets	(2,245)	(2,911)	1,369
Medical claims and benefits payable	(19,164)	6,683	51,550
Accounts payable and accrued liabilities	(4,904)	18,700	5,188
Deferred revenue	(10,566)	21,984	10,443
Income taxes	(9,965)	13,693	(579)
Net cash provided by operating activities	40,431	158,626	102,317
Investing activities:			
Purchases of equipment	(34,690)	(22,299)	(20,297)
Purchases of investments	(263,229)	(264,115)	(148,795)
Sales and maturities of investments	246,524	103,718	171,225
Net cash (paid) acquired in business purchase transactions	(1,000)	(70,172)	5,820
Increase in restricted investments	(9,183)	(8,365)	(912)
Increase in other assets	(8,973)	(4,330)	(3,334)
Increase in other long-term liabilities	6,031	9,290	239
Net cash (used in) provided by investing activities	(64,520)	(256,273)	3,946
Financing activities:			
Treasury stock purchases	(49,940)	—	—
Borrowings under credit facility	—	—	50,000
Proceeds from issuance of convertible senior notes	—	200,000	—
Repayment of amounts borrowed under credit facility	—	(45,000)	(5,000)
Payment of credit facility fees	—	(551)	(459)
Payment of convertible senior notes fees	—	(6,498)	—
Tax benefit from employee stock compensation recorded as additional paid-in capital	43	853	1,227
Proceeds from exercise of stock options and employee stock plan purchases	2,084	4,257	2,416
Net cash (used in) provided by financing activities	(47,813)	153,061	48,184
Net (decrease) increase in cash and cash equivalents	(71,902)	55,414	154,447
Cash and cash equivalents at beginning of year	459,064	403,650	249,203
Cash and cash equivalents at end of year	$ 387,162	$ 459,064	$ 403,650

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (Continued)

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 50,130	$ 27,734	$ 27,354
Interest	$ 7,797	$ 9,419	$ 2,260
Schedule of non-cash investing and financing activities:			
Unrealized (loss) gain on investments	$ (3,956)	$ 977	$ 474
Deferred income taxes	1,374	(368)	(182)
Net unrealized (loss) gain on investments	$ (2,582)	$ 609	$ 292
Retirement of common stock used for stock-based compensation	$ (555)	$ (480)	$ —
Accrued purchases of equipment	$ 65	$ 672	$ 945
Retirement of treasury stock	$ 49,940	$ —	$ —
Impairment of purchased software	$ —	$ 782	$ —
Cumulative effect of adoption of Financial Interpretation No. 48, *Accounting for Uncertainty in Income Taxes*	$ —	$ 445	$ —
Accrual of software license fees	$ —	$ —	$ 2,375
Value of stock issued for employee compensation earned in the previous year	$ —	$ —	$ 2,149
Details of business purchase transactions:			
Fair value of assets acquired	$ (2,262)	$(106,233)	$ (86,024)
Common stock issued to seller	1,262	—	—
Less cash acquired	—	10,843	49,820
Liabilities assumed	—	25,218	42,024
Net cash (paid) acquired in business purchase transactions	$ (1,000)	$ (70,172)	$ 5,820
Business purchase transactions adjustments:			
Accounts payable and accrued liabilities	$ 1,265	$ —	$ —
Other long-term liabilities	2,368		
Deferred taxes	(7,549)	2,747	—
Goodwill and intangible assets, net	$ (3,916)	$ 2,747	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. is a multi-state managed care organization participating exclusively in government-sponsored health care programs for low-income persons, such as the Medicaid program and the Children's Health Insurance Program, or CHIP. We also serve a small number of low-income Medicare members. We conduct our business primarily through 10 licensed health plans in the states of California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those ten states, each of which is licensed as a health maintenance organization, or HMO.

Our results of operations include the results of recent acquisitions, including the acquisition of Mercy CarePlus, a Medicaid managed care organization based in St. Louis, Missouri, effective as of November 1, 2007, and the acquisition of Cape Health Plan, Inc. based in Southfield, Michigan, effective as of May 15, 2006. We acquired the Cape Health Plan, Inc. by acquiring its parent, HCLB, Inc. ("HCLB"). The Cape Health Plan, Inc. was merged into our Michigan health plan effective December 31, 2006.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. All significant intercompany transactions and balances have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure 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. Principal areas requiring the use of estimates include medical claims payable and accruals, determination of allowances for uncollectible accounts, the valuation of certain investments, settlements under risks/savings sharing programs, impairment of long-lived and intangible assets, professional and general liability claims, reserves for potential absorption of claims unpaid by insolvent providers, reserves for the outcome of litigation, valuation allowances for deferred tax assets, and the determination of unrecognized tax benefits.

Reclassification

In the accompanying consolidated balance sheets, we have reclassified certain amounts to conform to the 2008 presentation.

2. Significant Accounting Policies

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2008, we received approximately 92% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

Approximately 3% of our premium revenue for the year ended December 31, 2008 was realized under a Medicaid cost-plus reimbursement agreement that our Utah plan has with that state. For the year ended December 31, 2008, we also received approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in Michigan, Missouri, Ohio, Texas, and Washington. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates. Chief among these are (1) that portion of premium revenue paid to our New Mexico health plan by the state of New Mexico that may be refunded to the state if certain minimum amounts are not expended on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts, (2) that portion of the revenue of our Ohio health plan that is at risk if certain performance measures are not met, (3) the additional premium revenue our Utah health plan is entitled to receive from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid, (4) the profit-sharing agreement between our Texas health plan and the state of Texas, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income above a certain specified percentage, according to a tiered rebate schedule, and (5) that portion of our Medicare revenue that is subject to retroactive adjustment for member risk adjustment and recoupment of pharmacy related revenue.

Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. During the six months ended June 30, 2008, we recorded adjustments totaling $12.9 million to increase premium revenue associated with this requirement. The revenue resulted from a reversal of previously recorded amounts due the state of New Mexico when we were below the minimum percentage, because we exceeded the minimum percentage for the six months ended June 30, 2008.

Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (1) expend on administrative costs; and (2) retain as profit. At December 31, 2008, there was no liability recorded under the terms of these contract provisions. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may trigger a change in the amounts owed. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required.

Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. At December 31, 2008, we had recorded a liability of approximately $1.6 million under the terms of this contract provision.

In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to work with the state to assure an appropriate determination of amounts due to us under the savings share agreement. When additional information is known, or agreement is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement.

As of December 31, 2008, we had a liability of approximately $619,000 accrued pursuant to our profit-sharing agreement with the state of Texas for the 2008 contract year (ending August 31, 2008) and the 2009 contract year

(ending August 31, 2009). During 2008, we paid the state of Texas $10.1 million relating to the 2007 and 2008 contract years, and the 2007 contract year is now closed. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.

Medicare revenue paid to us is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience. Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare revenue is subject to adjustment for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that our membership (measured on an individual by individual basis) requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that our membership requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

Medical Care Costs

Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management,

24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2008, 2007, and 2006, medically related administrative costs were approximately $75.9 million, $65.4 million, and $52.6 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2008			2007			2006		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for- service..	$1,709,806	$116.69	65.2%	$1,343,911	$103.77	64.6%	$1,125,031	$ 94.86	67.0%
Capitation.....	450,440	30.74	17.2	375,206	28.97	18.0	261,476	22.05	15.6
Pharmacy	356,184	24.31	13.6	270,363	20.88	13.0	209,366	17.65	12.5
Other	104,882	7.16	4.0	90,603	7.00	4.4	82,779	6.98	4.9
Total.....	$2,621,312	$178.90	100.0%	$2,080,083	$160.62	100.0%	$1,678,652	$141.54	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates. See Note 10, "Medical Claims and Benefits Payable."

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material as the cost is not significant and the likelihood that coverage will be applicable is low.

Taxes Based on Premiums

Our California, Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in general and administrative expenses. Premium tax expense totaled $95.1 million, $81.0 million, and $60.8 million in 2008, 2007, and 2006, respectively.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we

have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2008 or 2007.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2008, or 2007.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

We account for our investments in marketable securities in accordance with Statement of Financial Accounting Standards No. (SFAS) 115, *Accounting for Certain Investments in Debt and Equity Securities.* Except for restricted investments and certain student loan portfolios (the "auction rate securities"), marketable securities are designated as available-for-sale and are carried at fair value. Unrealized gains or losses on available-for-sale securities, if any, are recorded in stockholders' equity as other comprehensive income (loss) net of applicable income taxes. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis. Fair values of securities are generally based on quoted prices in active markets.

Our investment policy requires that all of our investments have final maturities of ten years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be four years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. During 2008, our auction rate securities were classified as non-current assets. During the fourth quarter of 2008, certain auction rate securities were designated as trading securities. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 4, "Fair Value Measurements," and Note 5, "Investments."

Receivables

Receivables consist primarily of amounts due from the various states in which we operate. All receivables are subject to potential retroactive adjustment. Because the amounts of all receivables are readily determinable and our creditors are state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 6, "Receivables."

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Software developed for internal use is capitalized in accordance with the provision of AICPA Statement of Position No. 98-1, *Accounting for the Costs of Computer Software Developed or Obtained for Internal Use.* Furniture and equipment are depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software is amortized over its estimated

useful life of three years. Leasehold improvements are amortized over the term of the lease or five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years. See Note 7, "Property and Equipment."

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are amortized on a straight-line basis over the expected period to be benefited (between one and 15 years). See Note 8, "Goodwill and Intangible Assets."

Under SFAS 142, *Goodwill and Other Intangible Assets*, goodwill and indefinite lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. Under the guidance of SFAS 142, we used a discounted cash flow methodology to assess the fair values of our reporting units at December 31, 2008 and 2007. If book equity values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite lived asset balance. Based on the results of our impairment testing, no adjustments were required for the years ended December 31, 2008, 2007, and 2006.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted expected cash flows associated with that asset. In such circumstances, the asset is deemed to be impaired. We review material long-lived assets for impairment on an annual basis, as well as when events or changes in business conditions suggest potential impairment. Impaired assets are written down to fair value. In the second quarter of 2007, we recorded an impairment charge totaling $782,000 related to commercial software no longer used in operations. Other than this 2007 charge, we have determined that no long-lived assets were impaired in the years ended December 31, 2008, 2007, and 2006.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 9, "Restricted Investments."

Receivable/Liability for Ceded Life and Annuity Contracts

We report an acquired 100% ceded reinsurance arrangement related to the December 2005 purchase of Molina Healthcare Insurance Company by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts.

Other Assets

During 2008, other assets increased due to the $9.0 million payment on the initial closing of the Florida NetPASS acquisition (see Note 3, "Business Purchase Transactions"), and the addition of a $6.9 million non-current asset in connection with a rights agreement (see Note 4, "Fair Value Measurements"). Other significant items included in other assets include deferred financing costs associated with long-term debt, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see

Note 14, "Related Party Transactions"). The deferred financing costs are being amortized on a straight-line basis over the seven-year term of the convertible senior notes.

Income Taxes

We account for income taxes under SFAS 109, *Accounting for Income Taxes*. Deferred tax assets and liabilities are recorded based on temporary differences between the financial statement basis and the tax basis of assets and liabilities using presently enacted tax rates. On January 1, 2007, we adopted the provisions of Financial Accounting Standards Board (FASB) Interpretation No. (FIN) 48, *Accounting for Uncertainty in Income Taxes*, which clarifies the accounting for uncertainty in income taxes recognized in companies' financial statements in accordance with SFAS 109. FIN 48 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. The evaluation of a tax position in accordance with FIN 48 is a two-step process. The first step is recognition to determine whether it is more likely than not that a tax position will be sustained upon examination. In the second step, a tax position that meets the more-likely-than-not recognition threshold is measured to determine the amount of benefit to recognize in the financial statements. FIN 48 also provides guidance on de-recognition of recognized tax benefits, classification, interest and penalties, accounting in interim periods, disclosure and transition. See Note 12, "Income Taxes."

Earnings Per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Shares outstanding at the beginning of the year	28,444	28,119	27,792
Weighted-average number of shares repurchased	(871)	—	—
Weighted-average number of shares issued	103	156	174
Denominator for basic earnings per share	27,676	28,275	27,966
Dilutive effect of employee stock options and stock grants(1)	96	144	198
Denominator for diluted earnings per share(2)	27,772	28,419	28,164

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented.

(2) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2008 and 2007.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Cash Management Class, PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts

receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

Fair Value of Financial Instruments

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see Note 4, "Fair Value Measurements."

Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was $115.5 million as of December 31, 2008, and $225.6 million as of December 31, 2007. The carrying amount of the convertible senior notes was $200.0 million as of December 31, 2008.

Risks and Uncertainties

Our profitability depends in large part on accurately predicting and effectively managing medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2008, we operated in 10 states, in some instances as a direct contractor with the state, and in others as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Segment Information

We present segment information externally in the same manner used by management to make operating decisions and assess performance. Each of our subsidiaries arranges for the provision of health care services to Medicaid and CHIP members in return for compensation from state agencies. They share similar characteristics in the membership they serve, the nature of services provided and the method by which medical care is rendered. The subsidiaries are also subject to similar regulatory environments and long-term economic prospects. As such, we have one reportable segment.

Recent Accounting Pronouncements

In May 2008, the Financial Accounting Standards Board ("FASB") issued FASB Staff Position APB 14-1, *Accounting for Convertible Debt Instruments That May Be Settled in Cash upon Conversion (Including Partial Cash Settlement)* (the "FSP"). The FSP requires the proceeds from the issuance of such convertible debt instruments to be allocated between a liability component and an equity component. The resulting debt discount is amortized over the period the convertible debt is expected to be outstanding, as additional non-cash interest expense. The change in accounting treatment is effective for fiscal years beginning after December 15, 2008, and shall be applied

retrospectively to prior periods. The FSP changes the accounting treatment for our $200.0 million 3.75% Convertible Senior Notes due 2014, which were issued in October 2007 (see Note 11, "Long-Term Debt"). The impact of this new accounting treatment will result in an increase to non-cash interest expense beginning in fiscal year 2009 for financial statements covering past and future periods. We have determined that the applicable interest rate will be 7.5%. This rate is principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus a credit spread. Using this interest rate, the incremental impact of the FSP to our results of operations in 2009 will be approximately $3.1 million, or $0.12 per diluted share, net of tax, but does not include the impact of our repurchase of $13 million face amount of the Notes in February 2009. See Note 20, "Subsequent Events." This estimate assumes a 38% combined federal and state statutory tax rate and 27 million diluted shares outstanding. We estimate the retroactive adjustment for prior periods will be approximately $627,000, or $0.02 per diluted share, net of tax, for 2007, and $2.9 million, or $0.11 per diluted share, net of tax, for 2008. For prior periods, the estimates assume a 38% combined federal and state statutory tax rate and actual diluted shares outstanding for those periods.

In December 2007, the FASB issued SFAS 141(R), *Business Combinations* and SFAS 160, *Noncontrolling Interests in Consolidated Financial Statements*. The standards are intended to improve, simplify, and converge internationally the accounting for business combinations and the reporting of noncontrolling (minority) interests in consolidated financial statements. SFAS 141(R) requires the acquiring entity in a business combination to recognize all (and only) the assets acquired and liabilities assumed in the transaction; establishes the acquisition-date fair value as the measurement objective for all assets acquired and liabilities assumed; and requires the acquirer to disclose to investors and other users all of the information they need to evaluate and understand the nature and financial effect of the business combination. SFAS 141(R) is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008, and is applied prospectively to business combinations for which the acquisition date is on or after the effective date. Earlier adoption is prohibited. We will apply SFAS 141(R) to the acquisition of Florida NetPASS, LLC, which we expect to complete by the third quarter of 2009. For more information on this acquisition, see Note 3, "Business Purchase Transactions."

SFAS 160 is designed to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report minority interests in subsidiaries in the same way — as equity in the consolidated financial statements. Moreover, SFAS 160 eliminates the diversity that currently exists in accounting for transactions between an entity and minority interests by requiring they be treated as equity transactions. In addition, SFAS 160 requires that a parent company recognize a gain or loss in net income when a subsidiary is deconsolidated upon a change in control. SFAS 160 is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. Earlier adoption is prohibited. In addition, SFAS 160 shall be applied prospectively as of the beginning of the fiscal year in which it is initially applied, except for the presentation and disclosure requirements. The presentation and disclosure requirements shall be applied retrospectively for all periods presented. As of December 31, 2008, we did not have material outstanding minority interests.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the AICPA, and the SEC did not, or are not believed by management to, have a material impact on our present or future consolidated financial statements.

3. Business Purchase Transactions

Missouri subsidiary. Effective November 1, 2007, we acquired Mercy CarePlus, a licensed Medicaid managed care plan based in St. Louis, Missouri, to expand our market share within our core Medicaid managed care business. The results of operations for Mercy CarePlus are included in the consolidated financial statements from periods following November 1, 2007. The purchase price for the acquisition was $80.0 million, and was funded with available cash and proceeds from our issuance of convertible senior notes in October 2007. The purchase price was subject to the following post-closing adjustments: (1) a reconciliation with respect to incurred but not reported medical costs; (2) a settlement of income taxes; and (3) the payment of an additional $5.0 million to

the sellers if the earnings of the health plan (as defined in the purchase agreement) exceeded $22.0 million for the twelve months ended June 30, 2008. Upon evaluation, we have preliminarily determined that: (1) the sellers owe us approximately $650,000 in connection with the reconciliation of incurred but not reported medical costs; (2) we owe the sellers approximately $400,000 in connection with the settlement of income taxes; and (3) the earnings condition was not met, so we believe that we do not owe the sellers the additional $5.0 million payment. However, the sellers have objected to our first and third determinations as listed above, and the dispute resolution process provided for under the parties' stock purchase agreement has commenced. During the post-acquisition period in 2008, we reduced goodwill relating to the Mercy CarePlus acquisition by approximately $6.2 million, primarily due to the establishment of a deferred tax asset relating to the carryover tax basis in certain identifiable intangibles.

Florida subsidiary. In August 2008, we announced our intention to acquire Florida NetPASS, LLC ("NetPASS"), a provider of care management and administrative services at that time to approximately 55,000 Florida MediPass members in South and Central Florida. We expect the closing of the transaction to occur by the third quarter of 2009, at a purchase price of approximately $42 million, subject to adjustments. On October 1, 2008, we completed the initial closing of the transaction, under which we acquired one percent of the ownership interests of NetPASS for $9.0 million. Additionally, we deposited $9.0 million to an escrow account that will be used for the purpose of reimbursing the state of Florida for any sums due under a final settlement agreement with the state. On October 7, 2008, we announced that our wholly owned subsidiary, Molina Healthcare of Florida, Inc., was awarded a Medicaid managed care contract by the state of Florida. The term of the contract commenced on December 1, 2008, at which time Molina Healthcare of Florida began its initial enrollment of NetPASS Medicaid members, with the full transition of NetPASS members expected to be completed by the third quarter of 2009.

Other. On June 30, 2008, we paid $1 million and issued a total of 48,186 shares of our common stock in connection with our acquisition of the assets of The Game of Work, LLC. The purchase price consideration totaled $2.3 million. The Game of Work, LLC is a company specializing in productivity measurement and improvement and will be used internally to increase operational efficiency.

4. Fair Value Measurements

Effective January 1, 2008, we adopted SFAS 157, *Fair Value Measurements*, for financial assets and liabilities. The statement defines fair value, provides guidance for measuring fair value and requires certain disclosures. SFAS 157 discusses valuation techniques, such as the market approach (comparable market prices), the income approach (present value of future income or cash flow) and the cost approach (cost to replace the service capacity of an asset or replacement cost). The statement establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three broad levels. The following is a brief description of those three levels:

- *Level 1:* Observable inputs such as quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities.
- *Level 2:* Inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets and quoted prices for identical or similar assets or liabilities in markets that are not active.
- *Level 3:* Unobservable inputs that reflect the reporting entity's own assumptions.

As of December 31, 2008, we held certain assets that are required to be measured at fair value on a recurring basis. These included cash and cash equivalents, investments and restricted investments as follows:

Balance Sheet Classification	Description
Current assets:	
Cash and cash equivalents	Cash and highly liquid securities with original or purchase date remaining maturities of up to three months that are readily convertible into known amounts of cash; reported at fair value based on market prices that are readily available (Level 1).
Investments	Investment grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1).
Non-current assets:	
Investments	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
	Auction rate securities; designated as trading; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Other assets	Other assets include auction rate securities rights (the "Rights"); reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Restricted investments	Interest-bearing deposits and U.S. treasury securities required by the respective states in which we operate, or required by contractual arrangement with a third party such as a provider group; designated as held-to-maturity; reported at amortized cost which approximates market value and based on market prices that are readily available (Level 1).

As of December 31, 2008, $70.5 million par value (fair value of $58.2 million) of our investments consisted of auction rate securities, of which all were securities collateralized by student loan portfolios, guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2008. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008. We used pricing models to estimate the fair value of these securities. These pricing models included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would be expected to have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of December 31, 2008.

As of December 31, 2008, we held $42.5 million par value (fair value of $34.9 million) auction rate securities with a certain investment securities firm. In November 2008, we entered into a rights agreement with this firm that (1) allows us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gives the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we receive the par value.

We have accounted for the Rights as a freestanding financial instrument and have elected to record the value of the Rights under the fair value option of SFAS 159, *The Fair Value Option for Financial Assets and Financial Liabilities*. In the fourth quarter of 2008, this resulted in the recognition of a $6.9 million non-current asset, with a corresponding increase to pretax income for the value of the Rights. To determine the fair value estimate of the Rights, we used a discounted cash-flow model that was based on the expectation that the auction rate securities will be put back to the investment securities firm at par on June 30, 2010, as permitted by the Rights Agreement.

Simultaneous to the recognition of the $6.9 million rights agreement, we recorded an other-than-temporary impairment of the underlying auction rate securities, and prior unrealized losses on the auction rate securities that

had been recorded to other comprehensive loss through November 2008 were charged to income, totaling $7.2 million. Also, at the time of the execution of the Rights agreement and pursuant to SFAS 115, we elected to transfer the underlying auction rate securities from available-for-sale to trading securities. For the month of December 2008, we recorded additional losses of $399,000 on these auction rate securities. We expect that the future changes in the fair value of the Rights will be substantially offset by the fair value movements in the underlying auction rate securities.

As of December 31, 2008, the remainder of our auction rate securities, which are still designated as available-for-sale, amounted to $28.0 million par value (fair value of $23.3 million). As a result of the decline in fair value of these auction rate securities, we recorded unrealized losses of $4.7 million ($2.9 million net of tax) to accumulated other comprehensive (loss) income for the year ended December 31, 2008. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive (loss) income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Our assets measured at fair value on a recurring basis subject to the disclosure requirements of SFAS 157 at December 31, 2008, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
		(In thousands)		
Cash and cash equivalents	$387,162	$387,162	$—	$ —
Investments	189,870	189,870	—	—
Auction rate securities (available-for-sale)	23,284	—	—	23,284
Auction rate securities (trading)	34,885	—	—	34,885
Auction rate securities rights	6,907	—	—	6,907
Restricted investments	38,202	38,202	—	—
Total assets measured at fair value	$680,310	$615,234	$—	$65,076

Based on market conditions that resulted in the absence of quoted prices in active markets for our auction rate securities, we changed our valuation methodology for auction rate securities to a discounted cash flow analysis during the first quarter of 2008. Accordingly, since our initial adoption of SFAS 157 on January 1, 2008, these securities changed from Level 1 to Level 3 within SFAS 157's hierarchy. The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in SFAS 157:

	(Level 3)
	(In thousands)
Balance at December 31, 2007	$ —
Transfers to Level 3	82,150
Auction rate securities rights	6,907
Total losses (realized or unrealized):	
Included in earnings	(7,565)
Included in other comprehensive loss	(4,716)
Settlements	(11,700)
Balance at December 31, 2008	$ 65,076
The amount of total losses for the period included in other comprehensive income attributable to the change in unrealized losses relating to assets still held at December 31, 2008	$ (4,716)

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

5. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2008			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Municipal securities (including auction rate securities)	$ 85,973	$ 23	$5,313	$ 80,683
U.S. government agency securities	93,994	1,309	79	95,224
U.S. treasury notes	8,604	295	—	8,899
Certificates of deposit	13,494	—	—	13,494
Corporate bonds	50,315	155	731	49,739
	$252,380	$1,782	$6,123	$248,039

	December 31, 2007			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Municipal securities (including auction rate securities)	$114,123	$ 10	$36	$114,097
U.S. government agency securities	42,727	162	18	42,871
U.S. treasury notes	31,563	510	—	32,073
Certificates of deposit	29,136	—	—	29,136
Corporate bonds	24,556	155	33	24,678
	$242,105	$837	$87	$242,855

The contractual maturities of our investments as of December 31, 2008 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$102,327	$102,293
Due one year through five years	87,071	87,672
Due after five years through ten years	1,230	1,146
Due after ten years	61,752	56,928
	$252,380	$248,039

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $55.3 million, $13.1 million, and $12.6 million for the years ended December 31, 2008, 2007 and 2006, respectively. Net realized investment gains (losses) for the years ended December 31, 2008, 2007 and 2006 were $342,000, $(78,000) and $(151,000) respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at December 31, 2008 and 2007 are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Our investment in municipal securities consists primarily of auction rate securities. As described in Note 4, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we have the ability and intent to hold these investments until a recovery of fair value, which may be maturity, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at December 31, 2008.

For investments presented in the table above, the disclosures required by FASB Staff Position Nos. FAS 115-1 and FAS 124-1, *The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments*, have not been included because our unrealized losses were immaterial at December 31, 2007. The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months and those that have been in a loss position for 12 months or more as of December 31, 2008.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Municipal securities	$41,901	$4,914	$—	$—	$41,901	$4,914
U.S. government agency securities	7,237	79	—	—	7,237	79
Corporate bonds	30,276	731	—	—	30,276	731
	$79,414	$5,724	$—	$—	$79,414	$5,724

6. Receivables

Accounts receivable by health plan operating subsidiary were as follows:

	December 31,	
	2008	2007
	(In thousands)	
California	$ 20,740	$ 23,046
Michigan	6,637	6,419
Missouri	24,024	15,986
New Mexico	5,712	3,887
Ohio	34,562	28,522
Utah	20,614	23,987
Washington	14,184	8,308
Other	2,089	1,382
Total	$128,562	$111,537

Substantially all receivables due our California and Missouri health plans at December 31, 2008 were collected in January 2009.

Ohio. As of December 31, 2008, the receivable due our Ohio health plan included two significant components. The first is approximately $11.8 million of accrued birth income, net, due from the state of Ohio. Birth income is a one-time payment for the delivery of a child from the Medicaid program in Ohio.

The second significant component of the Ohio receivable is approximately $20.6 million due from a capitated provider group. Although we have a capitation arrangement with this provider group, our agreement with them calls for us to pay for certain medical services incurred by the provider group's members, and then to deduct the amount

of such payments from future monthly capitation amounts owed to the provider group. Of the $20.6 million receivable, approximately $14.0 million represents medical services we have paid on behalf of the provider group, which we will deduct from capitation payments in the months of January and February 2009. The other component of the Ohio receivable includes an estimate of our liability for claims incurred by members of this provider group, not covered by capitation, for which we have not yet made payment. This amount totaled $6.6 million as of December 31, 2008. The offsetting liability for the amount of this receivable established for claims incurred but not paid is included in "Medical claims and benefits payable" in our consolidated balance sheets. As part of the agreement with this provider group, our Ohio health plan has withheld approximately $7.7 million from capitation payments due the group, and placed the funds in an escrow account. The Ohio health plan is entitled to the escrow amount if the provider group is unable to repay amounts owed to us for these incurred but not reported claims. The escrow account is included in "Restricted investments" in our consolidated balance sheets. During the quarter ended December 31, 2008, our average monthly capitation payment to this provider group was approximately $12 million.

Utah. Our Utah health plan's agreement with the state of Utah calls for the reimbursement of medical costs incurred in serving our members plus an administrative fee of 9% of that medical cost amount, plus a portion of any cost savings realized as defined in the agreement. Our Utah health plan bills the state of Utah monthly for actual paid health care claims plus administrative fees. Our receivable balance from the state of Utah includes: (1) amounts billed to the state for actual paid health care claims plus administrative fees; and (2) amounts estimated for incurred but not reported claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid. For amounts reimbursed by the state subsequent to December 31, 2008, the administrative fee will be reduced to 8% of the medical cost amount.

7. Property and Equipment

A summary of property and equipment is as follows:

	December 31,	
	2008	2007
	(In thousands)	
Land	$ 3,461	$ 3,000
Building and improvements	25,047	21,928
Furniture, equipment and automobiles	47,074	38,439
Capitalized computer software costs	56,211	34,895
	131,793	98,262
Less: accumulated depreciation and amortization on building and improvements, furniture, equipment and automobiles	(42,056)	(34,071)
Less: accumulated amortization on capitalized computer software costs	(24,679)	(14,636)
	(66,735)	(48,707)
Property and equipment, net	$ 65,058	$ 49,555

Depreciation expense recognized for building and improvements, furniture, equipment and automobiles was $9.0 million, $8.5 million, and $7.7 million for the years ended December 31, 2008, 2007, and 2006, respectively. Amortization expense recognized for capitalized computer software costs was $11.7 million, $8.6 million, and $4.3 million for the years ended December 31, 2008, 2007, and 2006, respectively.

8. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 11.5 years, and for provider network is approximately 9.9 years. Amortization expense on intangible assets recognized for the years ended December 31,

2008, 2007, and 2006 was $13.0 million, $10.8 million, and $9.5 million, respectively. We estimate that our intangible asset amortization expense will be $11.6 million in 2009, $11.6 million in 2010, $10.4 million in 2011, $8.3 million in 2012, and $5.9 million in 2013. The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses	$114,219	$46,160	$68,059
Provider network	14,548	3,474	11,074
Balance at December 31, 2008	$128,767	$49,634	$79,133
Intangible assets:			
Contract rights and licenses	$111,892	$34,775	$77,117
Provider network	14,548	1,889	12,659
Balance at December 31, 2007	$126,440	$36,664	$89,776

The changes in the carrying amount of goodwill and indefinite - lived intangible assets were as follows (in thousands):

Balance as of December 31, 2007	$117,447
Goodwill adjustment related to acquisition of Mercy CarePlus	(6,150)
Goodwill adjustment related to acquisition of Cape Health Plans	2,169
Balance at December 31, 2008	$113,466

9. Restricted Investments

Pursuant to the regulations governing our subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the balances of restricted investments by health plan, and by our insurance company:

	December 31,	
	2008	2007
	(In thousands)	
California	$ 367	$ 524
Florida	9,828	307
Insurance Company	4,718	4,722
Michigan	1,000	1,000
Missouri	506	500
Nevada	787	885
New Mexico	9,670	8,991
Ohio	8,459	9,370
Texas	1,521	1,491
Utah	577	575
Washington	151	154
Other	618	500
Total	$38,202	$29,019

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The increase in restricted investments at our Florida health plan relates primarily to an escrow deposit that will be used for the purpose of reimbursing the state of Florida for any sums due under a final settlement agreement with the state, under our purchase agreement with NetPASS, as discussed in Note 3, "Business Purchase Transactions."

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2008 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$33,485	$33,485
Due one year through five years	4,572	4,572
Due after five years through ten years	145	145
Due after ten years	—	—
	$38,202	$38,202

10. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2008 and 2007. The negative amounts displayed for "*components of medical care costs related to prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The benefit of this prior period development may be offset by the addition of a reserve for adverse claims development when estimating the liability at the end of the period (captured as "*components of medical care costs related to current year*").

	Year Ended December 31,	
	2008	2007
	(Dollars in thousands)	
Balances at beginning of period	$ 311,606	$ 290,048
Medical claims and benefits payable from business acquired	—	14,876
Components of medical care costs related to:		
Current year	2,683,399	2,136,381
Prior years	(62,087)	(56,298)
Total medical care costs	2,621,312	2,080,083
Payments for medical care costs related to:		
Current year	2,413,128	1,851,035
Prior years	227,348	222,366
Total paid	2,640,476	2,073,401
Balances at end of period	$ 292,442	$ 311,606
Benefit from prior period as a percentage of:		
Balance at beginning of period	19.9%	19.4%
Premium revenue	2.0%	2.3%
Total medical care costs	2.4%	2.7%
Days in claims payable	41	52
Number of members at end of period	1,256,000	1,149,000

11. Long-Term Debt

Convertible Senior Notes

In October 2007, we completed our offering of $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2008, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

See Note 20, "Subsequent Events," for a discussion of our repurchase of a portion of the Notes.

As discussed in Note 2, "Significant Account Policies," the FASB issued FSP APB 14-1 in 2008. The impact of this new accounting guidance will result in an increase to non-cash interest expense related to the Notes beginning in fiscal year 2009 for financial statements covering past and future periods.

Credit Facility

In 2005, we entered into the Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2007, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for working capital and general corporate purposes, and subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the amount available under the Credit Facility to up to $250.0 million.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Interest rates on borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest expense, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2008 and 2007, there were no amounts outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of our California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2008, we were in compliance with all financial covenants in the Credit Facility.

12. Income Taxes

The provision for income taxes consisted of the following:

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Current:			
Federal	$32,972	$36,171	$24,987
State	6,916	3,073	3,143
Total current	39,888	39,244	28,130
Deferred:			
Federal	1,886	(3,630)	(471)
State	(281)	(293)	(578)
Total deferred	1,605	(3,923)	(1,049)
Change in valuation allowance	—	45	650
Total provision for income taxes	$41,493	$35,366	$27,731

A reconciliation of the effective income tax rate to the statutory federal income tax rate is as follows:

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Taxes on income at statutory federal tax rate (35%)	$36,362	$32,794	$25,710
State income taxes, net of federal benefit	4,313	1,954	2,097
Other	818	618	(76)
Reported income tax expense	$41,493	$35,366	$27,731

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required

in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California enterprise zone credits.

During 2008, 2007, and 2006, tax-related benefits (deficiencies) on share-based compensation were $(292,000), $853,000 and $1.2 million, respectively. Such amounts were recorded as adjustments to income taxes payable with a corresponding increase (decrease) to additional paid-in capital.

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2008 and 2007 were as follows:

	December 31,	
	2008	2007
	(In thousands)	
Accrued expenses	$ 6,785	$ 6,335
Reserve liabilities	1,046	624
State taxes	172	911
Other accrued medical costs	1,724	863
Prepaid expenses	(3,979)	(2,783)
Net operating losses	27	27
Unrealized losses	(3,194)	(165)
Unearned premiums	2,063	2,806
Other, net	(41)	—
Valuation allowance	—	(2)
Deferred tax asset, net of valuation allowance — current	4,603	8,616
Net operating losses	971	856
State taxes	1,830	840
Depreciation and amortization	(10,698)	(14,453)
Deferred compensation	5,876	3,208
Other accrued medical costs	108	103
Reserve liabilities	1,684	885
Unrealized losses	4,667	—
Other, net	745	(882)
Valuation allowance	(695)	(693)
Deferred tax asset (liability) net of valuation allowance — long term	4,488	(10,136)
Net deferred income tax asset (liability)	$ 9,091	$ (1,520)

At December 31, 2008, we had federal and state net operating loss carryforwards of $422,000 and $10.9 million, respectively. The federal net operating loss begins expiring in 2011, and state net operating losses begin expiring in 2013. The utilization of the net operating losses is subject to certain limitations under federal and state law.

We have determined that as of both December 31, 2008, and December 31, 2007, $695,000 of deferred tax assets did not satisfy the recognition criteria set forth in SFAS 109. Accordingly, a valuation allowance has been recorded for these amounts. This valuation allowance primarily relates to the uncertainty of realizing certain state

net operating loss carryforwards. In the future, if we determine that the realization of the net operating losses is more likely than not, the reversal of the related valuation allowance will reduce the provision for income taxes.

During 2008, $7.4 million of net deferred tax assets were established with a corresponding reduction to goodwill for certain acquired intangible assets in connection with the 2007 purchase of Mercy CarePlus. Additionally during 2008, $2.2 million of deferred tax assets relating to the 2006 purchase of the Cape Health Plan were derecognized which resulted in a corresponding increase to goodwill under purchase accounting.

Accruals for uncertain tax positions are provided for in accordance with the requirements of FIN 48. Pursuant to FIN 48, tax benefits are recognized only if the tax position is "more likely than not" of being sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audit. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows (in thousands):

Gross unrecognized tax benefits at December 31, 2007	$(10,278)
Increases in tax positions for prior years	(3,310)
Decreases in tax positions for prior years	2,682
Increases in tax positions for current year	(2,061)
Decreases in tax positions for current year	892
Settlements	—
Lapse in statute of limitations	399
Gross unrecognized tax benefits at December 31, 2008	$(11,676)

As of December 31, 2008, we had $11.7 million of unrecognized tax benefits of which $5.8 million, if fully recognized, would affect our effective tax rate. We anticipate a decrease of $165,000 to our liability for unrecognized tax benefits within the next twelve-month period due to normal expiration of tax statutes.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2008, and December 31, 2007, we had accrued $1.4 million and $638,000, respectively, for the payment of interest and penalties.

We are under examination, or may be subject to examination, by the Internal Revenue Service ("IRS") for calendar years 2005 through 2008. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Missouri, and Michigan, for the years 2004 through 2008. Our subsidiary, HCLB, is being examined by the IRS for the year ended May 2006. The IRS has issued a notice of proposed adjustment to decrease HCLB's compensation deductions and related tax loss for the year ended May 2006 by approximately $16 million. If sustained, the reduction in the tax loss would increase taxes payable by $5.4 million. Management disagrees with the IRS assessment and believes that adequate accruals have been provided for the HCLB examination.

13. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense

recognized in connection with our contributions to the 401(k) plan totaled $3.9 million, $3.6 million and $2.5 million in the years ended December 31, 2008, 2007, and 2006, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

14. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that provides us with significant influence over operating and financial policies of the investee. As of December 31, 2008 and 2007, our carrying amount for this investment totaled $3.6 million and $3.5 million, respectively. During 2007, we paid this provider a $0.9 million network access fee that was fully amortized as of June 30, 2008. During 2008, we advanced this provider $1.3 million, of which $417,000 remained outstanding as of December 31, 2008. We expect to collect this outstanding advance in the first quarter of 2009. For the years ended December 31, 2008, 2007 and 2006, we paid $15.4 million, $10.9 million, and $7.9 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, our Executive Vice President, Research and Development. Amounts paid under the terms of this fee-for-service agreement were $242,000, $157,000 and $357,000 for the years ended December 31, 2008, 2007 and 2006, respectively. We also have a capitation arrangement with Pacific Hospital, where we pay a fixed monthly fee based on member type. We paid Pacific Hospital for capitation services totaling approximately $3.8 million, $4.8 million and $1.7 million for the years ended December 31, 2008, 2007 and 2006, respectively. We believe that both arrangements with Pacific Hospital are based on prevailing market rates for similar services. Also as of December 31, 2008, we had an advance outstanding to Pacific Hospital totaling $23,000, which will offset capitation payments in 2009.

15. Commitments and Contingencies

Leases

We lease office space, clinics, equipment, and automobiles under agreements that expire at various dates through 2018. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases, including those payments described in Note 14, "Related Party Transactions," consist of the following approximate amounts:

Year ending December 31,	(In thousands)
2009	$ 15,514
2010	15,321
2011	14,883
2012	13,771
2013	11,954
Thereafter	40,867
Total minimum lease payments	$112,310

Rental expense related to these leases totaled $17.5 million, $18.1 million and $12.2 million for the years ended December 31, 2008, 2007, and 2006, respectively.

Employment Agreements

During 2001 and 2002, we entered into employment agreements with three current executives with initial terms of one to three years, subject to automatic one-year extensions thereafter. In most cases, should the executive be terminated without cause or resign for good reason before a Change of Control, as defined, we will pay one year's base salary and Target Bonus, as defined, for the year of termination, in addition to full vesting of 401(k) employer contributions and stock options, and continued health and welfare benefits for the earlier of 18 months or the date the executive receives substantially similar benefits from another employer. If any of the executives are terminated for cause, no further payments are due under the contracts.

In most cases, if termination occurs within two years following a Change of Control, the employee will receive two times their base salary and Target Bonus for the year of termination in addition to full vesting of 401(k) employer contributions and stock options and continued health and welfare benefits for the earlier of three years or the date the executive receives substantially similar benefits from another employer.

Executives who receive severance benefits, whether or not in connection with a Change of Control, will also receive all accrued benefits for prior service including a pro rata Target Bonus for the year of termination.

Legal Proceedings

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Professional Liability Insurance

We carry medical malpractice insurance for health care services rendered through our clinics in California. Claims-made coverage under this policy is $1.0 million per occurrence with an annual aggregate limit of $3.0 million for each of the years ended December 31, 2008, 2007, and 2006. We also carry claims-made managed care errors and omissions professional liability insurance for our HMO operations. This insurance is subject to a coverage limit of $10.0 million per occurrence and $10.0 million in the aggregate for each policy year.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Washington and Utah. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $355.0 million at December 31, 2008, and $332.2 million at December 31, 2007. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Nevada, New Mexico, Ohio, Texas, Washington, and Utah have adopted these rules, which may vary from state to state. California has not yet adopted NAIC risk-based capital requirements for HMOs and has not formally given notice of its intention to do so. Such requirements, if adopted by California, may increase the minimum capital required for that state.

As of December 31, 2008, our health plans had aggregate statutory capital and surplus of approximately $362.5 million compared with the required minimum aggregate statutory capital and surplus of approximately $211.1 million. All of our HMOs were in compliance with the minimum capital requirements at December 31, 2008. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Stock Plans

In 2002, we adopted the 2002 Equity Incentive Plan (the "2002 Plan"), which provides for the award of stock options, restricted stock, performance shares, and stock bonuses to the company's officers, employees, directors, consultants, advisors, and other service providers. The 2002 Plan became effective upon our initial public offering ("IPO") of common stock in July 2003, and allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares eligible for issuance automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. There were 3.6 million shares reserved for issuance under the 2002 Plan as of January 1, 2008.

Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to five years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

In July 2002, we adopted the 2002 Employee Stock Purchase Plan (the "ESPP"), which also became effective upon our IPO in July 2003. During each six-month offering period, eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of the offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. Under the ESPP, we issued 86,400 and 48,000 shares of our common stock during the years ended December 31, 2008 and 2007, respectively. Beginning January 1, 2004, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance is reached, shares available for issuance under the ESPP automatically increase by 1% of total outstanding capital stock. The number of unissued common shares available for future grants under the 2002 Plan and the ESPP was 3.9 million and 3.6 million as of December 31, 2008 and 2007, respectively.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table illustrates the components of our stock-based compensation expense as reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2008		2007		2006	
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
	(In thousands)					
Restricted stock awards	$5,171	$3,206	$3,751	$2,335	$2,257	$1,404
Stock options (including shares issued under our ESPP)	2,640	1,637	3,437	2,139	3,248	2,020
Total	$7,811	$4,843	$7,188	$4,474	$5,505	$3,424

For both restricted stock and stock option awards, the expense is recognized over the vesting period, generally straight-line over four years. As of December 31, 2008, there was $14.2 million of unrecognized compensation cost related to unvested restricted stock awards, which we expect to recognize over a weighted-average period of 2.8 years. Also as of December 31, 2008, there was $1.8 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.6 years.

The total fair value of restricted shares vested during the years ended December 31, 2008, 2007, and 2006 was $2.5 million, $2.6 million, and $2.0 million, respectively. Unvested restricted stock activity for the year ended December 31, 2008 was as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested balance as of December 31, 2007	235,413	$34.14
Granted	392,000	$30.96
Vested	(89,446)	$32.04
Forfeited	(67,012)	$33.75
Unvested balance as of December 31, 2008	470,955	$31.95

The total intrinsic value of stock options exercised during the years ended December 31, 2008, 2007, and 2006 amounted to $69,000, $4.3 million, and $3.8 million, respectively. Stock option activity for the year ended December 31, 2008 was as follows:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value (000s)
Outstanding at December 31, 2007	733,713	$30.45		
Granted	12,000	$33.57		
Exercised	(18,987)	$27.85		
Forfeited	(61,387)	$33.70		
Outstanding at December 31, 2008	665,339	$30.29	6.9	$87
Exercisable and expected to vest at December 31, 2008(a)	638,532	$30.21	6.8	$87
Exercisable at December 31, 2008	427,450	$29.87	6.2	$87

(a) Stock options exercisable and expected to vest at December 31, 2008 information is based on a forfeiture rate of 12.9%.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following is a summary of information about stock options outstanding and exercisable at December 31, 2008:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31, 2008	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable at December 31, 2008	Weighted-Average Exercise Price
$4.50 - $27.49	164,170	5.0	$23.11	161,053	$23.08
$28.66 - $28.66	174,744	7.1	$28.66	113,100	$28.66
$29.17 - $30.85	12,700	7.3	$30.12	7,682	$29.97
$31.32 - $44.29	313,725	7.7	$34.95	145,615	$38.30
	665,339	6.9	$30.29	427,450	$29.87

In the year ended December 31, 2008, a total of 12,000 stock options were granted. The Black-Scholes valuation model was used to estimate the fair value of stock options at grant date based on the assumptions noted in the following table. The risk-free interest rate is based on the implied yield on U.S. treasury zero coupon issues for the expected option term. The expected volatility is based on historical volatility levels of our common stock. Beginning in the first quarter of 2008, we used an expected term for each option award based on historical experience of employee post-vesting exercise and termination behavior. Prior to 2008, the expected option term of each award granted was calculated using the "simplified method" in accordance with Staff Accounting Bulletin No. 107. This change did not produce materially different valuation results for the stock options awarded in 2008. The assumptions disclosed below represent a weighted-average of the assumptions used for all of our stock option grants throughout each of the years presented.

	Year Ended December 31,		
	2008	2007	2006
Risk-free interest rate	2.5%	4.5%	4.5%
Expected volatility	45.3%	47.1%	53.1%
Expected option life (in years)	4	6	6
Expected dividend yield	0%	0%	0%
Grant date weighted-average fair value	$12.80	$16.37	$16.01

17. Stockholders' Equity

As described in Note 16, "Stock Plans," we award shares of restricted stock to employees and others under our equity incentive plan. When these shares vest, employees may choose to settle their associated tax obligation by instructing us to withhold the number of shares that will settle the tax obligation based on the current market value of the stock. When we settle tax obligations associated with the vesting of restricted stock awards in this manner, we retire the stock used. During 2008, we retired 18,464 shares of common stock, totaling $555,000. During 2007, we retired 14,391 shares of common stock, totaling $480,000.

In April 2008, our board of directors authorized the repurchase of up to $30 million of our common stock on the open market or through privately negotiated transactions. We used working capital to fund the repurchases under this program. The timing and amount of repurchases were primarily made pursuant to a Rule 10b5-1 trading plan effective as of May 5, 2008, and terminated when the aggregate cost of the repurchases totaled $30 million on June 12, 2008. During the quarter ended June 30, 2008, we repurchased approximately 1.1 million shares. These shares were subsequently retired in 2008.

In July 2008, our board of directors authorized the repurchase of up to an additional one million shares of our common stock. We used working capital to fund the repurchases under this program. The timing and amount of

repurchases were primarily made pursuant to a Rule 10b5-1 trading plan effective as of August 1, 2008. During the third and fourth quarters of 2008, we repurchased approximately 812,000 shares for an aggregate purchase price of $20 million. These shares were subsequently retired in 2008.

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of securities, including common stock or debt securities, and up to 250,000 shares of our common stock, offered by selling stockholders. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

See Note 20, "Subsequent Events," regarding our share and convertible senior notes repurchase program that began in 2009.

18. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2008 and 2007.

	For The Quarter Ended			
	March 31, 2008	June 30, 2008	September 30, 2008	December 31, 2008
	(In thousands)			
Premium revenue	$729,638	$761,153	$791,554	$808,895
Operating income	24,451	30,258	30,429	27,467
Income before income taxes	22,179	27,951	28,449	25,312
Net income	13,155	16,516	17,186	15,541
Net income per share(1):				
Basic	$ 0.46	$ 0.59	$ 0.63	$ 0.58
Diluted	$ 0.46	$ 0.59	$ 0.62	$ 0.58

	For The Quarter Ended			
	March 31, 2007	June 30, 2007	September 30, 2007	December 31, 2007
	(In thousands)			
Premium revenue	$556,235	$607,127	$628,402	$670,605
Operating income	16,595	22,284	28,815	30,633
Income before income taxes	15,470	21,559	28,285	28,382
Net income	9,592	13,314	17,513	17,911
Net income per share(1):				
Basic	$ 0.34	$ 0.47	$ 0.62	$ 0.63
Diluted	$ 0.34	$ 0.47	$ 0.62	$ 0.63

(1) Potentially dilutive shares issuable pursuant to the Company's 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2008 and 2007.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

19. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2008 and 2007, and our condensed statements of income and condensed statements of cash flows for each of the three years in the period ended December 31, 2008.

Condensed Balance Sheets

	December 31, 2008	December 31, 2007
	(In thousands except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 42,776	$ 36,286
Investments	9,745	61,970
Income tax receivable	3,119	—
Deferred income taxes	1,762	4,072
Due from affiliates	13,247	6,705
Prepaid and other current assets	10,228	9,234
Total current assets	80,877	118,267
Property and equipment, net	53,471	37,448
Goodwill	3,721	1,742
Investments	16,364	—
Investment in subsidiaries	568,224	548,931
Deferred income taxes	4,869	1,583
Advances to related parties and other assets	20,477	19,933
Total assets	$748,003	$727,904
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 24,595	$ 29,222
Long-term debt	200,000	200,000
Other long-term liabilities	12,744	8,204
Total liabilities	237,339	237,426
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized, outstanding 26,725 shares at December 31, 2008 and 28,444 shares at December 31, 2007	27	28
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	146,179	185,808
Accumulated other comprehensive gain (loss), net of tax	(2,310)	272
Retained earnings	387,158	324,760
Treasury stock (1,201 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	510,664	490,478
Total liabilities and stockholders' equity	$748,003	$727,904

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Income

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Revenue:			
Management fees	$190,361	$154,071	$120,036
Other operating revenue	177	186	144
Investment income	2,733	2,915	1,361
Total revenue	193,271	157,172	121,541
Expenses:			
Medical care costs	21,759	22,042	20,764
General and administrative expenses	143,709	114,616	91,347
Depreciation and amortization	18,980	15,101	10,162
Total expenses	184,448	151,759	122,273
Operating income (loss)	8,823	5,413	(732)
Interest expense	(8,651)	(4,485)	(2,239)
Income (loss) before income taxes and equity in net income of subsidiaries	172	928	(2,971)
Income tax expense (benefit)	1,260	2,333	(610)
Net loss before equity in net income of subsidiaries	(1,088)	(1,405)	(2,361)
Equity in net income of subsidiaries	63,486	59,735	48,088
Net income	$ 62,398	$ 58,330	$ 45,727

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Operating activities:			
Cash provided by operating activities	$ 17,532	$ 23,500	$ 24,205
Investing activities:			
Net dividends from and capital contributions to subsidiaries	42,872	(16,890)	(51,260)
Purchases of investments	(25,515)	(74,604)	(20,613)
Sales and maturities of investments	56,833	29,946	29,181
Cash paid in business purchase transactions	(1,000)	(80,045)	—
Purchases of equipment	(33,047)	(20,159)	(17,723)
Changes in amounts due to and due from affiliates	(6,542)	2,887	5,684
Change in other assets and liabilities	3,170	1,192	(2,996)
Net cash provided by (used in) investing activities	36,771	(157,673)	(57,727)
Financing activities:			
Treasury stock purchases	(49,940)	—	—
Borrowings under credit facility	—	—	50,000
Proceeds from issuance of convertible senior notes	—	200,000	—
Repayments of amounts borrowed under credit facility	—	(45,000)	(5,000)
Payment of credit facility fees	—	(551)	(459)
Payment of convertible senior notes fees	—	(6,498)	—
Excess tax benefits from employee stock compensation	43	853	1,227
Proceeds from exercise of stock options and employee stock plan purchases	2,084	4,257	2,416
Net cash (used in) provided by financing activities	(47,813)	153,061	48,184
Net increase in cash and cash equivalents	6,490	18,888	14,662
Cash and cash equivalents at beginning of year	36,286	17,398	2,736
Cash and cash equivalents at end of year	$ 42,776	$ 36,286	$ 17,398

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Notes to Condensed Financial Information of Registrant

Note A — Basis of Presentation

Molina Healthcare, Inc. (Registrant) was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California HMO and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The parent company-only financial statements should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B — Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2008, 2007, and 2006 for these services totaled $190.4 million, $154.1 million, and $120.0 million, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C — Capital Contribution and Dividends

During 2008, 2007, and 2006, the Registrant received dividends from its subsidiaries totaling $91.5 million, $39.0 million, and $22.5 million, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2008, 2007, and 2006, the Registrant made capital contributions to certain subsidiaries totaling $48.6 million, $55.9 million, and $73.8 million, respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D — Related Party Transactions

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because it has an ownership interest in the investee in excess of 20%. As of December 31, 2008 and 2007, the Registrant's carrying amount for this investment totaled $3.6 million and $3.5 million, respectively. During 2007, the Registrant paid this provider a $0.9 million network access fee that was fully amortized as of June 30, 2008. During 2008, the Registrant advanced this provider $1.3 million, of which $417,000 remained outstanding as of December 31, 2008. We expect to collect this outstanding advance in the first quarter of 2009. For the years ended December 31, 2008, 2007, and 2006, the Registrant paid $15.4 million, $10.9 million, and $7.9 million, respectively, for medical service fees to this provider.

The Registrant is a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community

property by the husband of Dr. Martha Bernadett, the Registrant's Executive Vice President, Research and Development. Amounts paid under the terms of this fee-for-service agreement were $242,000, $157,000, and $357,000 for the years ended December 31, 2008, 2007, and 2006, respectively. The Registrant also has a capitation arrangement with Pacific Hospital, where the Registrant pays a fixed monthly fee based on member type. The Registrant paid Pacific Hospital for capitation services totaling approximately $3.8 million, $4.8 million and $1.7 million for the years ended December 31, 2008, 2007, and 2006, respectively. The Registrant believes that both arrangements with Pacific Hospital are based on prevailing market rates for similar services. Also as of December 31, 2008, the Registrant had an advance outstanding to this provider totaling $23,000 which will be offset to capitation payments in 2009.

Note 20. Subsequent Events

In January 2009, the board of directors authorized the repurchase of up to $25 million in aggregate of either our common stock or our 3.75% convertible senior notes due 2014. The repurchase program will be funded with working capital, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through June 30, 2009, but we reserve the right to suspend or discontinue the program at any time.

Under this program, we settled the repurchase of $13.0 million face amount of our convertible senior notes on February 18, 2009 (see Note 11, "Long-Term Debt" for a description of the Notes). We repurchased the notes at an average price of $74.25 per $100 principal amount, for a total of $9.6 million. Including accrued interest of approximately $186,000, our total payment was $9.8 million.

Also under this program, we repurchased approximately 724,000 shares of our common stock for an aggregate purchase price of $13.3 million (average cost of approximately $18.33 per share) during the period beginning February 27, 2009, through March 13, 2009. As of March 13, 2009, we had $1.7 million remaining to spend under this repurchase program. If we were to repurchase shares at an average cost of $20 per share, for example, this would result in the repurchase of approximately 85,000 additional shares.

On March 1, 2009 we awarded 364,700 shares of restricted stock to our officers and employees, primarily in connection with an annual recognition program. These shares will vest in equal annual installments over the four-year period following the date of grant.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting during the three months ended December 31, 2008 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2008. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework.* Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2008, based on those criteria.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on the page immediately following, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2008.

Item 9B. ***Other Information***

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2008, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying management's report on internal control over financial reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2008, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2008 and 2007, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2008 and our report dated March 16, 2008 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2009

PART III

Item 10. ***Directors, Executive Officers, and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2009 Annual Meeting of Stockholders under "Proposal No. 1 — Election of Two Class I Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 4 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers," and will also appear in our Proxy Statement for our 2009 Annual Meeting of Stockholders. Such portion of the Proxy Statement is incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2009 Annual Meeting of Stockholders under "Corporate Governance," "Corporate Governance and Nominating Committee," "Corporate Governance Guidelines," and "Code of Business Conduct and Ethics." These portions of our Proxy Statement are incorporated herein by reference.

***(d) Section 16*(a) Beneficial Ownership Reporting Compliance**

Section 16(a) of the Exchange Act requires our officers and directors, and persons who own more than 10% of a registered class of our equity securities, to file reports of ownership and changes in ownership with the SEC, and to furnish us with copies of the forms. Purchases and sales of our equity securities by such persons are published on our website at www.molinahealthcare.com. Based on our review of the copies of such reports, on our involvement in assisting our reporting persons with such filings, and on written representations from our reporting persons, we believe that, during 2008, each of our officers, directors, and greater than ten percent stockholders complied with all such filing requirements on a timely basis, with the single exception of one Form 4 for our chief information officer, Amir Desai, which due to an oversight we filed on August 18, 2008 with respect to a sale of 645 shares on July 28, 2008.

Item 11. ***Executive Compensation***

The information which will appear in our Proxy Statement for our 2009 Annual Meeting under the captions "Compensation Committee Interlocks," "Non-Employee Director Compensation," and "Compensation Discussion and Analysis," is incorporated herein by reference. The information which will appear in our Proxy Statement under the caption "Compensation Committee Report" is not incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management will appear in our Proxy Statement for our 2009 Annual Meeting of Stockholders under "Information About Stock Ownership." This portion of the Proxy Statement is incorporated herein by reference. The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning certain relationships and related transactions will appear in our Proxy Statement for our 2009 Annual Meeting of Stockholders under "Related Party Transactions." Information concerning director

independence will appear in our Proxy Statement under "Director Independence." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2009 Annual Meeting of Stockholders under "Disclosure of Auditor Fees." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The Company's consolidated financial statements, the notes thereto and the report of the Independent Registered Public Accounting Firm are on pages 60 through 98 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets — At December 31, 2008 and 2007

Consolidated Statements of Operations — Years ended December 31, 2008, 2007, and 2006

Consolidated Statements of Stockholders' Equity — Years ended December 31, 2008, 2007, and 2006

Consolidated Statements of Cash Flows — Years ended December 31, 2008, 2007, and 2006

Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 16th day of March, 2009.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina, M.D. **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	March 16, 2009
/s/ John C. Molina, J.D. **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	March 16, 2009
/s/ Joseph W. White, CPA, MBA **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	March 16, 2009
/s/ Charles Z. Fedak, CPA, MBA **Charles Z. Fedak, CPA, MBA**	Director	March 16, 2009
/s/ Frank E. Murray, M.D. **Frank E. Murray, M.D.**	Director	March 16, 2009
/s/ Steven Orlando, CPA **Steven Orlando, CPA**	Director	March 16, 2009
/s/ Sally K. Richardson **Sally K. Richardson**	Director	March 16, 2009
/s/ Ronna Romney **Ronna Romney**	Director	March 16, 2009
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	March 16, 2009

INDEX TO EXHIBITS

Number	Description	Method of Filing
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.2 to registrant's Form 8-K filed February 17, 2009.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2008.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2008.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2008.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	Form of Stock Option Agreement under 2002 Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.4	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.5	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.6	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.10	Employment Agreement with J. Mario Molina, M.D. dated January 2, 2002	Filed as Exhibit 10.7 to registrant's Form S-1 filed December 30, 2002.
10.11	Amendment to Employment Agreement with J. Mario Molina dated July 1, 2006	Filed as Exhibit 10.2 to registrant's Form 10-Q filed August 8, 2006.
10.12	Employment Agreement with John C. Molina dated January 1, 2002	Filed as Exhibit 10.8 to registrant's Form S-1 filed December 30, 2002.
10.13	Employment Agreement with Mark L. Andrews dated December 1, 2001	Filed as Exhibit 10.9 to registrant's Form S-1 filed December 30, 2002.
10.14	Change in Control Agreement dated June 15, 2006 with Terry Bayer	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2006.
10.15	Change in Control Agreement dated May 29, 2008 with James W. Howatt, M.D.	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 30, 2007.
10.16	Change in Control Agreement dated March 1, 2008 with Joseph White	Filed as Exhibit 10.15 to registrant's Form 10-K filed March 17, 2008.
10.17	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.18	Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare, Inc., as the Borrower, certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed March 10, 2005.

Number	Description	Method of Filing
10.19	First Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of October 5, 2005, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed October 13, 2005.
10.20	Second Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of November 6, 2006, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 10-Q filed November 9, 2006.
10.21	Third Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of May 25, 2008, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 31, 2008.
10.22	Office Lease with Pacific Towers Associates for 200 Oceangate Corporate Headquarters.	Filed as Exhibit 10.34 to registrant's Form 10-K filed March 17, 2008.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.

Molina Healthcare of Arizona

Arizona Health Care Cost Containment System (AHCCCS)
Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled
Solicitation No: YH12-0001

April 1, 2011 **Copy** Binder 2 of 2

MOLINA® HEALTHCARE

Molina Healthcare of Arizona, Inc.

Response to
Arizona Health Care Cost Containment System
(AHCCCS)

Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled

Solicitation No.:
YH12-0001

Copy

April 1, 2011

Binder 2 of 2

MOLINA® HEALTHCARE

Your Extended Family

CONTENTS

Binder 1 of 2

Binder 2 of 2

Attachment 17-2 -
2009 Audited Financial Report

Table of Contents

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2009

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐ Yes ☑ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☐ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☑ (Do not check if a smaller reporting company)	Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☑ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2009, the last business day of our most recently completed second fiscal quarter, was approximately $255 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2009).

As of March 5, 2010, approximately 25,700,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2010 Annual Meeting of Stockholders to be held on May 4, 2010, are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

Table of Contents
Form 10-K

PART I

Item 1: *Business*

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization. Our revenues are derived primarily from premium revenues paid to our health plans by the relevant state Medicaid authority, which revenues are jointly financed by the federal and state governments. Increasingly, we also derive revenues from the federal Centers for Medicare and Medicaid Services, or CMS, in connection with our Medicare services. As of December 31, 2009, approximately 1,455,000 members were enrolled in our health plans.

The payments made to our health plans generally represent an agreed upon amount per member per month, or a "capitation" amount, which is paid regardless of whether the member utilizes any medical services in that month or whether the member utilizes medical services in excess of the capitation amount. Each of our health plans is thus financially "at risk" for the medical care of its members. Each health plan contracts with health care providers in the relevant communities or states in which it operates, including primary care physicians, specialist physicians, physician groups, hospitals, and other medical care providers. These health care providers then provide medical care to the health plan's enrolled members. Various core administrative functions of our health plans — primarily claims processing, information systems, and finance — are centralized at our corporate parent in Long Beach, California. Our California health plan also operates 17 of its own primary care community clinics; we have a Virginia subsidiary which manages three county-owned primary care community clinics in Fairfax County, Virginia; and our Washington health plan recently began operating its own behavioral health clinic.

Dr. C. David Molina founded our Company in 1980 under the name "Molina Medical Centers" as a provider organization serving the Medicaid population in Southern California through a network of primary care clinics. Since then, we have increased our membership through the start-up development of new health plan operations, the acquisition of existing health plans, and internal or organic growth. Key milestones in our history have included the following:

Year	Milestone
1980	Molina Medical Centers founded in Los Angeles, California by Dr. C. David Molina
1985	Obtained HMO license in California
1994	Acquired minority interest in Michigan health plan
1997	Utah health plan established as start-up operation
1999	Incorporated in California as "American Family Care, Inc.," parent of the California and Utah health plan subsidiaries Acquired controlling interest in Michigan and Washington health plans
2000	Company name changed to Molina Healthcare, Inc., a California corporation
2003	Reincorporated in Delaware, and completed initial public offering and listing of shares for trading on the New York Stock Exchange under the symbol, MOH
2004	Acquired the New Mexico health plan
2005	Ohio health plan established as start-up operation
2006	The California, Michigan, Utah, and Washington health plans began operating Medicare Advantage Special Needs plans Acquired the Cape Health Plan in Michigan, merging it into the Michigan health plan Texas health plan established as start-up operation
2007	The California, Michigan, New Mexico, Texas, Utah, and Washington health plans began enrolling members in Medicare Advantage plans with prescription drug coverage, or MA-PD plans Acquired the Missouri health plan

Year	Milestone
2008	The New Mexico and Texas health plans began operating Medicare Advantage Special Needs plans Florida health plan established as a start-up operation
2009	The Ohio health plan began operating a Medicare Advantage Special Needs plan

On January 18, 2010, we entered into a definitive agreement to acquire the Health Information Management, or HIM, business of Unisys Corporation. The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. The acquisition is expected to close in the first half of 2010. We intend to operate the HIM business under the name, *Molina Medicaid Solutions*.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is *www.molinahealthcare.com.*

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to "Molina Healthcare," the "Company," "we," "our," and "us" herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge on our website, *www.molinahealthcare.com*, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, and Corporate Governance and Nominating Committee Charters, are also available on our website. Such information is also available in print upon the request of any stockholder to our Investor Relations Department at the address of our executive offices set forth above. In accordance with New York Stock Exchange, or NYSE, rules, on May 11, 2009, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Our Industry

The Medicaid and CHIP Programs. Established in 1965, the Medicaid program is an entitlement program funded jointly by the federal and state governments and administered by the states. The Medicaid program provides health care benefits to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced "TAN-if"). TANF is the successor to the Aid to Families with Dependent Children program, or AFDC, and most enrolled members are mothers and their children. Another common state-administered Medicaid program is for the aged, blind, or disabled, or ABD Medicaid members, who do not qualify under other Medicaid coverage categories. Although state programs must meet minimum federal standards, states have significant flexibility in determining eligibility thresholds, the amount of covered services, and payment rates for providers.

In addition, the Children's Health Insurance Program, known widely by the acronym CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage, but not enough to afford commercial health insurance. States have the option of administering CHIP through their Medicaid programs.

The federal government pays a portion of the costs that states incur to provide services to Medicaid enrollees. The proportion of states' costs that the federal government pays is based on the "federal medical assistance percentage," or FMAP. The percentage for each state is determined through a formula that assigns a higher federal reimbursement rate to states that have lower income per capita (and vice versa) relative to the national average. Prior to the implementation of the American Recovery and Reinvestment Act of 2009, or ARRA, the average matching rate that the federal government paid was 57 percent nationwide; states contributed the remaining 43 percent. The federal matching rates have both a floor

(50 percent) and a ceiling (83 percent). The matching rates for CHIP are approximately one-third higher than those under Medicaid. Generally, states have more programmatic flexibility in CHIP than in Medicaid.

As part of ARRA, enacted on February 17, 2009, states were scheduled to receive approximately $87 billion in assistance for their Medicaid programs through a temporary increase in the FMAP match rate. The funding is effective from October 1, 2008 to December 31, 2010. Under ARRA, every state has received a minimum FMAP increase of 6.2 percent. The balance of funding is based on unemployment rates in the states. In order to receive this additional FMAP increase, states may not reduce Medicaid eligibility levels below the eligibility levels that were in place on July 1, 2008. Medicaid is classified as an entitlement, and therefore there is no limit on the federal funds that may be expended. Federal payments for Medicaid are limited only by the amount states are willing and able to spend. Nevertheless, budgetary constraints at both the federal and state levels may limit the benefits paid and the number of members served by Medicaid. CHIP, however, is a capped allotment. Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 enacted on February 4, 2009, CHIP was reauthorized and expanded to cover up to a total of 11 million children by 2011. The legislation also provided an additional $32.8 billion in funding over the next four-and-a-half years, and allows states to expand coverage up to 300 percent of the federal poverty level. CHIP will continue to be funded at an enhanced match, with a minimum federal amount of 65 percent.

On March 10, 2010, the United States Senate approved legislation which would allocate $25 billion to the extension by six months of the 6.2% increase in the FMAP provided under ARRA. If this legislation is passed by the House and signed into law by President Obama, the increased FMAP paid to the states will continue through June 30, 2011.

Medicaid Managed Care. Under traditional fee-for-service Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These beneficiaries typically have minimal access to preventive care such as immunizations, and access to primary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, because providers are paid on a fee-for-service basis where additional services rendered result in additional revenues, they lack incentives to monitor utilization and control costs.

In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments for the covered health care services. The health plan, in turn, arranges for the provision of the covered health care services by contracting with a network of providers, including both physicians and hospitals, who agree to provide the covered services to the health plan's members. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore and, in many cases, to mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have mandatory Medicaid managed care programs.

Medicare Advantage Plans. During 2009, each of our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name, Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name, Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operate a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans at December 31, 2009 was approximately 12,000 members. Our 2009 premium revenues from Medicare across all health plans represented approximately 3.7% of our total premium revenues.

Other Government Programs for Low Income Individuals. In certain instances, states have elected to provide medical benefits to individuals and families who do not qualify for Medicaid. Such programs are often administered in a manner similar to Medicaid and CHIP, but without federal matching funds. At December 31, 2009, our Washington health plan served approximately 20,000 such members under one such program, that state's "Basic Health Plan."

Our Approach

We focus on serving financially vulnerable families and individuals who receive health care benefits through government-sponsored programs within a managed care model. These families and individuals generally represent diverse cultures and ethnicities. Many have had limited educational opportunities and do not speak English as their first language. Lack of adequate transportation is common. We believe we are well-positioned to capitalize on the growth opportunities in serving these members. Our approach to managed care is based on the following key attributes:

Experience. For 30 years we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. We have developed and forged strong relationships with the constituents whom we serve — members, providers, and government agencies. Our ability to deliver quality care and to establish and maintain provider networks, as well as our administrative efficiency, has allowed us to compete successfully for government contracts. We have a strong record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The successful integration of our New Mexico and Missouri health plans demonstrated our ability to expand into states in which we had not previously had any presence. The establishment of our health plans in Utah, Ohio, and Texas reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We arrange health care services through contracts with providers that include independent physicians and medical groups, hospitals, ancillary providers and, in California, our own clinics. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates, and diagnostic related groups, or DRGs. Our provider network strategy is to contract with providers that are best-suited, based on expertise, proximity, cultural sensitivity, and experience, to provide services to the members we serve.

Our California health plan operates 17 company-owned primary care clinics in California. In addition, in 2008, our unlicensed subsidiary in Virginia began to manage the Fairfax County Community Health Care Network. This network consists of three county-owned clinics, providing comprehensive medical services to over 16,000 of Fairfax County's uninsured residents. In 2010, our Washington health plan teamed with Compass Health to launch *Molina Medical at Compass Health*, a treatment center focused on integrating primary care and behavioral health services. We believe that our clinics serve a useful role in providing certain communities with access to primary care and providing us with insights into physician practice patterns, first-hand knowledge of the needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. We have 30 years of experience developing targeted health care programs for culturally diverse Medicaid members, and believe we are well-qualified to successfully serve these populations. We contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. We educate employees and providers about the differing needs among

our members. We develop member education materials in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

Medical Management. We believe that our experience as a health care provider has helped us to improve medical outcomes for our members while at the same time enhancing the cost-effectiveness of care. We monitor day-to-day medical management to provide appropriate care to our members, contain costs, and ensure an efficient delivery network. We have developed disease management and health education programs that address the particular health care needs of our members. We have established pharmacy management programs and policies that have allowed us to manage our pharmaceutical costs effectively. For example, our staff pharmacists educate our providers on the use of generic drugs rather than brand drugs.

Our Strategy

Our objective is to be an innovative health care leader while delivering competitive returns for our investors. We seek to provide quality care and accessible services in an efficient and caring manner to Medicaid, CHIP, Medicare, and other financially vulnerable members. To achieve these objectives, we intend to:

Focus on serving financially vulnerable families and individuals. We believe that the Medicaid and low-income Medicare population, which is characterized by significant ethnic diversity, requires unique services to meet its health care needs. Our 30 years of experience in serving this population has provided us significant expertise in meeting the unique needs of our members.

Increase our membership. We have grown our membership through a combination of acquisitions, start-up health plans, serving new populations, and internal or organic growth. Increasing our membership provides the opportunity to grow and diversify our revenues, increase profits, enhance economies of scale, and strengthen our relationships with providers and government agencies. We will continue to seek to grow our membership by expanding within existing markets and entering new strategic markets.

- *Expand within existing markets.* We expect to grow in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, extending our services to new populations, maintaining positive provider relationships, and integrating members from other health plans.
- *Enter new strategic markets.* We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size and, where possible, mandated Medicaid managed care enrollment.

Provide quality cost-effective care. We will use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the quality of care, these programs also facilitate the cost-effective delivery of that care. To document our commitment to quality, each Molina Healthcare health plan has adopted goals: (1) to achieve or continue accreditation by the National Committee for Quality Assurance, or NCQA, and (2) to achieve scores under the Healthcare Effectiveness Data and Information Set, or HEDIS, at the 75th percentile for Medicaid plans. It is our goal to be the health plan of choice, recognized for the quality and accessibility of our services. Financially vulnerable families and individuals covered by government programs have traditionally faced long-standing barriers to accessing care that include language, culture, and literacy. We want to be known for our ability to help others overcome these barriers. Among physicians, hospitals, and other providers, we want to be known for prompt and accurate payment of claims and sound medical decisions.

Leverage operational efficiencies. Our centralized administrative infrastructure, flexible information systems, and dedication to controlling administrative costs provide economies of scale. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and entry into new markets.

Our Health Plans

As of December 31, 2009, our health plans were located in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Additionally, we operate three county primary care clinics in Virginia. As of December 31, 2009, we ceased serving members in Nevada. An overview of our health plans and their principal governmental program contracts with the relevant state authority is provided below:

State	Expiration Date	Contract Description or Covered Program
California	3-31-12	Subcontract with Health Net for services to Medi-Cal members under Health Net's Los Angeles County Two-Plan Model Medi-Cal contract with the California Department of Health Services (DHS).
California	12-31-12	Medi-Cal contract for Sacramento Geographic Managed Care Program with DHS.
California	3-31-11	Two Plan Model Medi-Cal contract for Riverside and San Bernardino Counties (Inland Empire) with DHS.
California	6-30-10	Medi-Cal contract for San Diego Geographic Managed Care Program with DHS.
California	6-30-10	Healthy Families contract (California's CHIP program) with California Managed Risk Medical Insurance Board (MRMIB).
Florida	8-31-12	Medicaid contract with the Florida Agency for Health Care Administration.
Michigan	9-30-10	Medicaid contract with state of Michigan.
Missouri	6-30-10	Medicaid contract with the Missouri Department of Social Services.
New Mexico	6-30-11	Salud! Medicaid Managed Care Program contract (including CHIP) with New Mexico Human Services Department (HSD).
Ohio	6-30-10	Medicaid contract with Ohio Department of Job and Family Services (ODJFS).
Texas	8-31-10	Medicaid contract with Texas Health and Human Services Commission (HHSC).
Utah	6-30-10	Medicaid and CHIP contracts with Utah Department of Health.
Washington	12-31-10	Basic Health Plan and Basic Health Plus Programs contract with Washington State Health Care Authority (HCA).
Washington	6-30-10	Healthy Options Program (including Medicaid and CHIP) contract with state of Washington Department of Social and Health Services.

In addition to the foregoing, our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington have entered into a standardized form of contract with CMS with respect to their operation of a MA SNP, and our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington have also entered into a standardized form of contract with CMS with respect to their operations of a MA-PD plan. These contracts are renewed annually and were most recently renewed as of January 1, 2010.

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. We are usually paid a negotiated per member per month amount, or PMPM, with the PMPM amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also paid an additional amount for each newborn delivery in Michigan, Missouri, New Mexico, Ohio, Texas, and Washington. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. As of December 31, 2009, our California health plan served 351,000 members. Our plan serves the counties of Los Angeles, Riverside, San Bernardino, San Diego, and Sacramento. Our Medi-Cal members in

Los Angeles County are served pursuant to a subcontract we have entered into with Health Net, with Health Net in turn contracting with the state. Our California health plan also operates 17 of its own primary care community clinics.

Florida. As of December 31, 2009, our Florida plan served approximately 50,000 members, and operated in 7 of the state's 67 counties.

Michigan. As of December 31, 2009, our Michigan health plan served 223,000 members, and operated in 46 of the state's 83 counties, including the Detroit metropolitan area.

Missouri. As of December 31, 2009, our Missouri health plan served 78,000 members, and operated in 57 of the state's 114 counties.

New Mexico. As of December 31, 2009, our New Mexico health plan served 94,000 members, and operated in all of New Mexico's 33 counties.

Ohio. As of December 31, 2009, our Ohio health plan served 216,000 members, and operated in 50 of the state's 88 counties.

Texas. As of December 31, 2009, our Texas health plan served 40,000 members, serving STAR and CHIP members in 11 counties and STAR PLUS members in 13 counties. STAR stands for State of Texas Access Reform, and is Texas' Medicaid managed care program. STAR PLUS is the Texas Medicaid managed care program serving ABDs and includes a long-term care component.

Utah. As of December 31, 2009, our Utah health plan served 69,000 members including 4,000 Medicare Advantage SNP members. Our Utah health plan serves Medicaid members in 25 of the state's 29 counties, including the Salt Lake City metropolitan area, and CHIP members in all 29 counties.

Virginia. On July 1, 2008, Molina Healthcare of Virginia, Inc. began to operate the Fairfax County Community Health Care Network. This network consists of three county clinics, and, as of December 31, 2009, provided comprehensive medical services to over 16,000 of the county's uninsured residents.

Washington. As of December 31, 2009, our Washington health plan served 334,000 members, and operated in 34 of the state's 39 counties. In February 2010, our Washington health plan began operating a behavioral health clinic under the name, *Molina Medical at Compass Health*.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

The following table shows the total approximate number of primary care physicians, specialists, and hospitals participating in our network as of December 31, 2009:

	Primary Care Physicians	Specialists	Hospitals
California	3,015	7,320	72
Florida	707	931	60
Michigan	2,491	5,351	71
Missouri	2,001	6,156	96
New Mexico	1,568	6,549	63
Ohio	1,828	11,581	106
Texas	1,369	5,421	61
Utah	1,261	3,936	39
Washington	3,089	6,256	88
Total	17,329	53,501	656

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations, or IPAs. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California health plan operates 17 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a non-licensed subsidiary in Virginia which manages three health care clinics for Fairfax County, and our Washington health plan recently opened a behavioral health clinic.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert

data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*sm is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*sm is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*sm is a diabetes disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/Submit Authorizations.

- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/PCP.
- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (such as those that may be required by the Health Insurance Portability and Accountability Act of 1996, or HIPAA, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the HEDIS and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. At December 31, 2009, all of our eligible health plans were accredited by the NCQA. Our Missouri plan will begin the NCQA review and accreditation process in 2010, and our Florida plan expects to apply for NCQA review as soon as it is eligible.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 3.4 system), with the exception of our Missouri plan which we expect will be migrated to the Molina standard platform in the second quarter of 2010.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- *Medicaid HMOs* — National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- *Prepaid Health Plans* — Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- *Primary Care Case Management Programs* — Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources.

Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules can occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Each of our health plans is required to file quarterly reports on its operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC, and are administered by the states. Our Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington health plans are subject to RBC requirements. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state governments jointly fund it, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states, such as Washington, award contracts to any applicant demonstrating that it meets the state's requirements. Other states, such as California, engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that

we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Once awarded, our contracts generally have terms of one to three years, with renewal options at the discretion of the states. Our contracts generally set forth the requirements for operating in the Medicaid sector, and include provisions relating to: eligibility; enrollment and disenrollment processes; covered services; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education and wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by the insurance department of the jurisdiction that licenses the health plan, and must submit periodic utilization reports and other information to state or county Medicaid authorities. Health plans are not permitted to enroll members directly, and are permitted to market only in accordance with strict guidelines. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by CMS. Medicare beneficiaries have the option to enroll in a Medicare Advantage plan. Under Medicare Advantage, managed care plans contract with CMS to provide benefits that are comparable to original Medicare in exchange for a fixed PMPM that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, made numerous changes to the Medicare program, including expanding the Medicare program to include a prescription drug benefit. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan. Plans are not required to offer the same benefits, but are required to provide coverage that is at least actuarially equivalent to the standard drug coverage delineated in the MMA.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, or MIPPA, became law and, in September 2008, CMS promulgated implementing regulations. MIPPA impacts a broad range of Medicare activities and impacts all types of Medicare managed care plans. MIPPA and subsequent CMS guidance place

prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. MIPPA also establishes certain restrictions on agent and broker compensation.

HIPAA. In 1996, Congress enacted HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- Afford privacy to patient health information, and
- Protect the privacy of patient health information through physical and electronic security measures.

ARRA further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state attorneys general to bring enforcement actions and increasing penalties for violations.

Fraud and Abuse Laws. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2009, we had approximately 2,800 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Item X: Executive Officers of the Registrant

J. Mario Molina, M.D., 51, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 45, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 30 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Mark L. Andrews, Esq., 52, has served as Chief Legal Officer and General Counsel since 1998. He also has served as a member of the Executive Committee of our company since 1998. Before joining our company, Mr. Andrews was a partner at Wilke, Fleury, Hoffelt, Gould & Birney of Sacramento, California, where he chaired that firm's health care and employment law departments and represented Molina as outside counsel from 1994 through 1997. Mr. Andrews holds a Juris Doctorate degree from Hastings College of the Law.

Terry P. Bayer, 59, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has 26 years of health care management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional

responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University.

James W. Howatt, 63, has served as our Chief Medical Officer since May 2008. Dr. Howatt formerly served as the chief medical officer of Molina Healthcare of Washington. Prior to joining Molina Healthcare in February 2006, Dr. Howatt was Western Regional Medical Director for Humana, where he was responsible for the coordination and oversight of quality, utilization management, credentialing, and accreditation for Humana's activities west of Kansas City. Previously, he was Vice President and CMO of Humana Arizona, where he was responsible for leading a variety of medical management functions and worked closely with the company's sales division to develop customer-focused benefit structures. Dr. Howatt also served as CMO for Humana TRICARE, where he oversaw a $2.5 billion health care operation that served three million beneficiaries and comprised a professional network of 40,000 providers, 800 institutions, and 13 medical directors. Dr. Howatt received B.S. and M.D. degrees from the University of California, San Francisco, and also holds a Master of Business Administration degree with an emphasis in Health Management from the University of Phoenix. He interned and completed his residency program in family practice at Ventura County Hospital in Ventura, California. Dr. Howatt is a board-certified family physician and a member of the American College of Managed Care Medicine.

Item 1A: ***Risk Factors***

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This annual report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. We cannot guarantee that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to our Health Plan Business

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts or changes in member eligibility thresholds or criteria which could compress our profit margins.

With the exception of the relatively small portion of our revenues which come from Medicare, nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs are continuing to increase at the same time that state budgets are suffering from unprecedented deficits. In June 2009, 46.9 million members were enrolled in the Medicaid program throughout the nation, nearly 3.3 million more than in June 2008, representing the largest one-year increase since the inception of the Medicaid program. Because governmental health care programs account for such a large portion of state budgets, efforts to contain overall government spending and to achieve a balanced budget often result in significant political pressure being directed at the funding for these health care programs. The National Association of State Medicaid Directors estimates that state budget shortfalls in the coming fiscal year, which begins in July in most states, will total $140 billion. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it will likely be a prime target for cost-containment efforts. Thus, the sufficiency of the funding under our various state contracts, or the rates we expect to be paid during the course of a year, will be in jeopardy during 2010 while the state budget crises persist. All of the states in which we currently operate our health plans are currently facing significant budgetary pressures. Moreover, because Medicaid enrollment often lags behind unemployment, increases in Medicaid enrollment in 2010 could be even greater than it was in 2009, putting even greater pressure on state budgets.

As part of the American Recovery and Reinvestment Act of 2009, or ARRA, the federal government increased the amount of funding for federal Medicaid matching by approximately $87 billion for the period between October 1, 2008 and December 31, 2010. The actual matching percentage is computed from a formula that takes into account the average per capita income for each state relative to the national average, and a state's unemployment rate. As a result of the passage of this legislation, the share of Medicaid costs that are paid for by the federal government has gone up, and the share of costs that are paid for by the states has gone down. However, in order for states to receive these increased federal matching funds, they must first budget for and actually spend their own state dollars to cover their additional Medicaid and CHIP members. Medicaid spending will therefore be driven by states' available revenues. State governments may have insufficient funds to fully fund these programs or provide for expanded enrollment. As a result, states may seek to cut or revise health care programs, optional benefits, eligibility criteria and thresholds, or provider rates, causing the funding of one or more of our state contracts to be curtailed or cut off. In addition, the timing of payments we receive may be impacted by state budget shortfalls. In addition, the $87 billion in increased Medicaid funding provided by ARRA will expire as of December 31, 2010, in the middle of many states' fiscal years. On March 10, 2010, the United States Senate approved legislation which would allocate $25 billion to the extension by six months of the 6.2% increase in the FMAP provided under ARRA. If this legislation is passed by the House and signed into law by President Obama, the increased FMAP paid to the states will continue through June 30, 2011. Unless increased Medicaid funding similar to that provided under ARRA is renewed, the impending loss of this federal funding may cause states to curtail their health care programs or to slash membership in the middle of their fiscal year. Such an action could result in the abrupt loss of a significant number of our enrollees.

Because of their budget deficits, some of the states in which we operate may unexpectedly reduce the rates paid to our health plans or carve out certain elements of their Medicaid benefits, thereby undermining the assumptions used to generate our earnings projections. For instance, effective October 1, 2009, the state of Missouri carved out pharmacy from its Medicaid benefit package, and effective February 1, 2010 the state of Ohio did likewise with its pharmacy benefit. The provision of this benefit by our Missouri and Ohio health plans, respectively, had previously been a significant source of earnings for those health plans. Many states have moved to cut optional benefits in the face of budgetary pressures. There is a risk that cutting such benefits may drive Medicaid patients into expensive emergency rooms, further exacerbating the cost of the Medicaid program to a state. Any unexpected rate cuts or changes in benefit packages could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio for 2009 of 86.8% had been one percentage point higher, or 87.8%, our earnings for 2009 would have been $0.18 per diluted share rather than our actual 2009 earnings of $1.19 per diluted share, an 85% reduction in our earnings.

Factors that may affect our medical care costs include the level of utilization of health care services, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, unexpected patterns in the annual flu season, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. This was demonstrated in the third and fourth quarters of 2009, when our medical costs exceeded our previous estimates as a result of much higher utilization due to widespread influenza-related illness across the Company's health plans, higher medical costs associated with our rapid enrollment growth and the higher costs associated with new members, and higher emergency room costs. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our business may be negatively affected by the enactment of health care or health insurance reforms.

In response to escalating health care costs and the large and growing number of uninsured Americans, legislative proposals that would reform the health care system have been advanced by Congress and state legislatures and are currently pending at the federal and state levels. These proposals include policy changes that could fundamentally change the dynamics of the health care industry, such as having the federal government assume a larger role in the health care industry, or effecting a fundamental restructuring of the Medicare or Medicaid programs. These proposals may also affect certain aspects of our business, including our enrollment levels, our required payment of excise or premium taxes, our contracting with providers, provider reimbursement methods and payment rates, coverage determinations, mandated benefits, minimum medical expenditures, claims payment and processing, drug utilization and patient safety efforts, collection, use, disclosure, maintenance, and disposal of individually identifiable health information or personal health records. One proposal for partially financing the cost of health care reform is to assess an excise tax on the revenues of health plans based on their market share. If adopted as proposed, such an excise tax would have a significant impact on our profitability.

We cannot predict if any of these initiatives will ultimately become law, or, if enacted, what their terms or the regulations promulgated pursuant to such laws will be. But their enactment could increase our costs, expose us to expanded liability, and require us to revise the ways in which we conduct business or put us at risk for loss of business. In addition, our operating results could be adversely affected by such changes even if we correctly predict their occurrence.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves

for such "incurred but not paid," or IBNP medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to Medicare Advantage or ABD Medicaid members, is impacted by the more limited experience we have had with those populations. Finally, with regard to the new Medicaid and CHIP members we expect to enroll in 2010 through organic growth due primarily to the recession, new members may be disproportionately costly due to high utilization in their first several months of Medicaid or CHIP membership as a result of their previously having been uninsured and therefore not seeking or deferring medical treatment.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

If our government contracts are not renewed or are terminated, or if the responsive bids of our health plans for new Medicaid contracts are not successful, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts generally run for periods of one year to four years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. There is no guarantee that any of our government contracts will be renewed or extended. Moreover, our contracts may be subject to periodic competitive bidding. In the event the responsive bids of our health plans are not successful, we will lose our Medicaid contract in the applicable state, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, they may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or had previously been the case.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. In addition, most contracts are terminable without cause. We may face increased competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the contracting process. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions or reduce our liquidity and capital resources.

To provide liquidity, we have a $200 million senior secured credit facility that matures in May 2012. As of December 31, 2009, we had no outstanding indebtedness under our credit facility. Our credit facility imposes numerous restrictions and covenants, including prescribed consolidated leverage and fixed charge coverage ratios,

net worth requirements, and acquisition limitations that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends without lender approval. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to act with complete flexibility, or our inability to use our credit facility in the manner intended. If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, we may be unable to use the credit facility in the manner intended, and our operations, liquidity, and capital resources could be materially adversely affected.

Adverse equity and credit market conditions may have a material adverse affect on our liquidity or our ability to obtain financing on acceptable terms.

The securities and credit markets have been experiencing significant volatility and disruption over the past eighteen months. The availability of credit from virtually all types of lenders has been significantly affected. Such conditions may persist throughout 2010. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, fund net worth requirements, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant.

Our access to additional financing will depend on a variety of factors such as prevailing economic and equity and credit market conditions, the general availability of credit, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case we may not be able to successfully obtain additional financing on favorable terms or at all.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from nine state health plans. If we were unable to continue to operate in any of those nine states, or if our current operations in any portion of the states we are in were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

Portions of our premium revenue are subject to accounting estimates or retroactive adjustment.

Certain elements of the premium revenue earned by our Florida, New Mexico, Ohio, Texas, and Utah health plans, and by our Medicare Advantage plans, are subject to accounting estimates. Such estimates may subsequently prove to be inaccurate or may require adjustment based upon factual developments. If our accounting estimates with respect to our anticipated premiums are inaccurate or previously recognized premiums require retroactive adjustment, the change in our revenues could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Minimum medical cost floors could limit our profitability.

Our New Mexico health plan is subject to a minimum medical expense level as a percentage of the premium revenue it receives. Our Florida health plan is subject to minimum behavioral health expense levels as a percentage of its behavioral health premium revenues. In both states, premium revenue recoupment may occur if these levels are not met. In addition, our Ohio health plan is subject to certain limits on its administrative costs, and our Texas health plan is required to pay an experience rebate to the state of Texas in the event its profits exceed certain established levels. Other states may adopt similar medical cost floors. For instance, a proposal has been made in the

state of Washington to establish a minimum medical cost floor of 86% of premiums received. These regulatory requirements or new requirements could limit our ability to increase or maintain our overall profits as a percentage of revenues. Moreover, state governments may disagree with our interpretation or application of the contract provisions governing these medical cost floor requirements, which could result in our having to adjust the amount of our obligations under these provisions. Any changes to the terms of these provisions, or the adoption of new or similar provisions, could adversely affect our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we were unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also create increased net worth requirements. In such circumstances we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have an adverse impact on our business, financial condition, cash flows, or results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets — particularly operators of large commercial health plans — have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already

operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or comply with these regulatory requirements in a timely manner, if at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

In order to close on the acquisition of the HIM business, the parties must first obtain regulatory approvals from each of the states of West Virginia, Louisiana, New Jersey, Idaho, Maine, and Florida, as well as various consents to assignment of contract by various vendors. In addition, the parties must also satisfy numerous other conditions to closing. There can be no assurances that the parties will be successful in obtaining the necessary state approvals or contract assignments. In the event the parties are unable to satisfy all of the closing conditions, the Company may be unable to close on its acquisition of the HIM business.

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In fiscal year 2006, we had total premium revenue of $2.0 billion. In fiscal year 2009, we had total premium revenue of $3.7 billion, an increase of 84% over a four-year span. Continued rapid growth could place a significant strain on our management and on other Company resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems, could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the country. If a major earthquake were to strike the Los Angeles and Long Beach area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

If we are unable to maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to assure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial position, cash flows, or results of operations.

The insolvency of a delegated provider could obligate us to pay their referral claims which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which the Company does not participate. These actions and the resulting negative publicity could become associated with or imputed to the Company, regardless of the Company's actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which the Company does participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. Providers at the 17 primary care clinics we operate in California are employees of our California health plan. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our California plan is subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of its employees. We maintain medical malpractice insurance for our clinics in the amount of $1 million per occurrence, and an annual aggregate limit of $3 million, errors and omissions insurance in the amount of $15 million per occurrence and in aggregate for each policy year, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, cash flows, or results of operations, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and

other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2009, 2008, and 2007 without approval of the regulatory authorities were approximately $9.0 million, $7.6 million, and $18.7 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our credit facility and/or our senior convertible notes.

Unforeseen changes in regulations or pharmaceutical market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $16.12 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

- state and federal budget pressures,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- changes in government payment levels,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy, including our acquisition of the HIM business of Unisys Corporation,
- the operating and stock price performance of other comparable companies in the health care industry,
- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change, and
- general economic conditions, including unemployment rates, inflation, and interest rates.

Our stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our stock does not continue to develop, securities analysts may not maintain or initiate research coverage of our Company and our shares, and this could depress the market for our shares.

Members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate own or are entitled to receive upon certain events approximately 57% of our capital stock. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of our Company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

It may be difficult for a third party to acquire our Company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In

addition, any change in control of our state health plans would require the approvals of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our Company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

We do not anticipate paying any cash dividends in the foreseeable future.

We have not declared or paid any dividends since our initial public offering in July 2003. While we have in the past and may again use our available cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles ("GAAP") and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, the adoption of new pronouncements or the application of existing pronouncements to our business could significantly affect our results of operations.

Our investments in auction rate securities are subject to risks that may cause losses and have a material adverse effect on our liquidity.

As of December 31, 2009, our investments in auction rate securities included amounts designated as available-for-sale securities totaling $26.9 million par value (fair value of $23.0 million). As a result of the changes in fair value of auction rate securities designated as available-for-sale, we recorded unrealized gains of $0.8 million ($0.5 million, net of tax) to accumulated other comprehensive income for the year ended December 31, 2009, and we recorded unrealized losses of $7.6 million ($4.7 million, net of tax) to other comprehensive loss for the year ended December 31, 2008. We deem the cumulative unrealized losses on these securities to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost. However, if we were to sell these investments before recovery of their cost, we would be required to record a charge to earnings for any accumulated losses, which would impact our earnings for the quarter in which such event occurred.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated primarily as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full

cost can be recovered. Trading securities are carried at fair value and any realized gains or losses are included as a component of earnings. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may further deteriorate or provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines or losses related to our trading securities to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments or trading security losses may result in realized losses in future periods which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Another flu epidemic in 2010 or other kind of epidemic in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results during 2009 were significantly impacted by the widespread incidence of the H1N1 flu in the states in which we operate our health plans. The recurrence in 2010 of the H1N1 flu, another variant of the flu, or the outbreak and rapid spread of any other highly contagious and potentially virulent disease, could increase the utilization rates among our members, resulting in significantly increased outpatient, inpatient, emergency room, and pharmacy costs.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process, and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax

law changes. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations, or the accounting reversal of any tax benefits or revenue previously recognized by the Company, could have an adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel which could negatively impact our operations.

Risks Related to the Operation of the Health Information Management Business

The following risk factors are contingent upon the successful closing of our acquisition of the HIM business of Unisys Corporation, which is expected to close in the first half of 2010. We intend to operate the HIM business under the name, Molina Medicaid Solutions.

We have not previously operated a health information management business.

Our Company and senior management personnel have not previously operated a health information management business such as the HIM business, and there may be various aspects of the business with which we are unfamiliar. Although we expect most of the existing HIM business personnel to join our Company to continue to operate the HIM business, our lack of familiarity with the day-to-day operational issues of the HIM business, as well as our lack of experience in responding to requests for proposal to secure new HIM or MMIS business, may negatively impact the growth, future prospects, and the overall profitability of the HIM business.

We may have difficulty integrating the HIM business and its operations.

In connection with the acquisition of the HIM business, we are hiring approximately 900 new employees. These employees were not previously familiar with our operations or our corporate culture. In addition, to operate the HIM business, we will be required to develop new internal controls, accounting policies, accounting infrastructure, regulatory schemes, compliance requirements, and disclosure controls. Our inability to effectively integrate the new HIM business could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We may be unable to retain or renew the state government contracts of the HIM business on terms consistent with our expectations or at all.

The HIM business currently has management contracts in only six states. If, after the closing, we were unable to continue to operate in any of those six states, or if the HIM business' current operations in any of those six states were significantly curtailed, the revenues and cash flows of the HIM business could decrease materially, and as a result our profitability would be negatively impacted.

If we have underestimated the operating cost and capital outlay projections for the HIM business, our profitability could be adversely affected.

In negotiating the purchase price for the HIM business, we estimated the operating costs and capital outlays required to operate the business as a Molina entity. In the event we have underestimated the costs associated with the HIM business, the profitability of that business may be significantly less than expected.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of the HIM business, there are substantial risks associated with full performance under the contracts.

The state contracts of the HIM business typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or unanticipated delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our overall business, financial conditions, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business may be adversely affected.

The contracts of the HIM business with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments and the imposition of fines, and suspension from future government contracting. Further, any negative publicity related to the HIM business' state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have an adverse effect on our business, financial conditions, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results or damage our reputation.

Experienced computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

The HIM business routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to

time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

Item 1B: ***Unresolved Staff Comments***

There are no unresolved comments from the staff of the Securities and Exchange Commission which were received more than 180 days before the end of our 2009 fiscal year.

Item 2: ***Properties***

We lease a total of 51 facilities, including our corporate headquarters at 200 Oceangate in Long Beach, California. We own a 32,000 square-foot office building in Long Beach, California, our 26,000 square-foot data center in Albuquerque, New Mexico, and one of the community clinics in Pomona, California. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3: ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 4: ***Reserved***

PART II

Item 5: ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2009		
First Quarter	$22.74	$16.22
Second Quarter	$25.75	$18.11
Third Quarter	$25.05	$19.36
Fourth Quarter	$23.49	$17.05
2008		
First Quarter	$44.94	$23.46
Second Quarter	$30.50	$22.68
Third Quarter	$42.61	$24.08
Fourth Quarter	$32.45	$16.12

As of March 5, 2010, there were 116 holders of record of our common stock. We did not declare or pay any dividends in 2009, 2008, or 2007. While we have in the past and may again in the future use our cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Moreover, our ability to pay dividends to stockholders is dependent on cash dividends being paid to us by our subsidiaries. Laws of the states in which we operate or may operate our health plans, as well as requirements of the government sponsored health programs in which we participate, limit the ability of our health plan subsidiaries to pay dividends to us. In addition, the terms of our credit facility limit our ability to pay dividends.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2009)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	650,739(1)	$30.25	3,801,382(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and Incentive Plan have been suspended.

(2) Includes only shares remaining available to issue under the 2002 Equity Incentive Plan (the "2002 Incentive Plan") and the 2002 Employee Stock Purchase Plan (the "ESPP"). The 2002 Incentive Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares available for issuance under the 2002 Incentive Plan automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. The 400,000 share increase on January 1, 2010 increased the total number of shares reserved for issuance under the 2002 Incentive Plan to 4,400,000 shares. The ESPP initially allowed for the issuance of 600,000 shares of common stock. Beginning December 31, 2003, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares reserved for issuance under the ESPP automatically increased by 1% of total outstanding capital stock.

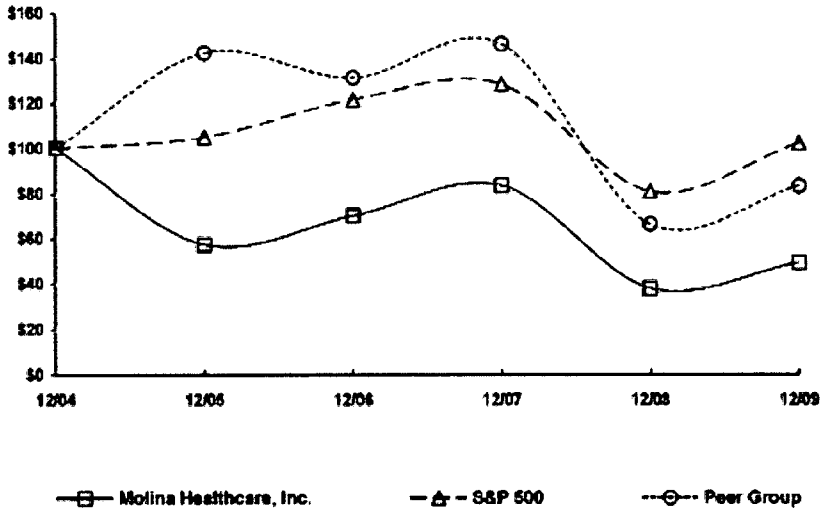
STOCK PERFORMANCE GRAPH

The following discussion shall not be deemed to be "soliciting material" or to be "filed" with the SEC nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500") and a peer group index for the five-year period from December 31, 2004 to December 31, 2009. The graph assumes an initial investment of $100 in Molina Healthcare, Inc. common stock and in each of the indices.

The peer group index consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN*
Among Molina Healthcare, Inc, The S&P 500 Index
And A Peer Group



* $100 invested on 12/31/04 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.

Item 6. *Selected Financial Data*

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics") for the five years ended December 31, 2009 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data. The data under the caption "Operating Statistics" has not been audited.

	Year Ended December 31,				
	2009	2008(1)	2007(1)(2)	2006(3)	2005
Statements of Income Data:					
Revenue:					
Premium revenue	$ 3,660,207	$ 3,091,240	$ 2,462,369	$ 1,985,109	$ 1,639,884
Investment income	9,149	21,126	30,085	19,886	10,174
Total revenue	3,669,356	3,112,366	2,492,454	2,004,995	1,650,058
Expenses:					
Medical care costs	3,176,236	2,621,312	2,080,083	1,678,652	1,424,872
General and administrative expenses	399,149	344,761	285,295	229,057	163,342
Loss contract charge	—	—	—	—	939
Impairment charge on purchased software(4)	—	—	782	—	—
Depreciation and amortization	38,110	33,688	27,967	21,475	15,125
Total expenses	3,613,495	2,999,761	2,394,127	1,929,184	1,604,278
Gain on purchase of convertible senior notes	1,532	—	—	—	—
Operating income	57,393	112,605	98,327	75,811	45,780
Interest expense	(13,777)	(13,231)	(5,605)	(2,353)	(1,929)
Income before income taxes	43,616	99,374	92,722	73,458	43,851
Provision for income taxes	12,748	39,776	34,996	27,731	16,255
Net income	$ 30,868	$ 59,598	$ 57,726	$ 45,727	$ 27,596
Net income per share:					
Basic	$ 1.19	$ 2.15	$ 2.04	$ 1.64	$ 1.00
Diluted	$ 1.19	$ 2.15	$ 2.03	$ 1.62	$ 0.98
Weighted average number of common shares outstanding	25,843,000	27,676,000	28,275,000	27,966,000	27,711,000
Weighted average number of common shares and potential dilutive common shares outstanding	25,984,000	27,772,000	28,419,000	28,164,000	28,023,000
Operating Statistics:					
Medical care ratio(5)	86.8%	84.8%	84.5%	84.6%	86.9%
General and administrative expense ratio (6)	10.9%	11.1%	11.5%	11.4%	9.9%
General and administrative expense ratio, excluding premium taxes	7.5%	8.0%	8.2%	8.4%	7.1%
Members(7)	1,455,000	1,256,000	1,149,000	1,077,000	893,000

	As of December 31,				
	2009	2008(1)	2007(1),(2)	2006(3)	2005
Balance Sheet Data:					
Cash and cash equivalents	$ 469,501	$ 387,162	$ 459,064	$403,650	$249,203
Total assets	1,245,235	1,148,068	1,170,016	864,475	659,927
Long-term debt (including current maturities)	158,900	164,873	160,166	45,000	—
Total liabilities	702,497	616,306	655,640	444,309	297,077
Stockholders' equity	542,738	531,762	514,376	420,166	362,850

(1) The consolidated balance sheet and operating results have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options*. The cumulative adjustments to reduce retained earnings were $3.4 million as of January 1, 2009, and $604,000 as of January 1, 2008. Additionally, interest expense increased $4.5 million for the year ended December 31, 2008, and $1.0 million for the year ended December 31, 2007.

(2) The balance sheet and operating results of the Mercy CarePlus acquisition, relating to our Missouri health plan, have been included since November 1, 2007, the effective date of the acquisition.

(3) The balance sheet and operating results of the Cape Health Plan acquisition, relating to our Michigan health plan, have been included since May 15, 2006, the effective date of the acquisition.

(4) Amount represents an impairment charge related to commercial software no longer used for operations.

(5) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See *Management's Discussion and Analysis of Financial Condition and Results of Operations* for further discussion.

(6) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(7) Number of members at end of period.

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Adoption of Convertible Debt Accounting

Our 2008 and 2007 consolidated financial statements have been recast to reflect the adoption of FASB Accounting Standards Codification (ASC) 470-20, *Debt with Conversion and Other Options*. This resulted in additional interest expense of $4.5 million ($0.10 per diluted share) for the year ended December 31, 2008, and $1.0 million ($0.02 per diluted share) for the year ended December 31, 2007.

Overview

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Effective December 31, 2009, we terminated operations at our small Medicare health plan in Nevada. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On January 18, 2010, we entered into a definitive agreement to acquire the Health Information Management, or HIM, business of Unisys Corporation. The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS, a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. The acquisition is expected to close in the first half of 2010. We intend to operate the HIM business under the name, *Molina Medicaid Solutions.*

Our financial performance for 2009, 2008, and 2007 is briefly summarized below (dollars in thousands, except per-share data):

	Year Ended December 31,		
	2009	2008	2007
Earnings per diluted share	$ 1.19	$ 2.15	$ 2.03
Premium revenue	$3,660,207	$3,091,240	$2,462,369
Operating income	$ 57,393	$ 112,605	$ 98,327
Net income	$ 30,868	$ 59,598	$ 57,726
Medical care ratio	86.8%	84.8%	84.5%
G&A expenses as a percentage of total revenue	10.9%	11.1%	11.5%
Total ending membership	1,455,000	1,256,000	1,149,000

Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2009, we received approximately 92% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for CHIP members of the are generally among our lowest, with rates as low as

approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to over $240 in Ohio. Among our Medicaid ABD membership, PMPM premiums range from approximately $320 in Utah to over $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare premiums are almost $1,200 PMPM, with Medicare revenue totaling $135.9 million, $95.1 million, and $49.3 million, for the years ended December 31, 2009, 2008, and 2007, respectively.

For the year ended December 31, 2009, we received approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in California (effective October 1, 2009), Michigan, Missouri, Ohio, Texas, Utah (effective September 1, 2009), and Washington. Such payments are recognized as revenue in the month the birth occurs. Approximately 2.5% of our premium revenue for the year ended December 31, 2009 was realized under a Medicaid cost-plus reimbursement agreement with the state of Utah that ended effective August 31, 2009. Effective September 1, 2009, the Utah health plan's contract with the state of Utah became a prepaid capitation contract, under which the plan is now paid a fixed PMPM amount, as in the other states in which we operate.

Certain components of premium revenue are subject to accounting estimates. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health.* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At December 31, 2009, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2009, we had not recorded any liability under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. Through December 31, 2009, our New Mexico health plan had received $3.6 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $2.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $1.4 million for the remainder.

- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009, our Ohio health plan had received $8.8 million in at-risk revenue for state fiscal year 2009

and the first half of state fiscal year 2010 combined. We have recognized $7.5 million of that amount as revenue through December 31, 2009 and recorded a liability of approximately $1.3 million for the remainder.

- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at December 31, 2009 and 2008.

- *Texas Health Plan Premium Revenue:* The contract entered into between our Texas health plan and the state of Texas includes a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of December 31, 2009, we had an aggregate liability of approximately $2.0 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2009 and 2010 contract years (ending August 31 of each year). During 2009, we paid the state of Texas $4.9 million relating to the 2008 and 2009 contract years, and the 2008 contract year is now closed. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009, our Texas health plan had received $1.7 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $1.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $0.5 million for the remainder.

- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue. Based upon our knowledge of member health care utilization patterns we have recorded a liability of approximately $0.6 million related to the potential recoupment of Medicare premium revenue at December 31, 2009.

Historically, membership growth has been the primary reason for our increasing annual premium revenues, although more recently our revenues have also grown due to the more care-intensive benefits and related higher premiums associated with our ABD and Medicare members. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2009	2008	2007
Total Ending Membership by Health Plan:			
California	351,000	322,000	296,000
Florida(1)	50,000	—	—
Michigan	223,000	206,000	209,000
Missouri	78,000	77,000	68,000
New Mexico	94,000	84,000	73,000
Ohio	216,000	176,000	136,000
Texas	40,000	31,000	29,000
Utah	69,000	61,000	55,000
Washington	334,000	299,000	283,000
Total	1,455,000	1,256,000	1,149,000
Total Ending Membership by State for our Medicare Advantage Special Needs Plans:			
California	2,100	1,500	1,100
Michigan	3,300	1,700	1,100
New Mexico	400	300	—
Texas	500	400	—
Utah	4,000	2,400	1,900
Washington	1,300	1,000	500
Total	11,600	7,300	4,600
Total Ending Membership by State for our Aged, Blind or Disabled ("ABD") Population:			
California	13,900	12,700	11,800
Florida(1)	8,800	—	—
Michigan	32,200	30,300	31,400
New Mexico	5,700	6,300	6,800
Ohio	22,600	19,000	14,900
Texas	17,600	16,200	16,000
Utah	7,500	7,300	6,800
Washington	3,200	3,000	2,800
Total	111,500	94,800	90,500

(1) The Florida health plan began enrolling members in December 2008.

The following table provides details of member months (defined as the aggregation of each month's membership for the period) by state for the years ended December 31, 2009, 2008, and 2007:

	2009	2008	2007
Total Member Months by Health Plan:			
California	4,135,000	3,721,000	3,500,000
Florida(1)	386,000	—	—
Michigan	2,523,000	2,526,000	2,597,000
Missouri	927,000	910,000	136,000
New Mexico	1,042,000	970,000	803,000
Ohio	2,411,000	1,998,000	1,567,000
Texas	402,000	348,000	335,000
Utah	793,000	659,000	593,000
Washington	3,847,000	3,514,000	3,419,000
Total	16,466,000	14,646,000	12,950,000

(1) The Florida health plan began enrolling members in December 2008.

Expenses

Our operating expenses include expenses related to the provision of medical care services and general and administrative, or G&A, expenses. Our results of operations are impacted by our ability to effectively manage expenses related to health care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with the providers. We pay hospitals on a fee-for-service basis in a variety of ways, including by per diem amounts, by diagnostic-related groups, or DRGs, as a percentage of billed charges, and by case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract; under certain circumstances, we pay escalated charges in connection with these stop-loss agreements. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance costs, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a

substantial portion of these expenses. For the years ended December 31, 2009, 2008 and 2007, medically related administrative costs were approximately $74.6 million, $75.9 million and $65.4 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,								
	2009			2008			2007		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$2,077,489	$126.14	65.4%	$1,709,806	$116.69	65.2%	$1,343,911	$103.77	64.6%
Capitation	558,538	33.91	17.6	450,440	30.74	17.2	375,206	28.97	18.0
Pharmacy	414,785	25.18	13.1	356,184	24.31	13.6	270,363	20.88	13.0
Other	125,424	7.62	3.9	104,882	7.16	4.0	90,603	7.00	4.4
Total	$3,176,236	$192.85	100.0%	$2,621,312	$178.90	100.0%	$2,080,083	$160.62	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities. The following table provides the details of our medical claims and benefits payable as of the dates indicated (in thousands):

	December 31,	
	2009	2008
Fee-for-service claims incurred but not paid (IBNP)	$246,508	$236,492
Capitation payable	39,995	28,111
Pharmacy	20,609	18,837
Other	9,404	9,002
Total	$316,516	$292,442

G&A expenses largely consist of wage and benefit costs for our employees, premium taxes, and other administrative expenses. Some G&A services are provided locally, while others are delivered to our health plans from a centralized location. The primary centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally provided functions include member services, plan administration, and provider relations. G&A expenses include premium taxes for each of our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, and Washington.

Results of Operations

The following table sets forth selected consolidated operating ratios. All ratios, with the exception of the medical care ratio, are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium revenue earned and the cost of health care.

	Year Ended December 31,		
	2009	2008	2007
Premium revenue	99.8%	99.3%	98.8%
Investment income	0.2	0.7	1.2
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	86.8%	84.8%	84.5%
General and administrative expense ratio, excluding premium taxes	7.5%	8.0%	8.2%
Premium taxes included in general and administrative expenses	3.4	3.1	3.3
Total general and administrative expense ratio	10.9%	11.1%	11.5%
Depreciation and amortization expense ratio	1.0%	1.1%	1.1%
Effective tax rate	29.2%	40.0%	37.7%
Operating income	1.6%	3.6%	3.9%
Net income	0.8%	1.9%	2.3%

Year Ended December 31, 2009 Compared with the Year Ended December 31, 2008

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2009					
	Premium Revenue		Medical Care Costs		Medical	Premium Tax
	Total	PMPM	Total	PMPM	Care Ratio	Expense
California	$ 481,717	$116.49	$ 443,892	$107.34	92.2%	$ 16,446
Florida(1)	102,232	264.94	95,936	248.62	93.8	16
Michigan	557,421	220.94	454,431	180.12	81.5	31,023
Missouri	230,222	248.25	191,585	206.59	83.2	—
New Mexico(2)	404,026	387.67	346,044	332.03	85.7	11,043
Ohio	803,521	333.33	691,402	286.82	86.1	47,849
Texas	134,860	335.69	110,794	275.78	82.2	2,513
Utah	207,297	261.43	190,319	240.02	91.8	—
Washington	726,137	188.77	613,876	159.58	84.5	14,175
Other(3),(4)	12,774	—	37,957	—	—	57
	$3,660,207	$222.24	$3,176,236	$192.85	86.8%	$ 123,122

	Year Ended December 31, 2008					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 417,027	$112.06	$ 363,776	$ 97.75	87.2%	$ 12,503
Florida(1)	—	—	—	—	—	—
Michigan	509,782	201.86	405,683	160.64	79.6	26,710
Missouri	225,280	247.62	184,298	202.58	81.8	—
New Mexico(2)	348,576	359.45	286,004	294.92	82.1	11,713
Ohio	602,826	301.76	549,182	274.91	91.1	30,505
Texas	110,178	316.32	84,324	242.09	76.5	1,995
Utah	155,991	236.75	139,011	210.98	89.1	—
Washington	709,943	202.02	575,085	163.64	81.0	11,668
Other(3),(4)	11,637	—	33,949	—	—	21
	$3,091,240	$210.97	$2,621,312	$178.90	84.8%	$ 95,115

(1) The Florida health plan began enrolling members in December 2008.

(2) The medical care ratio of the New Mexico health plan was 85.7% for the year ended December 31, 2009, up from 82.1% for the same period in 2008. During 2008, the New Mexico health plan had recognized $12.9 million of premium revenue due to the reversal of amounts previously recorded as payable to the state of New Mexico. Absent this revenue adjustment, the New Mexico health plan's medical care ratio would have been 85.2% for the year ended December 31, 2008.

(3) As of December 31, 2009, our Nevada health plan no longer served members. Premium revenue and medical care costs for the Nevada health plan have been included in "Other."

(4) "Other" medical care costs also include medically related administrative costs at the parent company.

Note: Estimates of utilization and unit costs may not match changes in reported costs due to the impact of shifts in case mix between the periods presented, prior period development, the existence of pass-through contracts in which third parties assume medical risk, and other factors. Additionally, estimates of utilization for the year ended December 31, 2009, exclude the month of December 2009 due to the substantial incompleteness of claims payment data for that month.

Operating results for the year ended December 31, 2009, were most significantly impacted by the following:

- Higher utilization due to widespread influenza-related illness across the Company's health plans.
- Margin compression related to state budget shortfalls.
- Enrollment growth and the higher costs associated with new members.
- Higher emergency room costs.

Net Income

For the year ended December 31, 2009, net income decreased to $30.9 million, or $1.19 per diluted share, from $59.6 million, or $2.15 per diluted share, for the year ended December 31, 2008.

Premium Revenue

Premium revenue grew approximately 18% in the year ended December 31, 2009 compared with the same period in 2008. During 2009, membership grew 16% overall, with Florida, California, Washington, and Ohio gaining the most members. Consolidated premium revenue increased 5.3% on a PMPM basis. Increased membership contributed 71% of the growth in premium revenue, and increases in PMPM revenue, as a result of both rate changes and shifts in member mix, contributed the remaining 29%.

We received PMPM premium reductions in 2009 that were in many cases correlated with reductions in the Medicaid fee schedule that also reduced our medical costs. However, PMPM premium reductions in Washington and Missouri in 2009 were not fully commensurate with changes in the Medicaid fee schedule in those states, and

thus decreases in premiums were not matched by lower medical costs. In Washington, premium reductions not linked to decreases in the Medicaid fee schedule lowered our medical margin by approximately $13 million in 2009. In Missouri, the retention of the pharmacy benefit by the state effective October 1, 2009 reduced our medical margin by approximately $1.2 million in 2009.

Investment income

Investment income for 2009 decreased $12.0 million to $9.1 million, from $21.1 million earned in 2008. This decline was due to lower interest rates in 2009.

Medical care costs

Medical care costs, in the aggregate, increased 8% on a PMPM basis for the year ended December 31, 2009 compared with the same period in 2008. The medical care ratio was 86.8% for the year ended December 31, 2009, compared with 84.8% for the same period in 2008. Increased expenses were generally the result of higher utilization rather than higher unit costs (except in the case of outpatient costs, where both utilization and unit costs increased) and were most pronounced in connection with physician and outpatient emergency room facility services. Influenza-related illnesses and the costs associated with more recently enrolled members were key factors in the higher utilization. We estimate that the incremental costs associated with influenza-related illnesses were approximately $35 million, or $0.83 per diluted share, in the year ended December 31, 2009 compared with the year ended December 31, 2008.

Physician and outpatient costs exhibited the most significant unfavorable cost trend in the year ended December 31, 2009. Together, these costs increased approximately 13% on a PMPM basis compared with the same period in 2008. Consistent with our experience throughout 2009, emergency room utilization (up approximately 9%) and cost per visit (up approximately 8%) were the primary drivers of increased cost in the year ended December 31, 2009.

Hospitals have billed us for more intensive levels of care than in the same period in 2008 for outpatient emergency room facility services. The billing codes for emergency room level of care — with Level 1 reflecting the least intensive care and Level 5 reflecting the most intensive care — changed significantly in the year ended December 31, 2009, compared with the same period in 2008. Level 1 and Level 2 visits decreased by 9% and 6%, respectively, while Level 3, Level 4, and Level 5 visits increased by 20%, 18%, and 20%, respectively.

Inpatient costs were flat on a PMPM basis year-over-year despite increased utilization.

Pharmacy costs (including the benefit of rebates) increased 6% on a PMPM basis year-over-year, excluding the Missouri health plan, where the pharmacy benefit was retained by the state of Missouri effective October 1, 2009. Pharmacy utilization increased approximately 6% year-over-year, while unit costs (excluding rebates) were flat.

Capitated costs increased approximately 10% PMPM year-over-year, primarily as a result of rate increases received for members capitated on a percentage of premium basis at the New Mexico health plan, and the transition of members into capitated arrangements in California.

General and administrative expenses

General and administrative expenses were $399.1 million, or 10.9% of total revenue, for 2009 compared with $344.8 million, or 11.1% of total revenue, for 2008. Included in G&A expenses were premium taxes totaling $123.1 million in 2009 and $95.1 million in 2008. Premium taxes increased in 2009 due to increased revenues in the states where premium taxes are assessed.

Core G&A expenses, which we define as G&A expenses less premium taxes, were 7.5% of revenue in the year ended December 31, 2009, compared with 8.0% in the same period in 2008. Year-over-year, premium revenue grew faster than administrative costs, causing administrative costs, as a percentage of revenue, to decrease. On a PMPM basis, core G&A decreased to $16.76 for the year ended December 31, 2009, from $17.04 for the same period in 2008.

	Year Ended December 31,			
	2009		2008	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 18,857	0.5%	$ 18,451	0.6%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	205,396	5.6	190,932	6.1
Florida health plan start up expenses	—	—	2,495	0.1
All other administrative expense	51,774	1.4	37,768	1.2
Core G&A expenses	$276,027	7.5%	$249,646	8.0%

Depreciation and Amortization

Depreciation and amortization expense increased $4.4 million for the year ended December 31, 2009 compared with 2008, primarily due to depreciation expense associated with investments in infrastructure. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2009	2008
Depreciation expense	$25,172	$20,718
Amortization expense on intangible assets	12,938	12,970
Total depreciation and amortization expense	$38,110	$33,688

Interest Expense

Interest expense for 2009 and 2008 includes non-cash interest expense relating to our convertible senior notes, as a result of the adoption of ASC Subtopic 470-20. The amounts recorded for this non-cash interest expense totaled $4.8 million for the year ended December 31, 2009, and $4.7 million for the same period in 2008.

Income Taxes

Income taxes were recorded at an effective rate of 29.2% for the year ended December 31, 2009 compared with 40.0% for the same period in 2008. The decrease in the effective tax rate was primarily due to discrete tax benefits recognized during the year relating to settling tax examinations, and higher than previously estimated California enterprise zone tax credits.

Year Ended December 31, 2008 Compared with the Year Ended December 31, 2007

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2008					
	Premium Revenue		Medical Care Costs		Medical	Premium Tax
	Total	PMPM	Total	PMPM	Care Ratio	Expense
California	$ 417,027	$ 112.06	$ 363,776	$ 97.75	87.2%	$ 12,503
Michigan	509,782	201.86	405,683	160.64	79.6	26,710
Missouri	225,280	247.62	184,298	202.58	81.8	—
Nevada	8,037	1,106.45	9,099	1,252.61	113.2	—
New Mexico	348,576	359.45	286,004	294.92	82.1	11,713
Ohio	602,826	301.76	549,182	274.91	91.1	30,505
Texas	110,178	316.32	84,324	242.09	76.5	1,995
Utah	155,991	236.75	139,011	210.98	89.1	—
Washington	709,943	202.02	575,085	163.64	81.0	11,668
Other	3,600	—	24,850	—	—	21
	$3,091,240	$ 210.97	$2,621,312	$ 178.90	84.8%	$ 95,115

	Year Ended December 31, 2007					
	Premium Revenue		Medical Care Costs		Medical	Premium Tax
	Total	PMPM	Total	PMPM	Care Ratio	Expense
California	$ 378,934	$ 108.29	$ 310,226	$ 88.66	81.9%	$ 11,338
Michigan	487,032	187.55	409,230	157.59	84.0	28,493
Missouri	30,730	226.65	26,396	194.69	85.9	—
Nevada	2,438	1,440.73	2,069	1,222.76	84.9	—
New Mexico	268,115	333.94	221,567	275.97	82.6	9,088
Ohio	436,238	278.39	394,451	251.72	90.4	19,631
Texas	88,453	263.90	68,173	203.40	77.1	1,598
Utah	116,907	197.19	109,895	185.36	94.0	—
Washington	652,970	190.96	519,763	152.00	79.6	10,844
Other	552	—	18,313	—	—	28
	$2,462,369	$ 190.13	$2,080,083	$ 160.62	84.5%	$ 81,020

Net Income

For the year ended December 31, 2008, net income increased to $59.6 million, or $2.15 per diluted share, from $57.7 million, or $2.03 per diluted share, for the year ended December 31, 2007.

Premium Revenue

Premium revenue for the year ended December 31, 2008 was $3,091.2 million, an increase of $628.8 million, or 26%, over the $2,462.4 million of premium revenue for the year ended December 31, 2007. Medicare premium revenue for 2008 was $95.1 million, compared with $49.3 million for 2007.

Investment income

Investment income for 2008 decreased $9.0 million to $21.1 million, from $30.1 million earned in 2007. This 30% decline was due to declining interest rates in 2008.

Medical care costs

Medical care costs as a percentage of premium revenue, or the medical care ratio, increased to 84.8% in 2008 from 84.5% in 2007. Excluding Medicare, our medical care ratio was 84.8% in 2008, compared with 84.7% in 2007.

- The medical care ratio of the California health plan was 87.2% for 2008, up from 81.9% in 2007. The increase in the plan's medical care ratio was caused primarily by increased fee-for-service and pharmacy costs that proportionally exceeded the increased revenue from premium rate increases.
- The medical care ratio of the Michigan health plan was 79.6% for 2008, down from 84.0% in 2007. This decrease was caused primarily by premium rate increases that proportionally exceeded the plan's increased medical costs.
- The medical care ratio of the Missouri health plan was 81.8% for 2008, down from 85.9% in 2007. Premium increases were proportionally greater than PMPM medical costs due to revised provider contracts and a fee schedule increase effective July 1, 2008.
- The medical care ratio of the New Mexico health plan was 82.1% in 2008, down from 82.6% in 2007. Between July 1, 2008 and December 31, 2008, the New Mexico health plan received a blended rate decrease of approximately 3% under the plan's Medicaid Salud! contract and two separate contracts serving membership under the state's coverage initiative for the uninsured. The impact of this blended rate decrease was exceeded by the reversal of a $12.9 million accrual established as of December 31, 2007, pursuant to a minimum medical care ratio contract provision. In 2007, the New Mexico health plan had recorded a charge of $6.0 million related to this contract provision. Absent the impact of the minimum medical care ratio contract provision, the New Mexico health plan's MCR would have been 85.2% in 2008, compared with 80.8% in 2007, due to higher fee-for-service and capitation costs and lower PMPM premium revenue.
- The medical care ratio of the Ohio health plan increased to 91.1% in the 2008 from 90.4% in the 2007, primarily due to higher pharmacy cost as a percentage of premium revenue. The medical care ratio of the Ohio health plan, by line of business, was as follows:

	Year Ended December 31,	
	2008	2007
Covered Families and Children (CFC)	89.7%	88.6%
Aged, Blind or Disabled (ABD)	93.7	94.7
Aggregate	91.1%	90.4%

- The medical care ratio of the Texas health plan was 76.5% in 2008, down from 77.1% in 2007. Increased premiums more than offset higher medical costs.
- The medical care ratio of the Utah health plan was 89.1% in 2008, down from 94.0% in 2007. In 2007, the Utah health plan had recorded a $4.2 million reduction of revenue as a result of a reconciliation of amounts due the state of Utah under a savings sharing arrangement. Absent the savings sharing adjustment, the medical care ratio in 2007 would have been 90.7%.
- The medical care ratio of the Washington health plan was 81.0% in 2008, up from 79.6% in 2007, primarily due to higher fee-for-service specialist and hospital costs.

General and administrative expenses

General and administrative expenses were $344.8 million, or 11.1% of total revenue, for 2008, compared with $285.3 million, or 11.5% of total revenue, for 2007. Included in G&A expenses were premium taxes totaling $95.1 million in 2008 and $81.0 million in 2007. Premium taxes increased in 2008 due to increased revenues in the states where premium taxes are assessed.

Core G&A expenses were 8.0% of revenue in 2008, compared with 8.2% in 2007. The decrease in core G&A compared with 2007 was primarily due to lower administrative payroll as a percentage of revenue, as indicated in the table below.

	Year Ended December 31,			
	2008		2007	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 18,451	0.6%	$ 9,778	0.4%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	190,932	6.1	163,420	6.6
Florida health plan start up expenses	2,495	0.1	—	—
All other administrative expense	37,768	1.2	31,077	1.2
Core G&A expenses	$249,646	8.0%	$204,275	8.2%

Depreciation and Amortization

Depreciation and amortization expense increased $5.7 million for the year ended December 31, 2008 compared to 2007, primarily due to depreciation expense associated with investments in infrastructure. Of the total increase, amortization expense contributed $2.1 million, primarily due to the Mercy CarePlus acquisition in Missouri in 2007. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2008	2007
Depreciation expense	$20,718	$17,118
Amortization expense on intangible assets	12,970	10,849
Total depreciation and amortization expense	$33,688	$27,967

Impairment Charge on Purchased Software

During the second quarter of 2007, we recorded an impairment charge of $782,000, related to purchased software no longer used for operations. No such charge was recorded in 2008.

Interest Expense

Interest expense increased to $13.2 million in 2008 from $5.6 million in 2007 primarily due to the issuance of our convertible senior notes in the fourth quarter of 2007. Interest expense for 2008 and 2007 includes non-cash interest expense relating to the convertible senior notes, as a result of the adoption of ASC Subtopic 470-20. The amounts recorded for this non-cash interest expense totaled $4.7 million and $1.0 million for the years ended December 31, 2008, and 2007, respectively.

Income Taxes

Income taxes were recorded at an effective rate of 40.0% for the year ended December 31, 2008, compared with 37.7% in the prior year. The increase in our effective tax rate was primarily the result of an increase in Michigan state taxes attributable to tax law changes that took effect on January 1, 2008. The increase in Michigan taxes was partially offset by prior years' tax benefits recorded during 2008 relating to California enterprise zone credits. Absent the enterprise zone credit tax benefits, our effective tax rate for the year ended December 31, 2008 would have been approximately 41%.

Acquisitions

HIM Business of Unisys. On January 19, 2010, we entered into a definitive agreement to acquire the Health Information Management business of Unisys Corporation. The purchase price is expected to be approximately $135 million, subject to a standard working capital adjustment, to be paid in cash at closing using our credit facility. The acquisition, which is expected to close in the first half of 2010, is subject to customary regulatory approvals and closing conditions, including receipt of customer consents.

The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. Annual revenues of the HIM business are currently approximately $110 million. We expect the approximately 900 employees of the HIM business to become our employees upon closing of the transaction, and following the closing Unisys has agreed to provide us certain transitional and technology support services for up to one year.

Florida Health Plan. On December 31, 2009 (the acquisition date), we acquired 100% of the voting equity interests in Florida NetPASS, LLC, or NetPASS. This acquisition included the purchase of the NetPASS limited liability company and its membership interests. We initially announced our intention to purchase NetPASS in August 2008. NetPASS was a provider of care management and administrative services at that time to approximately 58,000 Florida MediPass members in South and Central Florida (Florida MediPASS is the state of Florida's Medicaid program).

Our wholly owned subsidiary, Molina Healthcare of Florida, Inc., was awarded a Medicaid managed care contract by the state of Florida in October 2008. Subsequently, NetPASS members have been notified of our intention to acquire NetPASS and, beginning in December 2008, offered membership with our Florida health plan on a county-by-county basis. Once transitioned, these members become full-risk members of the Florida health plan. The Florida health plan receives fixed PMPM payments from the state of Florida for the care of these members, and the Florida health plan is at risk for the cost of the members' medical care.

As of December 31, 2009, we have transitioned approximately 48,000 NetPASS members to our Florida health plan, and have recorded $28.7 million of goodwill and intangible assets relating to these members. Of this amount, we have paid the sellers $23.4 million, with the balance accrued to accounts payable and accrued liabilities. The $5.3 million current liability includes a 10% indemnification hold back totaling $2.9 million, as provided in the purchase agreement, and a $2.4 million payable to the sellers for membership transitioned to date as of December 31, 2009. Because the final membership reconciliation will take place early in the second quarter of 2010, the provisional measurements of goodwill and intangible assets are subject to change.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of ten years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be four years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2009, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. The average annualized portfolio yields for the years ended December 31, 2009, 2008, and 2007 were approximately 1.2%, 3.0%, and 5.2%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the year ended December 31, 2009, was $155 million compared with $40 million for 2008, an increase of $115 million.

Significant components of cash provided by operating activities during 2009 included the following items:

- Net income, which decreased $29 million between 2008 and 2009.
- Deferred revenue, which contributed $114 million to the increase in cash provided by operating activities between 2008 and 2009. Deferred revenue increased substantially at the Ohio health plan between the years ended 2008 and 2009.
- Medical claims and benefits payable, which contributed $43 million to the increase in cash provided by operating activities between 2008 and 2009.

Cash used in investing activities was $37.7 million for the year ended December 31, 2009, compared with $64.5 million for 2008.

Cash used in financing activities totaled $35.3 million for the year ended December 31, 2009, compared with $47.8 million for 2008. The primary use of cash in both 2009 and 2008 was under our securities purchase programs, where we purchased $27.7 million and $49.9 million of our common stock in 2009, and 2008, respectively. In 2009, we additionally purchased, as described further below, convertible senior notes totaling $9.7 million ($9.8 million with accrued interest).

EBITDA(1)

	Year Ended December 31,	
	2009	2008
	(In thousands)	
Operating income	$57,393	$112,605
Add back:		
Depreciation and amortization expense	38,110	33,688
EBITDA	$95,503	$146,293

(1) We calculate EBITDA by adding back depreciation and amortization expense to operating income. Operating income included interest income of $8.0 million and $21.1 million for the years ended December 31, 2009, and 2008, respectively. EBITDA is not prepared in conformity with GAAP since it excludes depreciation and amortization expense, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to net income, operating income, operating margin, or cash provided by operating activities. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Securities Purchase Program. Under the $25 million securities purchase program announced in January 2009, we purchased and retired $13.0 million face amount of our convertible senior notes during the first quarter of 2009. We purchased the notes at an average price of $74.25 per $100 principal amount, for a total of $9.8 million, including accrued interest. The gain recognized during the quarter on the purchase of the notes was $1.5 million, or approximately $0.04 per diluted share. Also during the first quarter of 2009, we purchased approximately 808,000 shares of our common stock for $15 million (average cost of approximately $18.53 per share).

In March 2009, our board of directors authorized the purchase of up to an additional $25 million in aggregate of either our common stock or our convertible senior notes. The purchase program was funded with working capital.

Under the purchase program, we purchased approximately 544,000 shares of common stock for $12.7 million (average cost of approximately $23.41 per share) in the second quarter of 2009. We did not purchase any shares in the third or fourth quarters of 2009. This purchase program terminated December 31, 2009.

Capital Resources

At December 31, 2009, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $45.6 million, including $16.5 million in non-current auction rate securities, compared with $68.9 million of cash and investments at December 31, 2008. On a consolidated basis, at December 31, 2009, we had working capital of $321.2 million compared with $345.2 million at December 31, 2008. At December 31, 2009 and December 31, 2008, cash and cash equivalents were $469.5 million and $387.2 million, respectively. At December 31, 2009, investments were $234.5 million, including $59.7 million in non-current auction rate securities, and at December 31, 2008, investments were $248.0 million, including $58.2 million in non-current auction rate securities.

We intend to use a draw on our credit facility, which currently has no outstanding balance, to fund all or a substantial portion of the $135 million purchase price of the HIM business. Subject to the following discussion regarding our Credit Facility and its use to acquire the HIM business of Unisys Corporation, we believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

In 2005, we entered into an Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2008, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for general corporate purposes.

Pending the closing of the acquisition of the HIM business as discussed below, interest rates on borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest expense, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2009, there were no borrowings outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2009, we were in compliance with all financial covenants in the Credit Facility.

Subject to the closing of the HIM acquisition as described above under the heading, "Acquisitions," in November 2009 we agreed to enter into a fourth amendment to the Credit Facility. The fourth amendment will become effective upon the closing of the acquisition of the HIM business. The fourth amendment is required because the $135 million purchase price for the HIM business exceeds the currently applicable deal size threshold under the terms of the Credit Facility. Pursuant to the fourth amendment, the lenders have consented to our acquisition of the HIM business.

Upon its effectiveness at the closing, the fourth amendment would increase the commitment fee on the total unused commitments of the lenders under the facility to 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR

loans and base rate loans would be raised by 200 basis points at every level of the pricing grid. The applicable margins would thus range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. Until the delivery of a compliance certificate with respect to our financial statements for the quarter ending after the HIM business acquisition closes, the applicable margin shall be fixed at 3.5% for LIBOR loans and 2.5% for base rate loans. In connection with the lenders' approval of the fourth amendment, a consent fee of 10 basis points was paid on the amount of each consenting lender's commitment. In addition, the fourth amendment would carve out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the Notes (although the $187.0 million indebtedness would still be included in the calculation of our consolidated leverage ratio); increase the amount of surety bond obligations we may incur; increase our allowable capital expenditures; and reduce the fixed charge coverage ratio from 3.50x to 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

On March 15, 2010, we agreed to enter into a fifth amendment to the Credit Facility. The fifth amendment will also become effective upon the closing of the acquisition of the HIM business. The fifth amendment is required because, after giving effect to the acquisition of the HIM business on a pro forma basis, and inclusive of the Company's fourth quarter 2009 EBITDA of only $5.9 million, the Company's consolidated leverage ratio for the preceding four fiscal quarters would exceed the currently applicable ratio of 2.75 to 1.0. The fifth amendment will increase the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if the Company has actually reduced its consolidated leverage ratio to no more than 2.75 to 1.0 on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we will pay an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the SEC covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Long-Term Debt

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, for a remaining aggregate principal amount of $187.0 million as of December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading

days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;

- During the five business day period immediately following any five consecutive trading day period in which the trading price per $1,000 principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price, or VWAP, trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and $50 (representing 1/20th of $1,000); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above $50.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $368.7 million at December 31, 2009, and $355.0 million at December 31, 2008.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At December 31, 2009, our health plans had aggregate statutory capital and surplus of approximately $377.7 million, compared to the required minimum aggregate statutory capital and surplus of approximately $257.1 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2009. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2010.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Principal areas requiring the use of estimates include those areas listed below. The most significant of these estimates is the determination of medical claims and benefits payable, which is discussed in further detail below:

- The determination of medical claims and benefits payable;

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon either the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The impairment of long-lived and intangible assets;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Medical Claims and Benefits Payable

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management. As a result, the determination of our liability for claims and medical benefits is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed to providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. Our estimated IBNP liability represented $246.5 million of our total medical claims and benefits payable of $316.5 million as of December 31, 2009. Excluding amounts related to the run out of our cost-plus Medicaid contract in Utah (which contract was replaced with a prepaid capitation contract effective September 1, 2009) and amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at December 31, 2009 was $235.0 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2009 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding

December 31, 2009, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 72,782
(4)%	48,521
(2)%	24,261
2%	(24,261)
4%	(48,521)
6%	(72,782)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2009 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per Member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$(41,722)
(4)%	(27,815)
(2)%	(13,907)
2%	13,907
4%	27,815
6%	41,722

The following per-share amounts are based on a combined federal and state statutory tax rate of 38%, and 26 million diluted shares outstanding for the year ended December 31, 2009. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2009, net income for the year ended December 31, 2009 would increase or decrease by approximately $7.5 million, or $0.29 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2009, net income for the year ended December 31, 2009 would increase or decrease by approximately $4.3 million, or $0.17 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $37.6 million, or $1.45 per diluted share, net of tax, and $21.6 million, or $0.83 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. For example, if completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $7.5 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, also using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims

development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which much of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process which we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP liability and the methods used to determine that liability. Any adjustments are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been accurately estimated, we would expect that amounts ultimately paid would be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results in 2009 and 2008 when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of those years by approximately 18% and 20%, respectively.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2009 and 2008 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the two years, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

For the year ended December 31, 2009, we recognized a benefit from prior period claims development in the amount of $51.6 million (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2008. The overestimation of claims liability at December 31, 2008 was the result of the following factors:

- In Michigan, we underestimated the impact of a steep drop in claims inventory during December 2008, thereby overestimating our liability at December 31, 2008.
- In New Mexico, we overestimated the ultimate amounts we would need to pay to resolve certain high dollar provider claims, thereby overestimating our liability at December 31, 2008.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008, thereby overestimating our liability at December 31, 2008.

- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008, thereby overestimating our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt of paper claims (as opposed to electronically submitted claims) would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

For the year ended December 31, 2008, we recognized a benefit from prior period claims development in the amount of $62.1 million (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2007. The overestimation of claims liability at December 31, 2007 was the result of the following factors:

- In Michigan, we had overestimated the extent to which both catastrophic claims and state-mandated changes to the methodology used to pay outpatient claims had increased our liability at December 31, 2007.
- In Washington, we had overestimated the extent to which state-mandated changes to hospital fee schedules implemented in August 2007 had increased our liability at December 31, 2007.

In estimating our claims liability at December 31, 2009, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The rapid growth of membership across nearly all of our health plans in fiscal year 2009, particularly the growth in membership at our Florida health plan and the growth in ABD membership during the fourth quarter of 2009 at our Ohio health plan.
- A decrease in claims inventory at our California, Ohio, and Utah health plans through the fourth quarter of 2009.
- The impact of the 2009 H1N1 flu through the fourth quarter of 2009.
- The degree of change in the utilization of medical services and the cost per unit of those services during 2009.
- The impact of reductions to the state Medicaid fee schedules in Washington and Michigan effective July 1, 2009, and in New Mexico effective December 1, 2009.
- Potential provider settlements across all states, particularly in Missouri, New Mexico, Ohio, and Washington.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability. In 2009 and 2008 the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

We seek to maintain a consistent claims reserving methodology across all periods. Accordingly, any prior period benefit from an un-utilized reserve for adverse claims development may be offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) in the current period, and thus the impact on earnings for the current period may be minimal.

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2009 and 2008. The negative amounts displayed for "*components of medical care costs related to prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2009	2008
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of period	$ 292,442	$ 311,606
Components of medical care costs related to:		
Current year	3,227,794	2,683,399
Prior years	(51,558)	(62,087)
Total medical care costs	3,176,236	2,621,312
Payments for medical care costs related to:		
Current year	2,919,240	2,413,128
Prior years	232,922	227,348
Total paid	3,152,162	2,640,476
Balances at end of period	$ 316,516	$ 292,442
Benefit from prior period as a percentage of:		
Balance at beginning of period	17.6%	19.9%
Premium revenue	1.4%	2.0%
Total medical care costs	1.6%	2.4%
Days in claims payable	37	41
Number of members at end of period	1,455,000	1,256,000
Fee-for-service claims processing and inventory information:		
Number of claims in inventory at end of period	93,100	87,300
Billed charges of claims in inventory at end of period	$ 131,400	$ 115,400
Claims in inventory per member at end of period	0.06	0.07
Billed charges of claims in inventory per member at end of period	$ 90.31	$ 91.88
Number of claims received during the period	12,930,100	11,095,100
Billed charges of claims received during the period	$ 9,769,000	$ 7,794,900

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2009, our lease obligations for the next five years and thereafter were as follows: $21.3 million in 2010, $20.8 million in 2011, $18.6 million in 2012, $15.2 million in 2013, $13.5 million in 2014, and an aggregate of $39.6 million thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 18 to the accompanying audited consolidated financial statements for the year ended December 31, 2009.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2009. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2010	2011-2012	2013-2014	2015 and Beyond
Medical claims and benefits payable	$316,516	$316,516	$ —	$ —	$ —
Long-term debt(1)	187,000	—	—	187,000	—
Operating leases	128,980	21,334	39,365	28,705	39,576
Interest on long-term debt(1)	33,309	7,012	14,025	12,272	—
Purchase commitments	23,472	8,201	11,955	3,316	—
Total contractual obligations	$689,277	$353,063	$ 65,345	$231,293	$ 39,576

(1) Amounts relate to our 3.75% Convertible Senior Notes due 2014.

As of December 31, 2009, we have recorded approximately $4.1 million of unrecognized tax benefits. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 13 to the accompanying audited consolidated financial statements for the year ended December 31, 2009 for further information.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Inflation

Although the general rate of inflation has remained relatively stable and health care cost inflation has stabilized in recent years, the national health care cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. While we currently believe our strategies will mitigate health care cost inflation, competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2009. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2009 and 2008, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2009, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, during 2009 the Company changed its method of accounting for convertible debt instruments.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 16, 2010 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2010

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31, 2009	December 31, 2008(1)
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 469,501	$ 387,162
Investments	174,844	189,870
Receivables	136,654	128,562
Income tax refundable	6,067	4,019
Deferred income taxes	8,757	9,071
Prepaid expenses and other current assets	15,583	14,766
Total current assets	811,406	733,450
Property and equipment, net	78,171	65,058
Intangible assets, net	80,846	79,133
Goodwill and indefinite-lived intangible assets	133,408	113,466
Investments	59,687	58,169
Restricted investments	36,274	38,202
Receivable for ceded life and annuity contracts	25,455	27,367
Other assets	19,988	33,223
	$1,245,235	$1,148,068
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 316,516	$ 292,442
Accounts payable and accrued liabilities	71,732	81,981
Deferred revenue	101,985	13,804
Total current liabilities	490,233	388,227
Long-term debt	158,900	164,873
Liability for ceded life and annuity contracts	25,455	27,367
Deferred income taxes	12,506	12,911
Other long-term liabilities	15,403	22,928
Total liabilities	702,497	616,306
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 25,607 shares at December 31, 2009 and 26,725 shares at December 31, 2008	26	27
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	129,902	170,681
Accumulated other comprehensive loss	(1,812)	(2,310)
Retained earnings	414,622	383,754
Treasury stock, at cost; 1,201 shares at December 31, 2008	—	(20,390)
Total stockholders' equity	542,738	531,762
	$1,245,235	$1,148,068

(1) The Company's consolidated financial position as of December 31, 2008, has been recast to reflect the adoption of FASB Accounting Standards Codification (ASC) Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2009	2008(1)	2007(1)
	(In thousands, except per share data)		
Revenue:			
Premium revenue	$3,660,207	$3,091,240	$2,462,369
Investment income	9,149	21,126	30,085
Total revenue	3,669,356	3,112,366	2,492,454
Expenses:			
Medical care costs	3,176,236	2,621,312	2,080,083
General and administrative expenses	399,149	344,761	285,295
Depreciation and amortization	38,110	33,688	27,967
Impairment charge on purchased software	—	—	782
Total expenses	3,613,495	2,999,761	2,394,127
Gain on purchase of convertible senior notes	1,532	—	—
Operating income	57,393	112,605	98,327
Interest expense	(13,777)	(13,231)	(5,605)
Income before income taxes	43,616	99,374	92,722
Provision for income taxes	12,748	39,776	34,996
Net income	$ 30,868	$ 59,598	$ 57,726
Net income per share:			
Basic	$ 1.19	$ 2.15	$ 2.04
Diluted(2)	$ 1.19	$ 2.15	$ 2.03
Weighted average shares outstanding:			
Basic	25,843	27,676	28,275
Diluted(2)	25,984	27,772	28,419

(1) The Company's consolidated statements of income for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

(2) Potentially dilutive shares issuable pursuant to the Company's 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2009, 2008, and 2007.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock Outstanding	Common Stock Amount	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Total
				(In thousands)			
Balance at January 1, 2007	28,119	$ 28	$ 173,990	$ (337)	$266,875	$(20,390)	$420,166
Comprehensive income:							
Net income(1)	—	—	—	—	57,726	—	57,726
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	609	—	—	609
Total comprehensive income	—	—	—	609	57,726	—	58,335
Adjustment to adopt ASC Subtopic 470-20(1)	—	—	24,502	—	—	—	24,502
Adjustment to adopt ASC Subtopic 740-10 *Accounting for Uncertainty in Income Taxes*	—	—	—	—	(445)	—	(445)
Stock options exercised, employee stock grants and employee stock plan purchases	325	—	10,965	—	—	—	10,965
Tax benefit from employee stock compensation	—	—	853	—	—	—	853
Balance at December 31, 2007	28,444	28	210,310	272	324,156	(20,390)	514,376
Comprehensive income:							
Net income(1)	—	—	—	—	59,598	—	59,598
Other comprehensive income, net of tax:							
Unrealized loss on investments	—	—	—	(7,025)	—	—	(7,025)
Other-than-temporary impairment of available-for-sale securities	—	—	—	4,443	—	—	4,443
Total comprehensive income	—	—	—	(2,582)	59,598	—	57,016
Purchase of treasury stock	—	—	—	—	—	(49,940)	(49,940)
Retirement of treasury stock	(1,943)	(1)	(49,939)	—	—	49,940	—
Stock issued in business purchase transaction	48	—	1,262	—	—	—	1,262
Stock options exercised, employee stock grants and employee stock plan purchases	176	—	9,340	—	—	—	9,340
Tax deficiency from employee stock compensation	—	—	(292)	—	—	—	(292)
Balance at December 31, 2008	26,725	27	170,681	(2,310)	383,754	(20,390)	531,762
Comprehensive income:							
Net income	—	—	—	—	30,868	—	30,868
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	498	—	—	498
Total comprehensive income	—	—	—	498	30,868	—	31,366
Purchase of treasury stock	—	—	—	—	—	(27,712)	(27,712)
Retirement of treasury stock	(1,352)	(1)	(48,101)	—	—	48,102	—
Retirement of convertible debt	—	—	(476)	—	—	—	(476)
Employee stock grants and employee stock plan purchases	234	—	8,516	—	—	—	8,516
Tax deficiency from employee stock compensation	—	—	(718)	—	—	—	(718)
Balance at December 31, 2009	25,607	$ 26	$ 129,902	$ (1,812)	$414,622	$ —	$542,738

(1) The Company's consolidated statements of stockholders' equity for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2009	2008(1)	2007(1)
		(In thousands)	
Operating activities:			
Net income	$ 30,868	$ 59,598	$ 57,726
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	38,110	33,688	27,967
Other-than-temporary impairment on available-for-sale securities	—	7,166	—
Unrealized (gain) loss on trading securities	(3,394)	399	—
Loss (gain) on rights agreement	3,100	(6,907)	—
Deferred income taxes	(1)	(3,404)	(9,427)
Stock-based compensation	7,485	7,811	7,188
Non-cash interest on convertible senior notes	4,782	4,707	1,012
Gain on purchase of convertible senior notes	(1,532)	—	—
Amortization of deferred financing costs	1,872	1,435	1,004
Tax deficiency from employee stock compensation	(749)	(335)	—
Loss on disposal of property and equipment	—	142	—
Changes in operating assets and liabilities, net of effects of acquisitions:			
Receivables	(8,092)	(17,025)	15,007
Prepaid expenses and other current assets	(817)	(2,245)	(2,911)
Medical claims and benefits payable	24,074	(19,164)	6,683
Accounts payable and accrued liabilities	(26,467)	10,830	18,700
Deferred revenue	88,181	(26,300)	21,984
Income taxes	(2,049)	(9,965)	13,693
Net cash provided by operating activities	155,371	40,431	158,626
Investing activities:			
Purchases of equipment	(35,870)	(34,690)	(22,299)
Purchases of investments	(186,764)	(263,229)	(264,115)
Sales and maturities of investments	204,365	246,524	103,718
Net cash paid in business purchase transactions	(11,294)	(1,000)	(70,172)
Decrease (increase) in restricted investments	1,928	(9,183)	(8,365)
Increase in other assets	(2,553)	(8,973)	(4,330)
(Decrease) increase in other long-term liabilities	(7,525)	6,031	9,290
Net cash used in investing activities	(37,713)	(64,520)	(256,273)
Financing activities:			
Treasury stock purchases	(27,712)	(49,940)	—
Purchase and retirement of convertible senior notes	(9,653)	—	—
Proceeds from issuance of convertible senior notes	—	—	200,000
Repayment of amounts borrowed under credit facility	—	—	(45,000)
Payment of credit facility fees	—	—	(551)
Payment of convertible senior notes fees	—	—	(6,498)
Tax benefit from employee stock compensation	31	43	853
Proceeds from exercise of stock options and employee stock plan purchases	2,015	2,084	4,257
Net cash (used in) provided by financing activities	(35,319)	(47,813)	153,061
Net increase (decrease) in cash and cash equivalents	82,339	(71,902)	55,414
Cash and cash equivalents at beginning of year	387,162	459,064	403,650
Cash and cash equivalents at end of year	$ 469,501	$ 387,162	$ 459,064

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (Continued)

	Year Ended December 31,		
	2009	2008(1)	2007(1)
		(In thousands)	
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 27,100	$50,130	$ 27,734
Interest	$ 8,205	$ 7,797	$ 9,419
Schedule of non-cash investing and financing activities:			
Unrealized gain (loss) on investments	$ 699	$ (3,956)	$ 977
Deferred income taxes	(201)	1,374	(368)
Net unrealized gain (loss) on investments	$ 498	$ (2,582)	$ 609
Retirement of common stock used for stock-based compensation	$ (984)	$ (555)	$ (480)
Accrued purchases of equipment	$ 935	$ 65	$ 672
Retirement of treasury stock	$ 48,102	$49,940	$ —
Impairment of purchased software	$ —	$ —	$ 782
Cumulative effect of adoption of FASB ASC Subtopic 740-10, *Accounting for Uncertainty in Income Taxes*	$ —	$ —	$ 445
Details of business purchase transactions:			
Fair value of assets acquired	$(34,594)	$ (2,262)	$(106,233)
Release of escrow and other deposits	18,000	—	—
Common stock issued to seller	—	1,262	—
Less cash acquired	—	—	10,843
Less payable to seller	5,300	—	—
Liabilities assumed	—	—	25,218
Net cash paid in business purchase transactions	$(11,294)	$ (1,000)	$ (70,172)
Business purchase transactions adjustments:			
Accounts payable and accrued liabilities	$ —	$ 1,265	$ —
Other long-term liabilities	—	2,368	—
Deferred taxes	—	(7,549)	2,747
Goodwill and intangible assets, net	$ —	$ (3,916)	$ 2,747

(1) The Company's consolidated statements of cash flows for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010 we terminated operations at our small Medicare health plan in Nevada.

Our results of operations include the results of recent acquisitions, including the acquisition of Florida NetPASS, under which we began transitioning members in late December 2008. Additionally, we acquired Mercy CarePlus, a Medicaid managed care organization based in St. Louis, Missouri, effective November 1, 2007.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority-owned subsidiaries. All significant intercompany transactions and balances have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

Evaluation of Subsequent Events

We have evaluated subsequent events through the date of issuance of our financial statements in this Annual Report on Form 10-K.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure 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. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable;
- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon either the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The impairment of long-lived and intangible assets;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Reclassification

We have reclassified certain prior year balance sheet amounts to conform to the 2009 presentation.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Recast of Prior Periods

In May 2008, the FASB issued a new standard relating to convertible debt instruments. This standard requires the proceeds from the issuance of applicable convertible debt instruments to be allocated between a liability component and an equity component. The resulting debt discount is amortized over the period the convertible debt is expected to be outstanding, as additional non-cash interest expense. We adopted this new standard effective as of January 1, 2009. For further information regarding our convertible senior notes, see Note 12, "Long-Term Debt."

The following tables illustrate the impact of adopting this accounting standard on our consolidated statements of income.

	Year Ended December 31, 2009		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Operating income	$ 58,786	$ (1,393)	$ 57,393
Interest expense	(9,344)	(4,433)	(13,777)
Income before income taxes	49,442	(5,826)	43,616
Provision for income taxes	14,961	(2,213)	12,748
Net income	$ 34,481	$ (3,613)	$ 30,868
Net income per share:			
Basic	$ 1.33	$ (0.14)	$ 1.19
Diluted	$ 1.33	$ (0.14)	$ 1.19

	Year Ended December 31, 2008		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Operating income	$ 112,605	$ —	$ 112,605
Interest expense	(8,714)	(4,517)	(13,231)
Income before income taxes	103,891	(4,517)	99,374
Provision for income taxes	41,493	(1,717)	39,776
Net income	$ 62,398	$ (2,800)	$ 59,598
Net income per share:			
Basic	$ 2.25	$ (0.10)	$ 2.15
Diluted	$ 2.25	$ (0.10)	$ 2.15

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Year Ended December 31, 2007		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Operating income	$ 98,327	$ —	$ 98,327
Interest expense	(4,631)	(974)	(5,605)
Income before income taxes	93,696	(974)	92,722
Provision for income taxes	35,366	(370)	34,996
Net income	$ 58,330	$ (604)	$ 57,726
Net income per share:			
Basic	$ 2.06	$ (0.02)	$ 2.04
Diluted	$ 2.05	$ (0.02)	$ 2.03

The following tables illustrate the impact of adopting this standard on our consolidated balance sheets.

	December 31, 2009		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Noncurrent assets:			
Other assets	$ 20,651	$ (663)	$ 19,988
Noncurrent liabilities:			
Long-term debt	187,000	(28,100)	158,900
Deferred income taxes	3,352	9,154	12,506
Stockholders' equity:			
Additional paid-in capital	104,603	25,299	129,902
Retained earnings	421,639	(7,017)	414,622

	December 31, 2008		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Noncurrent assets:			
Other assets	$ 34,321	$ (1,098)	$ 33,223
Deferred income taxes	20	(20)	—
Noncurrent liabilities:			
Long-term debt	200,000	(35,127)	164,873
Deferred income taxes	—	12,911	12,911
Stockholders' equity:			
Additional paid-in capital	146,179	24,502	170,681
Retained earnings	387,158	(3,404)	383,754

There was no impact resulting from this accounting change on our cash flows from operating activities, investing activities, or financing activities as reflected in the consolidated statements of cash flows.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

2. Significant Accounting Policies

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2009, we received approximately 92% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue by health plan for the periods indicated:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
California	$ 481,717	$ 417,027	$ 378,934
Florida(1)	102,232	—	—
Michigan	557,421	509,782	487,032
Missouri(2)	230,222	225,280	30,730
New Mexico	404,026	348,576	268,115
Ohio	803,521	602,826	436,238
Texas	134,860	110,178	88,453
Utah	207,297	155,991	116,907
Washington	726,137	709,943	652,970
Other	12,774	11,637	2,990
	$3,660,207	$3,091,240	$2,462,369

(1) The Florida health plan began enrolling members in December 2008.

(2) We acquired the Missouri health plan in late 2007.

For the year ended December 31, 2009, we received approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in California (effective October 1, 2009), Michigan, Missouri, Ohio, Texas, Utah (effective September 1, 2009) and Washington. Such payments are recognized as revenue in the month the birth occurs. Approximately 2.5% of our premium revenue for the year ended December 31, 2009 was realized under a Medicaid cost-plus reimbursement agreement that our Utah health plan had with that state until August 31, 2009. Effective September 1, 2009, the Utah health plan's contract with the state of Utah became a prepaid capitation contract, under which the plan is paid a fixed PMPM amount.

Certain components of premium revenue are subject to accounting estimates. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health.* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not expended on defined behavioral health care costs. At December 31, 2009, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not expended on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2009, we had not recorded any liability under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.
- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. Through December 31, 2009, our New Mexico health plan had received $3.6 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $2.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $1.4 million for the remainder.
- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009 our Ohio health plan had received $8.8 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $7.5 million of that amount as revenue through December 31, 2009 and recorded a liability of approximately $1.3 million for the remainder.
- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at December 31, 2009 and 2008.
- *Texas Health Plan Premium Revenue:* The contract entered into between our Texas health plan and the state of Texas includes a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in

calculating the rebate, if any. As of December 31, 2009, we had an aggregate liability of approximately $2.0 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2009 and 2010 contract years (ending August 31 of each year). During 2009, we paid the state of Texas $4.9 million relating to the 2008 and 2009 contract years, and the 2008 contract year is now closed. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009, our Texas health plan had received $1.7 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $1.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $0.5 million for the remainder.
- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue. Based upon our knowledge of member health care utilization patterns we have recorded a liability of approximately $0.6 million related to the potential recoupment of Medicare premium revenue at December 31, 2009.

Medical Care Costs

Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to

significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2009, 2008, and 2007, medically related administrative costs were approximately $74.6 million, $75.9 million, and $65.4 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2009			2008			2007		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for- service	$2,077,489	$126.14	65.4%	$1,709,806	$116.69	65.2%	$1,343,911	$103.77	64.6%
Capitation	558,538	33.91	17.6	450,440	30.74	17.2	375,206	28.97	18.0
Pharmacy	414,785	25.18	13.1	356,184	24.31	13.6	270,363	20.88	13.0
Other	125,424	7.62	3.9	104,882	7.16	4.0	90,603	7.00	4.4
Total	$3,176,236	$192.85	100.0%	$2,621,312	$178.90	100.0%	$2,080,083	$160.62	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates. See Note 11, "Medical Claims and Benefits Payable."

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Our California, Florida, Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in general and administrative expenses. Premium tax expense totaled $123.1 million, $95.1 million, and $81.0 million in 2009, 2008, and 2007, respectively.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2009, or 2008.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2009, or 2008.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into three separate categories for accounting and reporting purposes: available-for-sale securities, held-to-maturity securities, and trading securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. Trading securities are recorded at fair value, and holding gains and losses are recognized in net income.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Except for restricted investments and certain student loan portfolios (the "auction rate securities"), our debt securities are designated as available-for-sale and are carried at fair value. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis. Fair values of securities are generally based on quoted prices in active markets.

Our investment policy requires that all of our investments have final maturities of ten years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be four years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. During 2008, our auction rate securities were classified as non-current assets. During the fourth quarter of 2008, certain auction rate securities were designated as trading securities. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," and Note 6, "Investments."

Receivables

Receivables consist primarily of amounts due from the various states in which we operate. All receivables are subject to potential retroactive adjustment. Because the amounts of nearly all receivables are readily determinable and our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables."

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Software developed for internal use is capitalized. Furniture and equipment are depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software is amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease or five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years. See Note 8, "Property and Equipment."

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are amortized on a straight-line basis over the expected period to be benefited (between one and 15 years). See Note 9, "Goodwill and Intangible Assets."

Goodwill and indefinite lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. We used a discounted cash flow methodology to assess the fair values of our reporting units at December 31, 2009 and 2008. If the carrying values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite lived asset balance. Based on the results of our impairment testing, no adjustments were required for the years ended December 31, 2009, 2008, and 2007.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted expected cash flows associated with that asset. In such circumstances, the asset is deemed to be impaired. We review material long-lived assets for impairment on an annual basis, as well as when events or changes in business conditions suggest potential impairment. Impaired assets are written down to fair value. In the second quarter of 2007, we recorded an impairment charge totaling $782,000 related to commercial software no longer used in operations.

Other than this 2007 charge, we have determined that no long-lived assets were impaired in the years ended December 31, 2009, 2008, and 2007.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Receivable/Liability for Ceded Life and Annuity Contracts

We report a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts.

Other Assets

Significant items included in other assets include deferred financing costs associated with our convertible senior notes and with our credit facility, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see Note 17, "Related Party Transactions"). The deferred financing costs are being amortized on a straight-line basis over the seven year term of the convertible senior notes and the five year term of the credit facility. As of December 31, 2009, other assets decreased compared with December 31, 2008 primarily due to the reclassification, to goodwill and intangible assets, of the $9.0 million initial purchase deposit of the Florida NetPASS acquisition (see Note 4, "Business Purchase Transactions"). Additionally, as of December 31, 2009, the fair value of the non-current asset relating to a rights agreement decreased $3.1 million (see Note 5, "Fair Value Measurements") compared with the balance as of December 31, 2008.

Income Taxes

Deferred tax assets and liabilities are recorded based on temporary differences between the financial statement basis and the tax basis of assets and liabilities using presently enacted tax rates. We record accruals for uncertain tax positions by applying a two-step process. First, we determine whether it is more likely than not that a tax position will be sustained upon examination. In the second step, a tax position that meets the more-likely-than-not recognition threshold is measured to determine the amount of benefit to recognize in the financial statements. For further discussion and disclosure, see Note 13, "Income Taxes."

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2009, and 2008, our investments with PFM totaled $296.0 million and $253.8 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2009, we operated in nine states (not including Nevada, where we no longer served members effective January 1, 2010), in some instances as a direct contractor with the state, and in others as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Segment Information

We present segment information externally in the same manner used by management to make operating decisions and assess performance. Each of our subsidiaries arranges for the provision of health care services to Medicaid, CHIP and Medicare members in return for compensation from state and Federal agencies. They share similar characteristics in the membership they serve, the nature of services provided and the method by which medical care is rendered. The subsidiaries are also subject to similar regulatory environments and long-term economic prospects. As such, we have one reportable segment.

Recent Accounting Pronouncements

In 2009, the FASB issued the FASB Accounting Standards Codification (the "Codification") for financial statements issued for interim and annual periods ending after September 15, 2009. The Codification became the single authoritative source for GAAP. Accordingly, previous references to GAAP accounting standards are no longer used in our disclosures, including these Notes to the Consolidated Financial Statements. The Codification does not impact our consolidated financial position, results of operations or cash flows.

In October 2009, the Financial Accounting Standards Board ("FASB") issued new revenue recognition standards for arrangements with multiple deliverables, where certain of those deliverables are non-software related. The new standards permit entities to initially use management's best estimate of selling price to value individual deliverables when those deliverables do not have vendor specific objective evidence, or VSOE, of fair value or when third-party evidence is not available. Additionally, these new standards modify the manner in which the transaction consideration is allocated across the separately identified deliverables by no longer permitting the residual method of allocating arrangement consideration. These new standards are effective for annual periods ending after June 15, 2010, however early adoption is permitted. We are currently evaluating the impact of adopting these new standards on our consolidated financial position, results of operations and cash flows.

In October 2009, the FASB issued an update that offers guidance on how to use a net asset value per share to estimate the fair value of investments in various types of funds including hedge funds, private equity funds, real estate funds, venture capital funds, and offshore fund vehicles. We adopted the update in the fourth quarter of 2009, and because we do not invest in such funds, it did not impact our consolidated financial position, results of operations or cash flows.

In August 2009, the FASB issued an update that provides additional guidance clarifying the measurement of liabilities at fair value. Because we do not measure any of our liabilities at fair value, the adoption of the new standards did not impact our consolidated financial position, results of operations or cash flows.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In June 2009, the FASB issued an amended standard for determining whether to consolidate a variable interest entity. This new standard amends the evaluation criteria to identify the primary beneficiary of a variable interest entity and requires ongoing reassessment of whether an enterprise is the primary beneficiary of the variable interest entity. We adopted the standards in the fourth quarter of 2009, and the standard did not impact our consolidated financial position, results of operations or cash flows.

In May 2009, the FASB issued a new standard for subsequent events, which establishes general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. We adopted the new standard during the second quarter of 2009 and, because the pronouncement only requires additional disclosure, the adoption did not impact our consolidated financial position, results of operations or cash flows. The required disclosure is included in Note 1, "Basis of Presentation."

In April 2009, the FASB issued a new standard for the recognition and measurement of other-than-temporary impairments for debt securities which replaced the pre-existing "intent and ability" indicator. This new standard specifies that if the fair value of a debt security is less than its amortized cost basis, an other-than-temporary impairment is triggered in circumstances where (1) an entity has an intent to sell the security, (2) it is more likely than not that the entity will be required to sell the security before recovery of its amortized cost basis, or (3) the entity does not expect to recover the entire amortized cost basis of the security (that is, a credit loss exists). Other-than-temporary impairments are separated into amounts representing credit losses which are recognized in earnings and amounts related to all other factors which are recognized in other comprehensive income (loss). We adopted this standard in the second quarter of 2009 and it did not have a material effect on our consolidated financial position, results of operations or cash flows.

In April 2009, the FASB issued a new standard that provides guidance on how to determine the fair value of assets and liabilities when the volume and level of activity for the asset or liability has significantly decreased. This new standard also provides guidance on identifying circumstances that indicate a transaction is not orderly. In addition, we are required to disclose in interim as well as annual reporting periods the inputs and valuation techniques used to measure fair value and discussion of changes in valuation techniques. We adopted this standard in the second quarter of 2009 and it did not have a material effect on our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the AICPA, and the SEC did not, or are not believed by management to, have a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Year Ended December 31,		
	2009	2008	2007
	(In thousands)		
Shares outstanding at the beginning of the year	26,725	28,444	28,119
Weighted-average number of shares repurchased	(988)	(871)	—
Weighted-average number of shares issued	106	103	156
Denominator for basic earnings per share	25,843	27,676	28,275
Dilutive effect of employee stock options and stock grants(1)	141	96	144
Denominator for diluted earnings per share(2)	25,984	27,772	28,419

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2009, 2008 and 2007, there were approximately 620,000, 532,000, and 136,000 anti-dilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per

share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2009, 2008 and 2007, there were approximately 21,000, 39,000, and 4,000 anti-dilutive weighted restricted shares, respectively.

(2) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2009, 2008 and 2007.

4. Business Purchase Transactions

On January 1, 2009, we adopted the FASB's revised standard for accounting for business combinations. The transaction described below under *"Florida health plan,"* was accounted for under the new standard. The adoption of the standard did not have a material effect on our consolidated financial position, results of operations or cash flows.

Florida health plan. On December 31, 2009 (the acquisition date), we acquired 100% of the voting equity interests in Florida NetPASS, LLC ("NetPASS"). This acquisition included the purchase of the NetPASS limited liability company and its membership interests. We initially announced our intention to purchase NetPASS in August 2008. NetPASS was a provider of care management and administrative services at that time to approximately 58,000 Florida MediPass members in South and Central Florida (Florida MediPASS is the state of Florida's Medicaid program). As a result of the acquisition, we have expanded our health plan operations to the southeastern United States.

Our wholly owned subsidiary, Molina Healthcare of Florida, Inc., was awarded a Medicaid managed care contract by the state of Florida in October 2008. Subsequently, NetPASS members have been notified of our intention to acquire NetPASS and, beginning in December 2008, offered membership with our Florida health plan on a county-by-county basis. Once transitioned, these members become full-risk members of the Florida health plan. That is, the Florida health plan receives fixed per member per month payments from the state of Florida for the care of these members, and the Florida health plan is at risk for the cost of the members' medical care. As of December 31, 2008, we had transitioned fewer than 50 NetPASS members to our Florida health plan.

As of December 31, 2009, we have transitioned approximately 48,000 NetPASS members to our Florida health plan, and have recorded $28.7 million to goodwill and intangible assets relating to these members. Of this amount, we have paid the sellers $23.4 million, with the balance accrued to accounts payable and accrued liabilities. The $5.3 million current liability includes a 10% indemnification hold back totaling $2.9 million, as provided in the purchase agreement, and a $2.4 million payable to the sellers for membership transitioned to date as of December 31, 2009. Because the final membership reconciliation will take place in the second quarter of 2010, the provisional measurements of goodwill and intangible assets recorded as of December 31, 2009, are subject to change. The final purchase price of the acquisition will be based on the final membership transitioned to our Florida health plan under the terms of the purchase agreement. As of December 31, 2009, we do not expect adjustments relating to the final membership reconciliation to be significant. The following table summarizes the estimated fair values of the assets acquired as of December 31, 2009:

	(In thousands)
Goodwill (indefinite life)	$ 17,048
Contract rights and licenses (five-year useful life)	8,576
Provider networks (10-year useful life)	3,076
	$ 28,700

The entire amount recorded for goodwill is deductible for income tax purposes. The amount recorded for goodwill as of December 31, 2009, represents intangible assets that do not qualify for separate recognition as identifiable intangible assets.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

We have received a series of demand letters from the sellers of NetPASS related to the enrollment of members and the applicable purchase price. We believe the sellers' demands are without merit, and in the event arbitration or litigation is commenced by the sellers, we intend to vigorously contest the sellers' claims.

Missouri health plan. Effective November 1, 2007, we acquired Mercy CarePlus, a licensed Medicaid managed care plan based in St. Louis, Missouri, to expand our market share within our core Medicaid managed care business. The results of operations for Mercy CarePlus are included in the consolidated financial statements from periods following November 1, 2007. The purchase price for the acquisition was $80.0 million, and was funded with available cash and proceeds from our issuance of convertible senior notes in October 2007. The purchase price was subject to certain post-closing adjustments. During the third quarter of 2009, we paid the sellers $2.5 million to settle all outstanding issues relating to the post-closing adjustments. We recorded this amount to goodwill in the accompanying consolidated balance sheets. Additionally during the post-acquisition period in 2008, we reduced goodwill by approximately $6.2 million, primarily due to the establishment of a deferred tax asset relating to the carryover tax basis in certain identifiable intangibles.

Other. In June 2008, we paid $1.0 million and issued a total of 48,186 shares of our common stock in connection with our acquisition of the assets of The Game of Work, LLC. The purchase price consideration totaled $2.3 million. The Game of Work, LLC is a company specializing in productivity measurement and improvement, and is used internally to improve operational efficiency.

See Note 21, "Subsequent Events," for further information regarding a business purchase transaction we announced in January 2010.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was approximately $160.8 million, and $115.5 million as of December 31, 2009, and 2008, respectively. The carrying amount of the convertible senior notes was $158.9 million, and $164.9 million as of December 31, 2009, and 2008, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

As of December 31, 2009, we held certain assets that are required to be measured at fair value on a recurring basis. These included investments and restricted investments as follows:

Balance Sheet Classification	Description
Current assets:	
Investments	Investment grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1). See Note 6, "Investments," for further information regarding fair value.
Non-current assets:	
Investments	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3). Auction rate securities; designated as trading; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Restricted investments	Interest-bearing deposits and U.S. treasury securities required by the respective states in which we operate, or required by contractual arrangement with a third party such as a provider group; designated as held-to-maturity; reported at amortized cost which approximates market value and based on market prices that are readily available (Level 1). See Note 10, "Restricted Investments," for further information regarding fair value.
Other assets	Other assets include auction rate securities rights; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).

As of December 31, 2009, $67.8 million par value (fair value of $59.7 million) of our investments consisted of auction rate securities, all of which were collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2009. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, and continued to be unavailable as of December 31, 2009. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of December 31, 2009. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As of December 31, 2009, we held $40.9 million par value (fair value of $36.7 million) auction rate securities (designated as trading securities) with a certain investment securities firm. In the fourth quarter of 2008, we entered into a rights agreement with this firm that (1) allows us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gives the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we receive the par value.

We account for the Rights as a freestanding financial instrument, and record the value of the Rights at fair value, which totaled $3.8 million, and $6.9 million at December 31, 2009, and 2008, respectively. To determine the fair value estimate of the Rights, we use a discounted cash-flow model based on the expectation that the auction rate securities will be put back to the investment securities firm at par on June 30, 2010, as permitted by the rights agreement.

For the year ended December 31, 2009, we recorded a pretax gain on the change in the fair value of the auction rate securities underlying the Rights totaling $3.4 million, which was offset by a pretax loss on the Rights totaling $3.1 million. In 2008, simultaneous to the recognition of the $6.9 million rights agreement described above, we

recorded an other-than-temporary impairment of the underlying auction rate securities, and prior unrealized losses on the auction rate securities that had been recorded to other comprehensive loss through November 2008 were charged to income, totaling $7.2 million. We expect that the future changes in the fair value of the Rights will continue to be substantially offset by the fair value movements in the underlying auction rate securities.

As of December 31, 2009, the remainder of our auction rate securities (designated as available-for-sale securities) amounted to $26.9 million par value (fair value of $23.0 million). As a result of the increase in fair value of auction rate securities designated as available-for-sale, we recorded unrealized gains of $0.8 million ($0.5 million, net of tax) to accumulated other comprehensive income for the year ended December 31, 2009. We recorded unrealized losses of $7.6 million ($4.7 million, net of tax) to other comprehensive loss for the year ended December 31, 2008. We have deemed these unrealized gains and losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Based on market conditions that resulted in the absence of quoted prices in active markets for our auction rate securities, we changed our valuation methodology for auction rate securities to a discounted cash flow analysis during the first quarter of 2008. Our assets measured at fair value on a recurring basis at December 31, 2009, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
		(In thousands)		
Investments (not including auction rate securities)	$174,844	$174,844	$ —	$ —
Auction rate securities (available-for-sale)	22,957	—	—	22,957
Auction rate securities (trading)	36,730	—	—	36,730
Auction rate securities rights	3,807	—	—	3,807
Restricted investments	36,274	36,274	—	—
Total assets measured at fair value	$274,612	$211,118	$ —	$63,494

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2008	$ 65,076
Total gains (realized or unrealized):	
Included in earnings	294
Included in other comprehensive income	824
Settlements	(2,700)
Balance at December 31, 2009	$ 63,494
The amount of total gains for the period included in other comprehensive income attributable to the change in unrealized gains relating to assets still held at December 31, 2009	$ 824

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2009			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Government-sponsored enterprise securities	$ 89,451	$ 504	$ 281	$ 89,674
Municipal securities (including auction rate securities)	82,009	3,120	4,154	80,975
U.S. treasury notes	28,052	92	84	28,060
Certificates of deposit	3,258	—	—	3,258
Corporate bonds	32,543	206	185	32,564
	$235,313	$3,922	$4,704	$234,531

	December 31, 2008			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Government-sponsored enterprise securities	$ 93,994	$1,309	$ 79	$ 95,224
Municipal securities (including auction rate securities)	85,973	23	5,313	80,683
U.S. treasury notes	8,604	295	—	8,899
Certificates of deposit	13,494	—	—	13,494
Corporate bonds	50,315	155	731	49,739
	$252,380	$1,782	$6,123	$248,039

The contractual maturities of our investments as of December 31, 2009 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 67,475	$ 67,387
Due one year through five years	106,624	106,934
Due after five years through ten years	1,430	1,400
Due after ten years	59,784	58,810
	$235,313	$234,531

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $60.3 million, $55.3 million, and $13.1 million for the years ended December 31, 2009, 2008 and 2007, respectively. Net realized investment gains (losses) for the years ended December 31, 2009, 2008 and 2007 were $267,000, $342,000 and $(78,000) respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at December 31, 2009 and 2008 are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Our investment in municipal securities consists primarily of auction rate securities. As described in Note 5, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at December 31, 2009.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months and those that have been in a loss position for 12 months or more as of December 31, 2009 and 2008.

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2009		In a Continuous Loss Position for 12 Months or More as of December 31, 2009		Total as of December 31, 2009	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
			(In thousands)			
Municipal securities	$ 10,427	$ 77	$ 24,031	$ 3,902	$ 34,458	$ 3,979
Government-sponsored enterprise securities	11,192	150	7,297	94	18,489	244
U.S. treasury notes	5,572	34	—	—	5,572	34
Corporate bonds	8,170	124	1,203	36	9,373	160
	$ 35,361	$ 385	$ 32,531	$ 4,032	$ 67,892	$ 4,417

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2008		In a Continuous Loss Position for 12 Months or More as of December 31, 2008		Total as of December 31, 2008	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
			(In thousands)			
Municipal securities	$ 41,901	$ 4,914	$ —	$ —	$ 41,901	$ 4,914
Government-sponsored enterprise securities	7,237	79	—	—	7,237	79
Corporate bonds	30,276	731	—	—	30,276	731
	$ 79,414	$ 5,724	$ —	$ —	$ 79,414	$ 5,724

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

7. Receivables

Accounts receivable by health plan operating subsidiary were as follows:

	December 31,	
	2009	2008
	(In thousands)	
California	$ 34,289	$ 20,740
Michigan	14,977	6,637
Missouri	19,670	24,024
New Mexico	11,919	5,712
Ohio	37,004	34,562
Utah	6,107	20,614
Washington	9,910	14,184
Other	2,778	2,089
Total	$136,654	$128,562

Accounts receivable as of December 31, 2009, increased compared with the prior year generally as a result of increased membership across several of our health plans. These increases were partially offset by the decrease at our Utah health plan, due to the termination of the plan's cost-plus reimbursement contract with the state of Utah effective September 1, 2009, as described further below.

Ohio. As of December 31, 2009, the receivable due our Ohio health plan included two significant components. The first is approximately $5.1 million of accrued birth income, net, due from the state of Ohio. Birth income is a one-time payment for the delivery of a child from the Medicaid program in Ohio.

The second significant component of the Ohio receivable is approximately $28.8 million due from a capitated provider group. Although we have a capitation arrangement with this provider group, our agreement with them calls for us to pay for certain medical services incurred by the provider group's members, and then to deduct the amount of such payments from future monthly capitation amounts owed to the provider group. Of the $28.8 million receivable, approximately $19.3 million represents medical services we have paid on behalf of the provider group, which we will deduct from capitation payments in the months of January and February 2010. The other component of the Ohio receivable includes an estimate of our liability for claims incurred by members of this provider group, not covered by capitation, for which we have not yet made payment. This amount totaled $9.5 million as of December 31, 2009. The offsetting liability for the amount of this receivable established for claims incurred but not paid is included in "Medical claims and benefits payable" in our consolidated balance sheets. As part of the agreement with this provider group, our Ohio health plan has withheld approximately $8.2 million from capitation payments due the group, and placed the funds in an escrow account. The Ohio health plan is entitled to the escrow amount if the provider group is unable to repay amounts owed to us for these incurred but not reported claims. The escrow account is included in "Restricted investments" in our consolidated balance sheets. During the year ended December 31, 2009, our average monthly capitation payment to this provider group was approximately $14 million.

Utah. Prior to September 1, 2009, our Utah health plan's agreement with the state of Utah called for the reimbursement of medical costs incurred in serving our members plus an administrative fee for a specified percentage of that medical cost amount (which was formerly 9% and most recently 6.5%), plus a portion of any cost savings realized as defined in the agreement. Our Utah health plan billed the state of Utah monthly for actual paid health care claims plus administrative fees. Prior to September 1, 2009, our receivable balance from the state of Utah included: (1) amounts billed to the state for actual paid health care claims plus administrative fees; and (2) amounts estimated for incurred but not paid claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid. Effective as of September 1, 2009, the Utah health plan's agreement with the state of Utah became a prepaid capitation contract, under which the plan is paid a fixed per member per month amount.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

California. Effective October 1, 2009, the state of California implemented a delivery payment as part of its Medicaid managed care payment methodology. Accordingly, the California health plan only receives delivery payments upon acceptance by the state of a delivery encounter. The substitution of this methodology for a portion of the state payment that was previously paid as part of monthly capitation has, combined with the increase in enrollment at the California health plan during 2009, increased that health plan's accounts receivable at December 31, 2009 when compared with December 31, 2008.

Michigan. Accounts receivable at our Michigan health plan increased at December 31, 2009 when compared with December 31, 2008 as a result of: (1) the state's notice that we would be receiving additional premium for the months of October and November 2009 in connection with a rate increase we received effective October 1, 2009; (2) the accrual of a performance bonus from the state of Michigan that was accrued at December 31, 2009 and received in January 2010; and (3) state delays in processing new born premiums at December 31, 2009.

Missouri. Effective October 1, 2009, the state of Missouri carved out the Medicaid pharmacy benefit from the payments made to Medicaid health plans contracted in that state and retained responsibility for administering that benefit. As a result, monthly revenue (and the related receivable) recorded by the Missouri health plan have decreased at December 31, 2009 when compared with December 31, 2008.

New Mexico Effective July 1, 2009, the New Mexico health plan began performing certain administrative services for that state's Medicaid program under a separate contract. Accounts receivable recorded in connection with that contract represent the majority of the increase in accounts receivable at the New Mexico health plan between December 31, 2008 and December 31, 2009.

Washington. More rapid collection of delivery payments due from the state has reduced the Washington health plan's accounts receivable at December 31, 2009 when compared with December 31, 2008.

8. Property and Equipment

A summary of property and equipment is as follows:

	December 31,	
	2009	2008
	(In thousands)	
Land	$ 3,524	$ 3,461
Building and improvements	41,476	25,047
Furniture, equipment and automobiles	54,898	47,074
Capitalized computer software costs	66,526	56,211
	166,424	131,793
Less: accumulated depreciation and amortization on building and improvements, furniture, equipment and automobiles	(50,911)	(42,056)
Less: accumulated amortization on capitalized computer software costs	(37,342)	(24,679)
	(88,253)	(66,735)
Property and equipment, net	$ 78,171	$ 65,058

The increase in property and equipment for the year ended December 31, 2009 was primarily due to the build out and commencement of operations of our new information technology data center in Albuquerque, New Mexico. Depreciation expense recognized for building and improvements, furniture, equipment and automobiles was $11.0 million, $9.0 million, and $8.5 million for the years ended December 31, 2009, 2008, and 2007, respectively. Amortization expense recognized for capitalized computer software costs was $14.2 million, $11.7 million, and $8.6 million for the years ended December 31, 2009, 2008, and 2007, respectively.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

9. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 11 years, and for provider networks is approximately 10 years. Amortization expense on intangible assets recognized for the years ended December 31, 2009, 2008, and 2007 was $12.9 million, $13.0 million, and $10.8 million, respectively. Based on the balances of our identifiable intangible assets as of December 31, 2009, we estimate that our intangible asset amortization expense will be $14.6 million in 2010, $13.4 million in 2011, $11.0 million in 2012, $7.8 million in 2013, and $7.0 million in 2014. The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses	$119,101	$ 51,246	$67,855
Provider networks	17,146	4,155	12,991
Balance at December 31, 2009	$136,247	$ 55,401	$80,846
Intangible assets:			
Contract rights and licenses	$114,219	$ 46,160	$68,059
Provider networks	14,548	3,474	11,074
Balance at December 31, 2008	$128,767	$ 49,634	$79,133

The changes in the carrying amount of goodwill and indefinite-lived intangible assets were as follows (in thousands):

Balance as of December 31, 2008	$113,466
Goodwill recorded for acquisition of Florida NetPASS	17,048
Goodwill adjustment related to acquisition of the Missouri health plan	2,894
Balance at December 31, 2009	$133,408

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

10. Restricted Investments

Pursuant to the regulations governing our subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities. Additionally, we maintain restricted investments as protection against the insolvency of

capitated providers. The following table presents the balances of restricted investments by health plan, and by our insurance company:

	December 31, 2009	December 31, 2008
	(In thousands)	
California	$ 368	$ 367
Florida	2,052	9,828
Insurance Company	4,686	4,718
Michigan	1,000	1,000
Missouri	503	506
New Mexico	15,497	9,670
Ohio	9,036	8,459
Texas	1,515	1,521
Utah	578	577
Washington	151	151
Other	888	1,405
Total	$36,274	$38,202

As of December 31, 2009, the Florida health plan's restricted investments decreased compared with the prior year due to the release of escrow funds relating to a settlement agreement with the state of Florida that was a component of the purchase price of NetPASS (see Note 4, "Business Purchase Transactions"). The increase in the New Mexico health plan's restricted investments over the same period was due primarily to an increase in premium revenue at the plan, a percentage of which is used to determine the restricted investment balance required by the state of New Mexico. Additionally, the state of New Mexico's calculation methodology changed to use gross premium revenue, rather than the net premiums after taxes and assessments, also resulting in an increase to the required balance.

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2009 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 35,408	$ 35,425
Due one year through five years	724	721
Due after five years through ten years	142	155
	$ 36,274	$ 36,301

11. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2009 and 2008. The negative amounts displayed for "*Components of medical care costs related to: Prior periods*" represent the amount by which our original estimate of claims and benefits payable at the

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31, 2009	2008
	(Dollars in thousands)	
Balances at beginning of period	$ 292,442	$ 311,606
Components of medical care costs related to:		
Current period	3,227,794	2,683,399
Prior periods	(51,558)	(62,087)
Total medical care costs	3,176,236	2,621,312
Payments for medical care costs related to:		
Current period	2,919,240	2,413,128
Prior periods	232,922	227,348
Total paid	3,152,162	2,640,476
Balances at end of period	$ 316,516	$ 292,442
Benefit from prior period as a percentage of:		
Balance at beginning of period	17.6%	19.9%
Premium revenue	1.4%	2.0%
Total medical care costs	1.6%	2.4%

The overestimation of our liability for claims and medical benefits payable at December 31, 2008 led to the recognition of a benefit from prior period claims development for the year ended December 31, 2009 totaling $51.6 million. The overestimation of the claims liability at our Michigan, New Mexico, Ohio, and Washington health plans was principally the cause of the recognition of a benefit from prior period claims development. This was partially offset by the underestimation of our claims liability at December 31, 2008 at our California health plan. The details were as follows:

- In Michigan, we underestimated the impact of a steep drop in claims inventory during December 2008, thereby overestimating our liability at December 31, 2008.
- In New Mexico, we overestimated at December 31, 2008 the ultimate amounts we would need to pay to resolve certain high dollar provider claims, thereby overestimating our liability at December 31, 2008.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008, thereby overestimating our liability at December 31, 2008.
- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008, thereby overestimating our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt of paper claims (as opposed to electronically submitted claims) would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

In 2008, overestimation of our claims liability, particularly at our Michigan and Washington health plans, at December 31, 2007 led to the recognition of a benefit from prior period claims development totaling $62.1 million, as follows:

- In Michigan, we overestimated the extent to which both catastrophic claims and state-mandated changes to the methodology used to pay outpatient claims had increased our liability at December 31, 2007.

- In Washington, we overestimated the extent to which state-mandated changes to hospital fee schedules implemented in August 2007 had increased our liability at December 31, 2007.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability. In 2009 and 2008 the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations as the amount of benefit recognized in each your was roughly consistent with that recognized in the previous year.

12. Long-Term Debt

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, so the remaining aggregate principal amount totaled $187.0 million as of December 31, 2009 (see further discussion below regarding the purchase program). The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

In May 2008, the FASB issued new standards relating to certain convertible debt instruments, which we adopted effective January 1, 2009 (see Note 1, "Basis of Presentation"). These standards require the proceeds from the issuance of such convertible debt instruments to be allocated between a liability component and an equity component, which we have done with respect to the Notes. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of December 31, 2009, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 57 months. The Notes' if-converted value did not exceed their principal amount as of December 31, 2009. We allocated $24.5 million, net of the impact of deferred taxes, to the equity component of the Notes, which amount continued to be the carrying amount of the equity component as of December 31, 2008. At December 31, 2009, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The slight reduction in the amount of the equity component was due to amounts recorded as a result of our purchase of $13.0 million face amount of the Notes during the first quarter of 2009 (described further below). The following table provides the details of the liability amounts recorded:

	As of December 30, 2009	As of December 31, 2008
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 200,000
Unamortized discount	(28,100)	(35,127)
Net carrying amount	$ 158,900	$ 164,873

	Years Ended December 31,		
	2009	2008	2007
	(In thousands)		
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate of 3.75%	$ 7,076	$ 7,500	$1,688
Amortization of the discount on the liability component	4,782	4,707	1,012
Total interest cost recognized	$11,858	$12,207	$2,700

Securities Purchase Program. Under the $25 million securities purchase program announced in January 2009, we purchased and retired $13.0 million face amount of the Notes during the first quarter of 2009. We purchased the Notes at an average price of $74.25 per $100 principal amount, for a total of $9.8 million, including accrued interest. The gain recognized during the quarter ended March 31, 2009 on the purchase of the Notes was $1.5 million, or approximately $0.04 per diluted share.

In March 2009, our board of directors authorized the purchase of up to an additional $25 million in aggregate of either our common stock or the Notes. The purchase program was funded with working capital, and common stock purchases were made from time to time on the open market or through privately negotiated transactions during

2009. The purchase program extended through December 31, 2009. See the details regarding the common stock purchases at Note 14, "Stockholders' Equity."

Credit Facility

In 2005, we entered into the Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2007, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for general corporate purposes.

Pending the closing of the acquisition of the HIM business and the effectiveness of the fourth amendment, interest rates on borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest expense, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2009 and 2008, there were no amounts outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of our California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2009, we were in compliance with all financial covenants in the Credit Facility. See Note 21, "Subsequent Events," for further discussion of our fourth amendment and fifth amendment of the Credit Facility, relating to a business purchase transaction announced in January 2010.

13. Income Taxes

The provision for income taxes consisted of the following:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Current:			
Federal	$ 9,421	$32,972	$36,171
State	3,901	6,916	3,073
Total current	13,322	39,888	39,244
Deferred:			
Federal	1,924	378	(3,955)
State	(2,498)	(490)	(338)
Total deferred	(574)	(112)	(4,293)
Change in valuation allowance	—	—	45
Total provision for income taxes	$12,748	$39,776	$34,996

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

A reconciliation of the effective income tax rate to the statutory federal income tax rate is as follows:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Taxes on income at statutory federal tax rate (35%)	$15,266	$34,782	$32,453
State income taxes, net of federal benefit	912	4,176	1,925
(Benefit) liability for unrecognized tax benefits	(3,315)	450	85
Other	(115)	368	533
Reported income tax expense	$12,748	$39,776	$34,996

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California enterprise zone credits.

During 2009, 2008, and 2007, tax-related benefits (deficiencies) on share-based compensation were $(718,000), $(292,000), and $853,000, respectively. Such amounts were recorded as adjustments to income taxes payable with a corresponding increase (decrease) to additional paid-in capital.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2009 and 2008 were as follows:

	December 31,	
	2009	2008
	(In thousands)	
Accrued expenses	$ 2,494	$ 6,785
Reserve liabilities	285	1,046
State taxes	1,151	172
Other accrued medical costs	1,628	1,724
Net operating losses	27	27
Unrealized (gains) losses	(408)	1,274
Unearned premiums	6,554	2,063
Prepaid expenses	(2,894)	(3,979)
Other, net	(80)	(41)
Deferred tax asset, net of valuation allowance — current	8,757	9,071
Accrued expenses	(281)	—
Reserve liabilities	2,501	1,684
State taxes	—	1,830
Other accrued medical costs	(866)	108
Net operating losses	237	971
Unrealized losses	1,480	199
Unearned premiums	(264)	—
Depreciation and amortization	(10,415)	(10,698)
Deferred compensation	6,817	5,876
Debt basis	(11,555)	(12,931)
Other, net	(160)	745
Valuation allowance	—	(695)
Deferred tax liability, net of valuation allowance — long term	(12,506)	(12,911)
Net deferred income tax liability	$ (3,749)	$ (3,840)

At December 31, 2009, we had federal and state net operating loss carryforwards of $344,000 and $3.8 million, respectively. The federal net operating loss begins expiring in 2011, and state net operating losses begin expiring in 2028. The utilization of the net operating losses is subject to certain limitations under federal and state law.

At December 31, 2009, we had California enterprise zone tax credit carryovers of $2.1 million which do not expire.

We have determined that as of December 31, 2008, $695,000 of deferred tax assets did not satisfy the recognition criteria. Accordingly, we recorded a valuation allowance of $695,000 as of December 31, 2008. The valuation allowance primarily related to the uncertainty of realizing certain Indiana state net operating loss carryforwards. We determined in 2009 that we would no longer file an Indiana state tax return, thus, rendering the state net operating loss carryover worthless. As such, we recorded a write-off of the deferred tax asset and corresponding valuation allowance relating to the Indiana state net operating loss carryover.

During 2008, $7.4 million of net deferred tax assets were established with a corresponding reduction to goodwill for certain acquired intangible assets in connection with the 2007 purchase of Mercy CarePlus.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Additionally during 2008, $2.2 million of deferred tax assets relating to the 2006 purchase of the Cape Health Plan were derecognized which resulted in a corresponding increase to goodwill under purchase accounting.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audit. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Gross unrecognized tax benefits at beginning of period	$(11,676)	$(10,278)	$ (4,355)
Increases in tax positions for prior years	(3,748)	(3,310)	(3,197)
Decreases in tax positions for prior years	6,804	2,682	1,527
Increases in tax positions for current year	—	(2,061)	(4,935)
Decreases in tax positions for current year	—	892	—
Settlements	4,355	—	202
Lapse in statute of limitations	137	399	480
Gross unrecognized tax benefits at end of period	$ (4,128)	$(11,676)	$(10,278)

As of December 31, 2009, we had $4.1 million of unrecognized tax benefits of which $3.4 million, if fully recognized, would affect our effective tax rate. We anticipate a decrease of $408,000 to our liability for unrecognized tax benefits within the next twelve-month period due to normal expiration of tax statutes.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2009, December 31, 2008, and December 31, 2007, we had accrued $75,000, $1.4 million and $638,000, respectively, for the payment of interest and penalties.

We may be subject to examination by the Internal Revenue Service ("IRS") for calendar years 2006 through 2009. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Missouri, and Michigan, for the years 2004 through 2009. Our subsidiary, HCLB, entered into a closing agreement with the IRS in December 2009 that successfully concluded with certainty the IRS examination of HCLB for the year ended May 2006.

14. Stockholders' Equity

Under the purchase program described in Note 12, "Long-Term Debt," we have purchased approximately 1.4 million shares of our common stock for $27.7 million (average cost of approximately $20.49 per share) during 2009. These purchases have increased diluted earnings per share for the year ended December 31, 2009 by $0.04. We have retired the $27.7 million of treasury shares purchased in 2009, and we have also retired $20.4 million of treasury shares that were purchased prior to 2009 ($48.1 million in aggregate). This resulted in the reduction of additional paid-in capital as of December 31, 2009, compared with December 31, 2008. Also in 2009, the treasury stock balance decreased as a result of the retirement of the $20.4 million of treasury shares purchased prior to 2009.

In April 2008, our board of directors authorized the purchase of up to $30 million of our common stock on the open market or through privately negotiated transactions, and then subsequently in July 2008, authorized the purchase of up to an additional one million shares of our common stock. We used working capital to fund the

purchases under these programs. The timing and amount of purchases were primarily made pursuant to a Rule 10b5-1 trading plans. Under these programs, we purchased approximately 1.9 million shares for an aggregate purchase price of $49.9 million (average cost of approximately $25.70 per share). These shares were subsequently retired in 2008.

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of securities, including common stock or debt securities, and up to 250,000 shares of our common stock, offered by selling stockholders. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

15. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $4.7 million, $3.9 million and $3.6 million in the years ended December 31, 2009, 2008, and 2007, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

16. Stock Plans

In 2002, we adopted the 2002 Equity Incentive Plan (the "2002 Plan"), which provides for the award of stock options, restricted stock, performance shares, and stock bonuses to the company's officers, employees, directors, consultants, advisors, and other service providers. The 2002 Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares eligible for issuance automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. There were 4.0 million shares reserved for issuance under the 2002 Plan as of January 1, 2009.

Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our 2002 Employee Stock Purchase Plan (the "ESPP"), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. Under the ESPP, we issued 120,300 and 86,400 shares of our common stock during the years ended December 31, 2009 and 2008, respectively. Beginning January 1, 2004, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares available for issuance under the ESPP automatically increased by 1% of total outstanding capital stock. The aggregate number of unissued common shares available for future grants under the 2002 Plan and the ESPP combined was 3.8 million as of December 31, 2009, and 3.9 million as of December 31, 2008.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table illustrates the components of our stock-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2009		2008		2007	
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock awards	$5,789	$ 3,589	$5,171	$ 3,206	$3,751	$ 2,335
Stock options (including expense relating to our ESPP)	1,696	1,052	2,640	1,637	3,437	2,139
Total	$7,485	$ 4,641	$7,811	$ 4,843	$7,188	$ 4,474

For both restricted stock and stock option awards, the expense is recognized over the vesting period, generally straight-line over four years. As of December 31, 2009, there was $12.2 million of unrecognized compensation cost related to unvested restricted stock awards, which we expect to recognize over a weighted-average period of 2.6 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 6% as of December 31, 2009. Also as of December 31, 2009, there was $0.9 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.3 years.

The total fair value of restricted shares vested during the years ended December 31, 2009, 2008, and 2007 was $3.2 million, $2.5 million, and $2.6 million, respectively. Unvested restricted stock activity for the year ended December 31, 2009 was as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested balance as of December 31, 2008	470,955	$ 31.95
Granted	425,000	$ 18.93
Vested	(163,700)	$ 30.52
Forfeited	(44,625)	$ 25.82
Unvested balance as of December 31, 2009	687,630	$ 24.64

No stock options were exercised during the year ended December 31, 2009; the total intrinsic value of stock options exercised during the year ended December 31, 2008 was nominal. The total intrinsic value of stock options exercised during the year ended December 31, 2007 amounted to $4.3 million. Stock option activity for the year ended December 31, 2009 was as follows:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value (000s)
Outstanding at December 31, 2008	665,339	$ 30.29		
Forfeited	(14,600)	$ 31.96		
Outstanding at December 31, 2009	650,739	$ 30.25	5.8	$ 288
Exercisable and expected to vest at December 31, 2009(a)	640,478	$ 30.22	5.8	$ 288
Exercisable at December 31, 2009	542,905	$ 29.92	5.5	$ 288

(a) Stock options exercisable and expected to vest at December 31, 2009 information is based on an estimated forfeiture rate of 13%.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following is a summary of information about stock options outstanding and exercisable at December 31, 2009:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31, 2009	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable at December 31, 2009	Weighted-Average Exercise Price
$4.50 - $27.49	164,170	4.0	$ 23.11	162,670	$ 23.10
$28.66 - $28.66	173,744	6.1	$ 28.66	173,744	$ 28.66
$29.17 - $30.05	9,350	5.9	$ 29.86	9,350	$ 29.86
$31.32 - $44.29	303,475	6.7	$ 35.03	197,141	$ 36.66
	650,739	5.8	$ 30.25	542,905	$ 29.92

The Black-Scholes valuation model was used to estimate the fair value of stock options at grant date (for options awarded in 2008 and 2007; no options were awarded in 2009) based on the assumptions noted in the following table. The risk-free interest rate is based on the implied yield on U.S. treasury zero coupon issues for the expected option term. The expected volatility is based on historical volatility levels of our common stock. Beginning in the first quarter of 2008, we used an expected term for each option award based on historical experience of employee post-vesting exercise and termination behavior. Prior to 2008, the expected option term of each award granted was calculated using the "simplified method" in accordance with Staff Accounting Bulletin No. 107. This change did not produce materially different valuation results for the stock options awarded in 2008. The assumptions disclosed below represent a weighted-average of the assumptions used for all of our stock option grants throughout each of the years presented.

	Year Ended December 31,	
	2008	2007
Risk-free interest rate	2.5%	4.5%
Expected volatility	45.3%	47.1%
Expected option life (in years)	4	6
Expected dividend yield	0%	0%
Grant date weighted-average fair value	$12.80	$16.37

17. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2009 and 2008, our carrying amount for this investment totaled $4.1 million and $3.6 million, respectively. During 2008, we advanced this provider $1.3 million, all of which was collected during 2009. For the years ended December 31, 2009, 2008, and 2007, we paid $21.8 million, $15.4 million, and $10.9 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $745,000, $242,000, and $157,000 for the years ended December 31, 2009, 2008, and 2007, respectively. We also had a capitation arrangement with Pacific Hospital, where we paid Pacific Hospital a fixed monthly fee per member. This contract was terminated by the parties effective August 31, 2009. Amounts paid to Pacific Hospital for capitated services totaled approximately $1.1 million, $3.8 million, and $4.8 million for the years ended

December 31, 2009, 2008, and 2007, respectively. We believe that both arrangements with Pacific Hospital are based on prevailing market rates for similar services.

18. Commitments and Contingencies

Leases

We lease office space, clinics, equipment, and automobiles under agreements that expire at various dates through 2018. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases consist of the following approximate amounts:

Year ending December 31,	(In thousands)
2010	$ 21,334
2011	20,761
2012	18,604
2013	15,183
2014	13,522
Thereafter	39,576
Total minimum lease payments	$ 128,980

Rental expense related to these leases totaled $20.8 million, $17.5 million, and $18.1 million for the years ended December 31, 2009, 2008, and 2007, respectively.

Employment Agreements

During 2001 and 2002, we entered into employment agreements with three current executives with initial terms of one to three years, subject to automatic one-year extensions thereafter. In most cases, should the executive be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for 18 months. If any of the executives are terminated for cause, no further payments are due under the contracts.

In most cases, if termination occurs within two years following a change of control, the employee will receive two times their base salary and termination bonus, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for three years.

Executives who receive severance benefits, whether or not in connection with a change of control, will also receive all accrued benefits for prior service including a termination bonus.

Legal Proceedings

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Professional Liability Insurance

We carry medical malpractice insurance for health care services rendered through our clinics in California. Claims-made coverage under this policy is $1.0 million per occurrence with an annual aggregate limit of $3.0 million for each of the years ended December 31, 2009, 2008, and 2007. We also carry claims-made managed care errors and omissions professional liability insurance for our health plan operations. This insurance is subject to a coverage limit of $15.0 million per occurrence and $15.0 million in the aggregate for each policy year.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $368.7 million at December 31, 2009, and $355.0 million at December 31, 2008. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Washington, and Utah have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2009, our health plans had aggregate statutory capital and surplus of approximately $377.7 million compared with the required minimum aggregate statutory capital and surplus of approximately $257.1 million. All of our HMOs were in compliance with the minimum capital requirements at December 31, 2009. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

19. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2009 and 2008.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	For The Quarter Ended			
	March 31, 2009	June 30, 2009	September 30, 2009	December 31, 2009
	(In thousands)			
Premium revenue	$857,484	$925,507	$ 914,805	$ 962,411
Operating income (loss)	24,115	20,726	16,274	(3,722)
Income (loss) before income taxes	20,700	17,503	12,995	(7,582)
Net income (loss)	12,211	14,565	8,564	(4,472)
Net income (loss) per share(1),(2):				
Basic	$ 0.46	$ 0.56	$ 0.34	$ (0.18)
Diluted	$ 0.46	$ 0.56	$ 0.33	$ (0.18)

	For The Quarter Ended			
	March 31, 2008(1)	June 30, 2008(1)	September 30, 2008(1)	December 31, 2008(1)
	(In thousands)			
Premium revenue	$729,638	$761,153	$ 791,554	$ 808,895
Operating income	24,451	30,258	30,429	27,467
Income before income taxes(3)	21,083	26,833	27,309	24,149
Net income(3)	12,475	15,823	16,480	14,820
Net income per share(1),(3):				
Basic	$ 0.44	$ 0.57	$ 0.60	$ 0.55
Diluted	$ 0.44	$ 0.56	$ 0.60	$ 0.55

(1) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2009 and 2008.

(2) For the quarter ended December 31, 2009, no potentially dilutive options or nonvested stock were included in the computation of our diluted loss per share because to do so would have been anti-dilutive for that period.

(3) The Company's consolidated statement of income for the year ended December 31, 2008 has been recast to reflect the adoption of ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

20. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2009 and 2008, and our condensed statements of income and condensed statements of cash flows for each of the three years in the period ended December 31, 2009.

Condensed Balance Sheets

	December 31, 2009	December 31, 2008(1)
	(In thousands except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 26,040	$ 42,776
Investments	3,002	9,745
Income tax receivable	—	3,119
Deferred income taxes	—	6,230
Due from affiliates	19,121	13,247
Prepaid and other current assets	11,435	10,228
Total current assets	59,598	85,345
Property and equipment, net	65,067	53,471
Goodwill	45,943	3,721
Investments	16,516	16,364
Investment in subsidiaries	545,731	568,224
Advances to related parties and other assets	16,742	19,379
	$749,597	$746,504
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 24,577	$ 24,595
Long-term debt	158,900	164,873
Deferred income taxes	10,769	12,530
Other long-term liabilities	12,613	12,744
Total liabilities	206,859	214,742
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized, outstanding 25,607 shares at December 31, 2009 and 26,725 shares at December 31, 2008	26	27
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	129,902	170,681
Accumulated other comprehensive loss, net of tax	(1,812)	(2,310)
Retained earnings	414,622	383,754
Treasury stock, at cost; 1,201 shares at December 31, 2008	—	(20,390)
Total stockholders' equity	542,738	531,762
	$749,597	$746,504

(1) The Registrant's condensed statement of financial position as of December 31, 2008, has been recast to reflect the adoption of FASB Accounting Standards Codification (ASC) Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Income

	Year Ended December 31,		
	2009	2008(1)	2007(1)
		(In thousands)	
Revenue:			
Management fees	$218,571	$190,361	$154,071
Other operating revenue	340	177	186
Investment income	1,540	2,733	2,915
Total revenue	220,451	193,271	157,172
Expenses:			
Medical care costs	26,865	21,759	22,042
General and administrative expenses	160,792	143,709	114,616
Depreciation and amortization	25,223	18,980	15,101
Total expenses	212,880	184,448	151,759
Gain on purchase of convertible senior notes	1,532	—	—
Operating income	9,103	8,823	5,413
Interest expense	(13,770)	(13,167)	(5,459)
Loss before income taxes and equity in net income of subsidiaries	(4,667)	(4,344)	(46)
Income tax (benefit) expense	(3,755)	(456)	1,963
Net loss before equity in net income of subsidiaries	(912)	(3,888)	(2,009)
Equity in net income of subsidiaries	31,780	63,486	59,735
Net income	$ 30,868	$ 59,598	$ 57,726

(1) The Registrant's condensed statements of income for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Operating activities:			
Cash provided by operating activities	$ 40,551	$ 17,532	$ 23,500
Investing activities:			
Net dividends from and capital contributions to subsidiaries	21,960	42,872	(16,890)
Purchases of investments	(3,844)	(25,515)	(74,604)
Sales and maturities of investments	12,669	56,833	29,946
Cash paid in business purchase transactions	(2,894)	(1,000)	(80,045)
Purchases of equipment	(32,245)	(33,047)	(20,159)
Changes in amounts due to and due from affiliates	(17,074)	(6,542)	2,887
Change in other assets and liabilities	(540)	3,170	1,192
Net cash provided by (used in) investing activities	(21,968)	36,771	(157,673)
Financing activities:			
Treasury stock purchases	(27,712)	(49,940)	—
Purchase of convertible senior notes	(9,653)	—	—
Proceeds from issuance of convertible senior notes	—	—	200,000
Repayments of amounts borrowed under credit facility	—	—	(45,000)
Payment of credit facility fees	—	—	(551)
Payment of convertible senior notes fees	—	—	(6,498)
Excess tax benefits from employee stock compensation	31	43	853
Proceeds from exercise of stock options and employee stock plan purchases	2,015	2,084	4,257
Net cash (used in) provided by financing activities	(35,319)	(47,813)	153,061
Net (decrease) increase in cash and cash equivalents	(16,736)	6,490	18,888
Cash and cash equivalents at beginning of year	42,776	36,286	17,398
Cash and cash equivalents at end of year	$ 26,040	$ 42,776	$ 36,286

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Notes to Condensed Financial Information of Registrant

Note A — Basis of Presentation

Molina Healthcare, Inc. (Registrant) was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The parent company-only financial statements should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B — Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2009, 2008, and 2007 for these services totaled $218.6 million, $190.4 million, and $154.1 million, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C — Capital Contribution and Dividends

During 2009, 2008, and 2007, the Registrant received dividends from its subsidiaries totaling $76.7 million, $91.5 million, and $39.0 million, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2009, 2008, and 2007, the Registrant made capital contributions to certain subsidiaries totaling $54.7 million, $48.6 million, and $55.9 million, respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D — Related Party Transactions

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because the Registrant has an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2009 and 2008, the Registrant's carrying amount for this investment totaled $4.1 million and $3.6 million, respectively. During 2008, the Registrant advanced this provider $1.3 million, all of which was collected during 2009. For the years ended December 31, 2009, 2008 and 2007, the Registrant paid $21.8 million, $15.4 million, and $10.9 million, respectively, for medical service fees to this provider.

The Registrant is a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $745,000, $242,000, and $157,000 for the years ended December 31, 2009, 2008, and 2007, respectively. The Registrant also had a capitation arrangement with Pacific Hospital, where the Registrant paid

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Pacific Hospital a fixed monthly fee per member. This contract was terminated by the parties effective August 31, 2009. Amounts paid to Pacific Hospital for capitated services totaled approximately $1.1 million, $3.8 million, and $4.8 million for the years ended December 31, 2009, 2008, and 2007, respectively. The Registrant believes that both arrangements with Pacific Hospital are based on prevailing market rates for similar services.

Note 21. Subsequent Events

Acquisition of HIM

On January 18, 2010, we entered into a definitive agreement to acquire the Health Information Management, or HIM, business of Unisys Corporation. The purchase price is expected to be approximately $135 million, subject to a standard working capital adjustment, to be paid in cash at closing using our credit facility. The acquisition, which is expected to close in the first half of 2010, is subject to customary regulatory approvals and closing conditions, including receipt of customer consents.

The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. Annual revenues of the HIM business are currently approximately $110 million. We expect the approximately 900 employees of the HIM business to become our employees upon closing of the transaction, and following the closing Unisys has agreed to provide certain transitional and technology support services to us for up to one year.

Subject to the closing of the HIM acquisition, in November 2009 we agreed to enter into a fourth amendment to the Credit Facility. The fourth amendment will become effective upon the closing of the acquisition of the HIM business. The fourth amendment is required because the $135 million purchase price for the HIM business exceeds the currently applicable deal size threshold under the terms of the Credit Facility. Pursuant to the fourth amendment, the lenders have consented to our acquisition of the HIM business.

Upon its effectiveness at the closing, the fourth amendment would increase the commitment fee on the total unused commitments of the lenders under the Credit Facility to 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans would be raised by 200 basis points at every level of the pricing grid. The applicable margins would thus range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. Until the delivery of a compliance certificate with respect to our financial statements for the quarter ending after the HIM business acquisition closes, the applicable margin shall be fixed at 3.5% for LIBOR loans and 2.5% for base rate loans. In connection with the lenders' approval of the fourth amendment, a consent fee of 10 basis points was paid on the amount of each consenting lender's commitment. In addition, the fourth amendment would carve out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the Notes (although the $187.0 million indebtedness would still be included in the calculation of our Consolidated Leverage Ratio); increase the amount of surety bond obligations we may incur; increase our allowable capital expenditures; and reduce the fixed charge coverage ratio from 3.50x to 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

On March 15, 2010, we agreed to enter into a fifth amendment to the Credit Facility. The fifth amendment will also become effective upon the closing of the acquisition of the HIM business. The fifth amendment is required because, after giving effect to the acquisition of the HIM business on a pro forma basis, and inclusive of the Company's fourth quarter 2009 EBITDA of only $5.9 million, the Company's consolidated leverage ratio for the preceding four fiscal quarters would exceed the currently applicable ratio of 2.75 to 1.0. The fifth amendment will increase the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if the Company has actually reduced its consolidated leverage ratio to no more than 2.75 to 1.0

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we will pay an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting during the three months ended December 31, 2009 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2009. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework.* Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2009, based on those criteria.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on page 109 of this Annual Report on Form 10-K, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2009.

Item 9B. ***Other Information***

On March 15, 2010, we agreed to enter into a fifth amendment to our Credit Facility. The fifth amendment will become effective upon the closing of the acquisition of the HIM business. The fifth amendment is required because, after giving effect to the acquisition of the HIM business on a pro forma basis, and inclusive of the Company's fourth quarter 2009 EBITDA of only $5.9 million, the Company's consolidated leverage ratio for the preceding four fiscal quarters would exceed the currently applicable ratio of 2.75 to 1.0. The fifth amendment will increase the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma

basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if the Company has actually reduced its consolidated leverage ratio to no more than 2.75 to 1.0 on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we will pay an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010.

The foregoing summary of the terms of the fifth amendment does not purport to be complete and is qualified in its entirety by reference to the fifth amendment, which is filed as Exhibit 10.22 hereto.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2009 and our report dated March 16, 2010 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2010

PART III

Item 10. *Directors, Executive Officers, and Corporate Governance*

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Proposal No. 1 — Election of Three Class II Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item X of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders. Such portion of the Proxy Statement is incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Corporate Governance," "Corporate Governance and Nominating Committee," "Corporate Governance Guidelines," and "Code of Business Conduct and Ethics." These portions of our Proxy Statement are incorporated herein by reference.

(d) Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Exchange Act requires our executive officers and directors, and persons who own more than 10% of a registered class of our equity securities, to file reports of ownership and changes in ownership with the SEC, and to furnish us with copies of the forms. Purchases and sales of our equity securities by such persons are published on our website at www.molinahealthcare.com. Based on our review of the copies of such reports, on our involvement in assisting our reporting persons with such filings, and on written representations from our reporting persons, we believe that, during 2009, each of our executive officers, directors, and greater than ten percent stockholders complied with all such filing requirements on a timely basis.

Item 11. *Executive Compensation*

The information which will appear in our Proxy Statement for our 2010 Annual Meeting under the captions "Compensation Committee Interlocks," "Non-Employee Director Compensation," and "Compensation Discussion and Analysis," is incorporated herein by reference. The information which will appear in our Proxy Statement under the caption "Compensation Committee Report" is not incorporated herein by reference.

The table below, which was inadvertently omitted from our 2009 Proxy Statement, shows the number of shares of restricted stock held by our named executive officers which vested during fiscal year 2008.

OPTION EXERCISES AND STOCK VESTED

	Option Awards		Stock Awards	
Name	Number of Shares Acquired On Exercise (#)	Value Realized on Exercise ($)	Number of Shares Acquired on Vesting (#)	Value Realized on Vesting ($)
J. Mario Molina	—	—	—	—
John C. Molina	—	—	—	—
Mark L. Andrews	—	—	1,387	43,899(1)
	—	—	1,000	24,680(2)
Terry Bayer	—	—	1,387	43,899(3)
James W. Howatt	—	—	550	18,431(4)
	—	—	625	19,781(5)
	—	—	763	21,707(6)

1. On March 1, 2008, 1,387 restricted shares vested in favor of Mr. Andrews at a closing market price of $31.65.
2. On July 1, 2008, 1,000 restricted shares vested in favor of Mr. Andrews at a closing market price of $24.68.
3. On March 1, 2008, 1,387 restricted shares vested in favor of Ms. Bayer at a closing market price of $31.65.
4. On February 9, 2008, 550 restricted shares vested in favor of Dr. Howatt at a closing market price of $33.51.
5. On March 1, 2008, 625 restricted shares vested in favor of Dr. Howatt at a closing market price of $31.65.
6. On May 29, 2008, 763 restricted shares vested in favor of Dr. Howatt at a closing market price of $28.45.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Information About Stock Ownership." This portion of the Proxy Statement is incorporated herein by reference. The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning certain relationships and related transactions will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Related Party Transactions." Information concerning director independence will appear in our Proxy Statement under "Director Independence." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Disclosure of Auditor Fees." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. *Exhibits and Financial Statement Schedules*

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The Company's consolidated financial statements, the notes thereto and the report of the Independent Registered Public Accounting Firm are on pages 60 through 108 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm
Consolidated Balance Sheets — At December 31, 2009 and 2008
Consolidated Statements of Operations — Years ended December 31, 2009, 2008, and 2007
Consolidated Statements of Stockholders' Equity — Years ended December 31, 2009, 2008, and 2007
Consolidated Statements of Cash Flows — Years ended December 31, 2009, 2008, and 2007
Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 16th day of March, 2010.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	March 16, 2010
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	March 16, 2010
/s/ Joseph W. White **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	March 16, 2010
/s/ Charles Z. Fedak **Charles Z. Fedak, CPA, MBA**	Director	March 16, 2010
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	March 16, 2010
/s/ Steven Orlando **Steven Orlando, CPA (inactive)**	Director	March 16, 2010
/s/ Sally K. Richardson **Sally K. Richardson**	Director	March 16, 2010
/s/ Ronna Romney **Ronna Romney**	Director	March 16, 2010
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	March 16, 2010

INDEX TO EXHIBITS

Number	Description	Method of Filing
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.2 to registrant's Form 8-K filed February 17, 2009.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2008.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2008.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2008.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	Form of Stock Option Agreement under 2002 Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.4	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.5	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.6	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.10	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.
10.11	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
10.12	Amended and Restated Employment Agreement with Mark L. Andrews dated as of December 31, 2009	Filed as Exhibit 10.3 to registrant's Form 8-K filed January 7, 2010.
10.13	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
10.14	Amended and Restated Change in Control Agreement with James W. Howatt, M.D., dated as of December 31, 2009	Filed as Exhibit 10.5 to registrant's Form 8-K filed January 7, 2010.
10.15	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
10.16	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.17	Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare, Inc., as the Borrower, certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed March 10, 2005.

Number	Description	Method of Filing
10.18	First Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of October 5, 2005, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed October 13, 2005.
10.19	Second Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of November 6, 2006, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 10-Q filed November 9, 2006.
10.20	Third Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of May 25, 2008, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 31, 2008.
10.21	Fourth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of _____, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent (date to be inserted on Fourth Amendment Effective Date)	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 19, 2010.
10.22	Fifth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of _____, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent (date to be inserted on Fifth Amendment Effective Date)	Filed herewith.
10.23	Office Lease with Pacific Towers Associates for 200 Oceangate Corporate Headquarters.	Filed as Exhibit 10.34 to registrant's Form 10-K filed March 17, 2008.
10.24	Hospital Services Agreement (fee-for-service) by and between Molina Healthcare of California, a California corporation, and Pacific Hospital of Long Beach	Filed herewith.
10.25	Hospital Services Agreement (capitation) by and between Molina Healthcare of California, a California corporation, and HealthSmart Pacific, Inc., dba Pacific Hospital of Long Beach	Filed herewith.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.

FIFTH AMENDMENT

THIS **FIFTH AMENDMENT** dated as of [_____ ___][1], 2010 (this "***Fifth Amendment***"), among **MOLINA HEALTHCARE, INC.**, a Delaware corporation (the "***Borrower***"), the Lenders (as defined below) party hereto, and **BANK OF AMERICA, N.A.**, as Administrative Agent (in such capacity, the "***Administrative Agent***") for the Lenders.

W I T N E S S E T H:

WHEREAS, the Borrower is a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005 (as amended by the First Amendment and Waiver dated as of October 5, 2005, the Second Amendment and Waiver dated as of November 6, 2006, the Third Amendment dated as of May 25, 2007 and the Fourth Amendment, and as otherwise amended, restated, supplemented or modified to but excluding the Fifth Amendment Effective Date, as hereinafter defined, the "***Existing Credit Agreement***"; and as hereby amended and otherwise amended, restated, supplemented or modified from time to time on or after the Fifth Amendment Effective Date, the "***Amended Credit Agreement***") among the Borrower, the lenders from time to time party thereto (the "***Lenders***"), Bank of America, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer, and the other agents, joint lead arrangers and joint book managers party thereto. Capitalized terms used and not otherwise defined herein shall have the meanings assigned to such terms in the Existing Credit Agreement; and

WHEREAS, the Borrower, the Required Lenders and the Administrative Agent previously executed and delivered the Fourth Amendment to the Existing Credit Agreement (the "***Fourth Amendment***"), pursuant to which the Required Lenders consented to certain amendments and to the Dakota Acquisition upon the terms and conditions set forth in the Fourth Amendment; and

WHEREAS, the Borrower has requested that in connection with the pending Dakota Acquisition the Administrative Agent and the Required Lenders amend and modify the Existing Credit Agreement as provided herein;

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1.01. Amendments to the Existing Credit Agreement.

(a) The definition of "Letter of Credit Sublimit" in Section 1.01 of the Existing Credit Agreement is hereby amended by replacing the reference to"$10 million" in clause (a) thereof with a reference to "$40 million".

(b) Section 1.01 of the Existing Credit Agreement is hereby amended by inserting the following definitions in alphabetical order:

[1] To be dated as of the Fifth Amendment Effective Date.

"Consolidated Leverage Ratio Reset Date" means either (x) August 15, 2010, if the Borrower has reduced its actual Consolidated Leverage Ratio to no more than 2.75 to 1.00 as of August 15, 2010 or (y) September 30, 2010, if the Borrower has not reduced its actual Consolidated Leverage Ratio to no more than 2.75 to 1.00 as of August 15, 2010.

"Fifth Amendment" means that certain Fifth Amendment, dated as of [_____ ___], 2010, among the Borrower, the Lenders party thereto and the Administrative Agent.

"Fifth Amendment Effective Date" has the meaning given such term in the Fifth Amendment.

(c) Section 2.06 of the Existing Credit Agreement is hereby amended by (i) numbering the existing paragraph as clause (a) and (ii) inserting the following new clause (b):

(b) The Aggregate Commitments shall be automatically, permanently and ratably reduced to $150,000,000 on the Consolidated Leverage Ratio Reset Date.

(d) Section 2.09 of the Existing Credit Agreement is hereby amended by inserting the following new clauses (c) and (d):

(c) Incremental Commitment Fee. The Borrower shall pay to the Administrative Agent for the account of each Lender in accordance with its Applicable Percentage, an incremental commitment fee equal to 0.125% per annum times the actual daily amount by which the Aggregate Commitments exceed the sum of (i) the Outstanding Amount of Loans and (ii) the Outstanding Amount of L/C Obligations; provided that for purposes of calculating such fee, Swing Line Loans will not be deemed to be utilized. The incremental commitment fee provided for in this clause (c) of Section 2.09 shall accrue at all times during the period from the Fifth Amendment Effective Date to the Consolidated Leverage Ratio Reset Date, including at any time during which one or more of the conditions in Article IV is not met, and shall be due and payable quarterly in arrears on the last Business Day of March and June during such period and on the Consolidated Leverage Ratio Reset Date.

(d) Duration Fee. If the actual Consolidated Leverage Ratio is not reduced to 2.75 to 1.0 or below as of August 15, 2010, the Borrower shall pay to the Administrative Agent for the account of each Lender in accordance with its Applicable Percentage a fee equal to 0.50% times the Aggregate Commitments, which fee shall be due and payable on August 15, 2010.

(e) Section 7.18(b) of the Existing Credit Agreement is hereby deleted in its entirety and replaced with the following:

(b) Consolidated Leverage Ratio. Permit the Consolidated Leverage Ratio at any time during any period set forth below to be greater than the ratio set forth below opposite such period.

Period	Maximum Consolidated Leverage Ratio
September 30, 2006 through September 30, 2009	2.75 to 1.00
October 1, 2009 through December 31, 2009	3.25 to 1.00
January 1, 2010 through but excluding the Consolidated Leverage Ratio Reset Date	3.50 to 1.00
Consolidated Leverage Ratio Reset Date and at all times thereafter	2.75 to 1.00

SECTION 1.02. Representations and Warranties. The Borrower hereby represents and warrants to the Administrative Agent and the Lenders, as follows:

(a) After giving effect to this Fifth Amendment, the representations and warranties of the Borrower contained in Article V of the Amended Credit Agreement or any other Loan Document or which are contained in any document furnished at any time under or in connection therewith are true and correct in all material respects on and as of the date hereof, (i) except to the extent such representations and warranties specifically refer to an earlier date, in which case they are true and correct in all material respects as of such earlier date, (ii) except the representations and warranties contained in subsections (a) and (b) of Section 5.05 of the Amended Credit Agreement shall be deemed to refer to the most recent financial statements furnished pursuant to subsections (a) and (b), respectively, of Section 6.01 of the Amended Credit Agreement and (iii) references to Schedules shall be deemed to refer to the most updated supplements to the Schedules furnished pursuant to subsection (b) of Section 6.02 of the Amended Credit Agreement.

(b) After giving effect to this Fifth Amendment, each of the Borrower and the other Loan Parties is in compliance with all the terms and conditions of the Amended Credit Agreement, as amended by this Fifth Amendment, and the other Loan Documents on its part to be observed or performed and no Default has occurred or is continuing under the Amended Credit Agreement.

(c) The execution, delivery and performance by the Borrower of this Fifth Amendment have been duly authorized by the Borrower.

(d) Each of this Fifth Amendment and the Amended Credit Agreement constitutes the legal, valid and binding obligation of the Borrower, enforceable against

the Borrower in accordance with its terms, except as enforceability may be limited by Debtor Relief Laws and by general equitable principles (whether enforcement is sought by proceedings in equity or at law).

(e) The execution, delivery, performance and compliance with the terms and provisions by the Borrower of this Fifth Amendment and the consummation of the transactions contemplated herein do not and will not: (i) contravene the terms of any of the Borrower's Organization Documents; (ii) conflict with or result in any breach or contravention of, or (except for the Liens created under the Loan Documents) the creation of any Lien under, (A) any material Contractual Obligation to which the Borrower is a party or (B) any order, injunction, writ or decree of any Governmental Authority or any arbitral award to which the Borrower or its property is subject or (C) violate any material Law, including, without limitation, state and Federal Laws relating to health care organizations and health care providers, except for such violations as could not reasonably be expected to have a Material Adverse Effect.

SECTION 1.03. Effectiveness. This Fifth Amendment shall become effective only upon satisfaction of the following conditions precedent (the first date upon which each such condition has been satisfied being herein called the "***Fifth Amendment Effective Date***"):

(a) The Administrative Agent shall have received duly executed counterparts of this Fifth Amendment which, when taken together, bear the authorized signatures of the Borrower, the Administrative Agent and the Required Lenders.

(b) The Fourth Amendment Effective Date (as defined in the Fourth Amendment) shall have occurred.

(c) The Administrative Agent shall have received duly executed counterparts of the Consent executed by each Guarantor in the form of Exhibit A hereto.

(d) The Borrower shall have certified in writing that the representations and warranties set forth in Section 1.03 hereof are true and correct on and as of such date.

(e) There shall exist no actions, suits, proceedings, claims or disputes pending or, to the Actual Knowledge of the Borrower, threatened, at law, in equity, in arbitration or before any Governmental Authority, by or against the Borrower or any of the Subsidiaries or against any of their respective properties or revenues or injunctions, writs, temporary restraining orders or other orders of any nature issued by any court or Governmental Authority that (i) purport to affect, pertain to or enjoin or restrain the execution, delivery or performance of this Fifth Amendment or the Amended Credit Agreement or any other Loan Document, or any transactions contemplated hereby or thereby or (ii) either individually or in the aggregate, in the case of any such suit, proceeding, claim or dispute which is reasonably likely to be adversely determined, either individually or in the aggregate, if determined adversely, could reasonably be expected to have a Material Adverse Effect.

(f) The Administrative Agent on behalf of the Lenders shall have received such other documents, instruments and certificates as they shall reasonably request and such other documents, instruments and certificates shall be satisfactory in form and substance to the Lenders and their counsel. All corporate and other proceedings taken or to be taken in connection with this Fifth Amendment and all documents incidental thereto, whether or not referred to herein, shall be satisfactory in form and substance to the Lenders and their counsel.

(g) The Borrower shall have paid in full (i) all expenses referred to in Section 1.06, and (ii) all fees due and payable as of the Fifth Amendment Effective Date under the Engagement Letter, dated as of March 8, 2010, among the Borrower, the Administrative Agent and Banc of America Securities LLC, including, without limitation, the 25.0 basis point Amendment Fee payable to each Lender that timely consents to this Fifth Amendment, calculated based upon the full amount of each consenting Lender's commitment.

SECTION 1.04. Lender Consent. For purposes of determining compliance with the conditions specified in Section 1.03, each Lender that has signed this Fifth Amendment shall be deemed to have consented to, approved or accepted or to be satisfied with, each document or other matter required thereunder to be consented to or approved by or acceptable or satisfactory to a Lender unless the Administrative Agent shall have received notice from such Lender prior to the proposed Fifth Amendment Effective Date specifying its objection thereto.

SECTION 1.05. APPLICABLE LAW. THIS FIFTH AMENDMENT SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK, EXCEPT TO THE EXTENT THAT THE FEDERAL LAWS OF THE UNITED STATES OF AMERICA MAY APPLY.

SECTION 1.06. Costs and Expenses. On the Fifth Amendment Effective Date, the Borrower shall pay all reasonable out-of-pocket costs and expenses of the Administrative Agent in connection with the preparation, execution and delivery of this Fifth Amendment and the other instruments and documents to be delivered hereunder (including, without limitation, the reasonable fees and expenses of counsel for the Administrative Agent) in accordance with the terms of Section 10.04(a) of the Amended Credit Agreement which are invoiced to the Borrower on or prior to the date payment would be due hereunder.

SECTION 1.07. Counterparts. This Fifth Amendment may be executed in any number of counterparts, each of which shall constitute an original but all of which when taken together shall constitute but one agreement. Delivery by facsimile or PDF by any of the parties hereto of an executed counterpart of this Fifth Amendment shall be as effective as an original executed counterpart hereof and shall be deemed a representation that an original executed counterpart hereof will be delivered, but the failure to deliver a manually executed counterpart shall not affect the validity, enforceability or binding effect of this Fifth Amendment.

SECTION 1.08. Existing Credit Agreement. Except as expressly set forth herein, the amendment provided herein shall not, by implication or otherwise, limit, constitute a waiver of, or otherwise affect the rights and remedies of the Lenders or the Administrative Agent under the Existing Credit Agreement or any other Loan Document, nor shall it constitute a waiver of any Default, nor shall it alter, modify, amend or in any way affect any of the terms, conditions, obligations, covenants or agreements contained in the Existing Credit Agreement or any other

Loan Document. The amendments provided herein shall apply and be effective only on the Fifth Amendment Effective Date and only with respect to the provisions of the Existing Credit Agreement specifically referred to by such amendments. Except to the extent a provision in the Existing Credit Agreement is expressly amended herein, the Existing Credit Agreement shall continue in full force and effect in accordance with the provisions thereof.

[Signature pages follow]

IN WITNESS WHEREOF, the parties hereto have caused this Fifth Amendment to be duly executed by their duly authorized officers, all as of the date first above written.

MOLINA HEALTHCARE, INC., a Delaware corporation, as the Borrower

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

BANK OF AMERICA, N.A., as Administrative Agent

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

BANK OF AMERICA, N.A., as a Lender, Swing Line Lender and L/C Issuer

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

CIBC INC., as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

CITICORP NORTH AMERICA, INC., as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

U.S. BANK NATIONAL ASSOCIATION, as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

UBS LOAN FINANCE LLC, as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

HARRIS N.A., as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

UNION BANK, NATIONAL ASSOCIATION, as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

EAST WEST BANK, as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

JPMORGAN CHASE BANK, N.A., as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

CITY NATIONAL BANK, as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

JEFFERIES FINANCE LLC, as Lender

By: _____

Name: _____

Title: _____

Fifth Amendment to Credit Agreement
Signature Page

EXHIBIT A
to
Fifth Amendment

FORM OF
CONSENT

This **CONSENT**, dated as of [_____] [___], 2010 (this "***Consent***"), to the Agreement referred to below is delivered by each of the undersigned (each a "***Guarantor***").

W I T N E S S E T H:

WHEREAS, in connection with the transactions contemplated by the Amended and Restated Credit Agreement, dated as of March 9, 2005 among Molina Healthcare, Inc. (the "***Borrower***"), the lenders from time to time party thereto (the "***Lenders***"), Bank of America, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer (the "***Administrative Agent***"), and the other agents, joint lead arrangers and joint book managers party thereto, as amended by the First Amendment and Waiver dated as of October 5, 2005, the Second Amendment and Waiver dated as of November 6, 2006, and the Third Amendment dated as of May 25, 2007, and as may be amended by the Fourth Amendment upon its effectiveness, should it become effective, (the "***Existing Credit Agreement***") each Guarantor has executed and delivered to the Administrative Agent and the Lenders that certain Subsidiary Guaranty dated as of March 9, 2005 (as amended or otherwise modified from time to time, the "***Subsidiary Guaranty***");

WHEREAS, the Borrower, the Lenders and the Administrative Agent have entered into the Fifth Amendment dated as of the date hereof (the "***Fifth Amendment***"; capitalized terms not otherwise defined herein to have the meanings provided in the Fifth Amendment and in the Existing Credit Agreement) to amend certain provisions in the Existing Credit Agreement; and

WHEREAS, it is a condition of effectiveness of the Fifth Amendment that each Guarantor deliver to the Administrative Agent and the Lenders an executed counterpart of this Consent;

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, each Guarantor hereby agrees, as follows:

1. each Guarantor consents and agrees to the terms of (a) the Fifth Amendment and (b) the Existing Credit Agreement, as amended by the Fifth Amendment (the "***Amended Credit Agreement***"); and

each Guarantor confirms and agrees that notwithstanding the effectiveness of the Fifth Amendment, the Subsidiary Guaranty is, and shall continue to be, in full force and effect and is hereby ratified and confirmed in all respects, except that, on and after the effectiveness of the Fifth Amendment, each reference in the Subsidiary Guaranty to the "Credit Agreement", "thereunder", "thereof" or words of like import shall mean and be a reference to the Amended Credit Agreement.

IN WITNESS WHEREOF, the undersigned have caused this Consent to be executed by their respective officers thereunto duly authorized, as of the date first above written.

[INSERT GUARANTORS' NAMES]

By: _____
Name:
Title:

Exhibit A
A-2

MOLINA HEALTHCARE OF CALIFORNIA

HOSPITAL SERVICES AGREEMENT

This Hospital Services Agreement ("Agreement") is entered by and between Molina Healthcare of California, a California corporation ("Health Plan"), and **Pacific Hospital of Long Beach.**

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE — DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B.

ARTICLE TWO — PROVIDER OBLIGATIONS

2.1 Serving as a Panel Provider. Provider shall provide hospital inpatient and/or outpatient services to Members for the products specified in Attachment C. Provider agrees that its facility information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material

made available to the public and Members. Facility Information includes, but is not limited to, name, address, telephone number, hours of operation, and services. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care.**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member as an inpatient or outpatient, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Provider shall notify Health Plan or its agent within twenty-four (24) hours of admission and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan's notification procedures described in the Provider Manual for all inpatient admissions (acute, rehabilitation, mental health and SNF) including admissions resulting from an outpatient visit, and Provider shall notify Health Plan of any admission within twenty-four (24) hours of admission.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

g. **Availability of Services.** Provider shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

h. **Hospital Services** are those Plan benefits to include short term inpatient or outpatient general hospital services including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, emergency services, drugs, including drugs to be dispensed at time of emergency room visit in amount sufficient to last until such time Member can reasonably be expected to fill a prescription, medications, biological, anesthesia and oxygen services, ambulatory care services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

2.3 **Standards for Hospital Providers.**

a. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Provider's contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information.** Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the

provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(s) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.

e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's contracted providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider's medical staff and the bylaws, rules and regulations of Provider.

f. **Notification.** Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider's notification to Health Plan shall state Provider's actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the

same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **National Provider Identification ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider shall obtain an NPI from the National Plan and Provider Enumeration System ("NPPES")

for itself or for any subpart of the Provider. Provider shall make best efforts to report its NPI and any subparts to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider shall use its NPI to identify itself on all claims and encounters (both electronic and paper formats) submitted to Health Plan.

Delivery of Patient Care Information. Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify,

confirm, and/or assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.

e. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Promotional Activities.** At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) shall cooperate with and participate in all reasonable Health Plan's marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.8 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act

(42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider shall deliver copies of such insurance policies to Health Plan within five business days of a written request by Health Plan.

2.9 **Claims Payment**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within ninety (90) days of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments and Deductibles.** Provider is responsible for collection of co- payments and deductibles, if any.

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.

e. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan, who receives a global capitation from Health Plan for both professional and facility services and is responsible for arranging for Covered Services through subcontract arrangements ("Capitated Provider"), that Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

2.10 **Claims Review.**

a. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider's intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider's operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in a one (1) day admission, Health Plan reserves the right to retrospectively review such claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition. Health Plan will not retrospectively deny payment for any services rendered by Provider in good faith pursuant to the prior authorization of Health Plan.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or

prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless Provider's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.

c. **Reporting Requirements.** Provider's failure to comply with Health Plan's requirements regarding Provider's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.

d. **Offset.** In the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days notice in which to exercise Provider's appeal rights under this Agreement. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

e. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits.

Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

2.11 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to state licensing statutes and regulations set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.

c. Provider acknowledges that all Covered Services rendered in conjunction with the Medicare program are subject to the Medicare provisions set forth in Attachment H, the effect of which provisions is limited solely to activities and Covered Services related to the Medicare program.

2.12 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.13 **Fraud and Abuse Reporting.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to

and during the course of any such investigations.

2.14 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self- Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2. **Reciprocity Agreements.** Provider shall cooperate with Health Plan's Participating Providers and affiliates of Health Plan and agrees to provide Covered Services to Members enrolled in various government sponsored health programs and other health products, and various government sponsored health programs and other health products of affiliates, and to assure reciprocity of health care services. Without limiting the foregoing, if any Member receives services or treatment constituting Covered Services from Provider and a capitated Participating Provider is financially responsible for such services, such Participating Provider shall be solely responsible for compensating Provider for any Covered Services provided by the Provider in accordance with the applicable Payments which are the Responsibility of a Capitated Provider provisions of this Agreement. Payment by the Participating Provider shall be at; (i) the rates agreed by the Participating Provider and Provider, or (ii) if there is no applicable agreement, at the lesser of Provider's billed charges or an amount equivalent to one hundred percent (100%) of the governing rates provided by applicable State and Federal Law specific to the Member's enrolled benefit plan (i.e. Medicaid, Medicare, etc) in place at the time services are rendered, or (iii) at the election of the Participating Provider, at the rates set forth in this Agreement. Provider agrees that the applicable provisions of the Compensation section of this Agreement shall continue to be binding upon Provider, especially in that Provider shall not balance bill Members for any Covered Services. Provider shall comply with the procedures established by Health Plan or its affiliates and this Agreement for reimbursement of such services or treatment. Provider shall not encourage Members to receive Covered Services from non-Participating Providers. Breach of this section shall constitute breach of a material term of the Agreement and will give rise to cause for termination of this Agreement pursuant to the applicable Termination with Cause provisions of this Agreement. Provider shall abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

ARTICLE THREE — HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member

eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be in the interest of the Member.

3.5 **Provider Directory.** Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of both the; (i) medical, and (ii) medically-related scientific and technical, aspects of Health Plan.

ARTICLE FOUR — TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for one year; thereafter, it shall automatically renew for successive one year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable provisions set forth in the attachments.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least one hundred and twenty (120) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty

(30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4. **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

e. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

f. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise is terminated as a provider by any state or federal health care program;

g. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

h. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.

ARTICLE FIVE — GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees,

agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The contract between the state and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend this Agreement only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without

the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5. **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules then in effect by a single arbitrator in Long Beach, CA; provided, however, that binding arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters. If possible, the arbitrator shall be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor shall the arbitrator have the authority to award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement

Attachment A — Provider Identification Sheet
Attachment B — Definitions
Attachment C — Products/Programs
Attachment D — Compensation Schedule
Attachment E — Licensing Provisions
Attachment F — Medicaid Program Provisions
Attachment G — Acknowledgment of Receipt of Provider Manual
Attachment H — Medicare Program Provisions
Attachment I — Disclosure Form
Attachment J — Certificate of Ownership

5.10 **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:
Molina Healthcare of California
200 Oceangate, Suite 100, Long Beach, California, 90802
Attention: President/CEO

If to Provider:
Pacific Hospital of Long Beach

Attention: Michael D Drobot, CEO

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

***** THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK *****

SIGNATURE AUTHORIZATION

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth by Health Plan below. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

Pacific Hospital of Long Beach		**Molina Healthcare of California**	
Provider Signature:	/s/ M. Drobot	Molina Signature:	/s/ Lisa Rubino
Signatory Name (Printed):	M. Drobot	Signatory Name (Printed):	Lisa Rubino
Signatory Title (Printed):	CEO	Signatory Title (Printed):	President
Signature Date:	4/16/09	Signature Date:	4/30/09
		Effective Date:	(To be completed by Health Plan)

ATTACHMENT A

Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

_____ Primary Care Physician _____

_____ Specialist: type _____

_____

_____ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)

__X__ Hospital _____

_____ Ancillary Provider: type _____

_____ Pharmacy _____

_____ Other: type _____

Please enter "N/A" for the following if not applicable or not available:

Provider Name	Pacific Hospital of Long Beach	Billing Address:
Telephone No.	562-997-2500	P O Box 77417, Los Angeles, CA, 90084
Facsimile No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.		_____
NPI (or UPIN if NPI not yet designated)	NPI: 1861407637 UPIN:	
DEA No.		

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

Provider Signature:	/s/ M. Drobot
Signatory Name (Printed):	M. Drobot
Signatory Title (Printed):	CEO
Signature Date:	4/16/09

ATTACHMENT A
Provider Identification Sheet (Continuation Page)

U[illegible]e or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of th[illegible] are expected to bill Health Plan under more than one TIN and/or billing address. Please enter "N/A" for the following if not applicable or not available:

Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
Email Address		State, Zip ,
Tax I.D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,

Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
Email Address		State, Zip ,
Tax I.D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,

Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
E[illegible] Address		State, Zip ,
T[illegible]D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,

Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
Email Address		State, Zip ,
Tax I.D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,

ATTACHMENT B

Definitions

1. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.
2. **Agreement** means this Provider Services Agreement, all Attachments, and incorporated documents or materials.
3. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.
4. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
5. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.
6. **CMS Agreement** means the Medicare Advantage contract between Health Plan and CMS.
7. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.
8. **Emergency Services are Covered Services** necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid / Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.
9. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.

10. **Health Plan** means Molina Healthcare of California

11. **HEDIS Studies** means Health Employer Data and Information Set.

12. **IPA** means Independent Practice Association.

13. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

14. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

15. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D services.

16. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

17. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

18. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a Group/IPA or Hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Group/IPA or Hospital. All of said persons are bound by the terms of this Agreement.

19. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

20. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

21. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

22. **Utilization Management Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event that Provider is de-delegated responsibility for utilization management.

ATTACHMENT C

Products/Programs

Provider hereby elects to participate as a panel provider for each of the following Health Plan products as offered and applicable.

____ 1. Medi-Cal Primary Care Case Manager

____ 2. Medi-Cal Prepaid Health Plan

____ 3. Medi-Cal Geographic Managed Care

__X__ 4. Medi-Cal Two-Plan Model

__X__ 5. Healthy Families

__X__ 6. Medicare Advantage (Molina Medicare Options)

__X__ 7. MA-SNP (Molina Medicare Options Plus)

____ 8. Other Products — Provider agrees that Health Plan may from time to time add additional products for which provider agrees to participate as a contracted provider

Health Plan shall maintain any applicable benefit and Covered Services descriptions in its Provider Manual.

ATTACHMENT D

Compensation Schedule
Pacific Hospital of Long Beach
Medi-Cal & Healthy Families

Molina shall pay Provider on a fee for service basis at the lesser of: (i) Provider's billed charges; or (ii) in accordance with the fee schedule set forth below for all Covered Services provided to a Member, which are authorized, by Molina or its designee for Molina Healthcare's Managed Medi-Cal & Healthy Family Members, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

SERVICE DESCRIPTION	APPLICABLE CODES (if designated)	PAYMENT RATES
Medical/Surgical	UB: 100, 101, 110, 111, 112, 117, 119, 120, 121, 127, 129, 130, 131, 132, 137, 139, 140, 141, 142, 147, 149, 150, 151, 152, 157, 159, 160, 164, 169,	$1,200 Per Diem
DOU	UB: 206, 214	$1,200 Per Diem
ICU/CCU	UB: 200, 201, 202, 207, 208, 209, 210, 211, 213, 219	$1,300 Per Diem
OB Vaginal Delivery 2 days	DRG's 767, 768, 774, 775 includes One well baby defined by UB codes 170 or 171 Additional baby is Reimbursed at Boarder Baby Rate	$2,400 Case Rate
OB C-Section 3 days	DRG-765, 766 includes one well baby defined by UB codes 170-or 171	$3,600 Case Rate
Outpatient Diagnostic Services/Emergency Room Procedures	UB: 300-319, UB: 320-359, UB: 610-619; UB: 730-749, UB: 450-459, UB: 351, 352, 359	105% of Medi-Cal
Outpatient Surgery	UB: 360, 361, 369, 490, 499, 500	100% of applicable APC. Multiple procedures shall be reimbursed according to the Medicare guidelines.
Partial Psych Care	UB: 114, 124, 134, 154, 513	$600.00 Case Rate
Exclusions	UB: 274, 275, 276, 278	The following items with a cost greater than $500.00 are excluded from the rates above and shall be reimbursed at a rate of Hospital Cost plus 5%: Implantable devices (including non-reusable orthopedic instrumentations, spinal cages, alugraphs, putty, pacemakers, leads, orthotics and prosthetics.

ATTACHMENT D-1

Compensation Schedule

Pacific Hospital of Long Beach
Molina Medicare Options (MMO) &
Molina Medicare Options Plus (MMOP)

Molina shall pay Provider on a fee for service basis at the lesser of: (i) Provider's billed charges; or (ii) in accordance with the fee schedule set forth below for all Covered Services provided to a Member, which are authorized, by Molina or its designee for Molina Healthcare's Managed Molina Medicare Options & Molina Medicare Options Plus Members, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

INPATIENT SERVICES:
Inpatient Services with Codable Medicare DRGs:

- Health Plan agrees to reimburse Provider **one hundred percent (100%)** of the prevailing Medicare Inpatient Prospective Payment System **(DRG)** in effect at the time of service. Such Medicare DRG reimbursement will include DME, IME, DSH, Capital, and all other Medicare payments, including outliers.
- This reimbursement methodology is not intended to imply any governance or regulations set forth by Centers of Medicare and Medicaid Services (CMS), but is used to describe the type of mathematical reimbursement formula agreed upon by Provider and Health Plan.
- Provider uses its Fiscal Intermediary to administer their Medicare program. The Fiscal Intermediary calculates and updates factors used in the calculation of the Medicare reimbursement formulas, which will be adopted for use in this Agreement. Any change in the reimbursement formula factors, including, but not limited to, changes in DRG definitions to comply with industry mandated standards, will be applicable to the reimbursement set forth in this Agreement, effective concurrently with the effective date of updates to the Inpatient PPS PC Pricer.

OUTPATIENT SERVICES

- Health Plan agrees to reimburse Provider at **one hundred percent (100%)** of the prevailing Medicare Ambulatory Payment Classification **(APC)** in effect at the time services are rendered.

ARTICLE FIVE — NOTATIONS

6.1 Capitalized terms utilized in this Attachment, which are not otherwise defined in this Attachment, if any, shall have the same meaning set forth in the definitions to this Agreement.

6.2 Unless otherwise set forth above, the stipulated Hospital Provider payment rates shall apply to all Professional Clean Claims submitted by Hospital Providers.

4/16/09

ATTACHMENT E

REQUIRED PROVISIONS

(Health Care Service Plans)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

DMHC Provisions

1. In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan. Provider shall not collect or attempt to collect from a Member or subscriber any sums owed to Provider by the Health Plan. Provider may not and will not maintain any action at law against a Member or subscriber to collect sums owed to the Provider by Health Plan. (Health and Safety Code section 1379)
2. To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system. (Rule 1300.51, J-5)
3. Provider is responsible for coordinating the provision of health care services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))
4. Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))
5. Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))
6. To the extent Provider has any role in rendering emergency health care services, Provider shall make such emergency health care services available and accessible twenty-four (24) hours a day, seven days a week. (Rule 1300.67.2(c))
7. Provider shall participate in Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or ability to maintain Health Plan's access standards. (Rule 1300.67(f))

8. Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 of the Health and Safety Code), and the Regulations promulgated hereunder (subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulation that is required to be in this Agreement shall bind the Health n whether or not expressly set forth in this Agreement. (Rule 1300.67.4(a)(9))

9. Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Section 1345 of the Health and Safety Code) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code section 1373.96) (Rule 1300.67.4(a)(10))

10. Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f)

11. Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least two years: this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code section 1381) (Rule 1300.67.8(b))

12. Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c))

13. Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services. Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and

offsetting the cost of the same against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))

14. Upon Health Plan's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code section 1385)

15. To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)

16. Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Provider Services Department, Molina Medical Centers, Third Floor, One Golden Shore Drive, Long Beach, CA 90802 (800) 526-8196, ext. 1249. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)

17. Provider shall display in each reception and waiting area a notice informing Members how to contact their health plan, file a complaint with their plan, obtain assistance from the DMHC, and seek an independent medical review. (Rule 1300.67.8(f))

18. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68(b))

19. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code section 3040.

20. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend the Provider Manual only after forty-five (45) business days prior written notice to Provider and only if

mutually agreed to by the parties as evidenced by the amendment being executed by each party.

21. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider is not the primary payer under coordination of benefits, Provider may submit claims to Health Plan or Health Plan's capitated provider within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

22. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider denies a claim because it was filed beyond the claim filing deadline, Health Plan will, upon Provider's submission of a provider dispute pursuant to Title 28, California Code of Regulations, section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to California Health & Safety Code section 1371 or 1371.35, which ever is applicable, and the California Code of Regulations.

ATTACHMENT F

DHCS Provisions

following provisions apply exclusively to Covered Services provided and activities engaged in pursuant to Medicaid Program:

1. All Medicaid covered services are set forth in Attachment C and the Provider Manual as set forth in this Agreement. (Rule 53250(c)(1))
2. This Agreement shall be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Health Plan. (Rule 53250(c)(2))
3. This Agreement shall become effective upon approval by the Department of Health Care Services ("DHCS") in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within 60 days of receipt. (Rule 53250(c)(3))
4. Amendments to this Agreement shall be submitted to the DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the Amendment, whichever is later. (Rule 53250(c)(3))
5. Provider agrees to submit all reports required and requested by Health Plan, in a form acceptable to Health Plan. (Rule 53250(c)(5))
6. Provider shall make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:
   a. By the DHCS, the United States Department of Health and Human Services, the DMHC, and the Department of Justice;
   b. At all reasonable times, at Provider's place of business or at such other mutually agreeable location in California;
   c. In a form maintained in accordance with the general standards applicable to such book or record keeping;
   d. For a term of at least five years from the close of the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created;

e. Including all encounter data for a period of at least five years. (Rule 53250(e)(1))

7. Provider agrees to notify the DHCS in the event that this Agreement is amended or terminated. Notice to the DHCS shall be considered given when properly addressed and deposited in the United States Postal Service as First Class Registered Mail, postage attached. (Rule 53250(e)(4))

8. Provider shall maintain and make available to the DHCS, upon request, copies of all subcontracts and shall ensure that all subcontracts are in writing and require that subcontractors:

   a. Make all applicable books and records available at all reasonable times for inspection, examining or copying by the DHCS, the U.S. Department of Health and Human Services, the DMHC, and the Department of Justice;

   b. Retain such books and records for a term of at least five years from the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created. (Rule 53250(e)(3))

9. Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. (Rule 53250(e)(5))

10. Provider agrees to hold harmless both the State of California and Health Plan members in the event that Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. (Rule 53250(e)(6))

11. Provider shall assist Health Plan in the transfer of care in the event Health Plan's Two-Plan Model Contract with the DHCS expires or terminates. Providers shall assist Health Plan in the transfer and care in the event this Agreement expires or terminates for any reason.

12. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers' compensation. Provider shall report to the DHCS within ten (10) days after discovery any circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation award. (Rule 53222(b))

13. Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider, if any, and major creditors holding more than five percent (5%) of the dept of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (W&I Code section 14452(a))

14. Provider acknowledges that Health Plan bears significant risk by assuming financial responsibility for all in-patient hospitalization expenditures, including expenditures for services connected with the period of hospitalization. (Rule 53251(c) & (e))

15. Non-Discrimination Clause. During the performance of this Agreement, Provider and Provider's subcontractors will not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and denial of family care leave. Provider and Provider's subcontractors will ensure the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. Provider and Provider's subcontractors will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et. seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990(a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and Provider's subcontractors as the case may require will give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

16. Provider agrees to arrange for the provision of interpreter services for Members at all provider sites.

17. Nothing in this Agreement shall be interpreted in any manner to terminate or diminish Health Plan's independent obligations to the State of California under one or more of its contracts with the Department of Health Services.

Upon request by DHCS, Provider shall timely gather, preserve and provide to DSHS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan's contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms

specified in Health Plan's contract with DHCS.

ATTACHMENT G

Acknowledgement of Receipt of Provider Manual

Provider hereby acknowledges receipt of Health Plan's Provider Manual.

Date of receipt: 4|16|09

Initials of authorized
representative of Provider: /s/ Michael D. Drobot

HSA — Hospital Services Agreement

Molina ECMS ref# 729
MHC v122706 / MHI v091707
Pacific Hospital of Long Beach

Provider or authorized
representative's initials: _____

ATTACHMENT H

Medicare Program Provisions

The following provisions apply to all services rendered in conjunction with Health Plan's Medicare Programs as set forth in Attachment C to this Agreement. The Agreement shall be automatically modified to conform to subsequent amendments to Medicare standards. Any purported modification to the Agreement inconsistent with Medicare standards is not effective. In the event of any inconsistency between the terms of this Attachment and the terms of the Agreement, the terms of this Attachment shall control.

1. Right to Audit. Provider shall make all of its "Relevant Records" available for inspection, examination and copying by all federal and state agencies with regulatory authority over the subject matter of this Agreement. Provider shall permit such inspection at Provider's place of business and at all reasonable times. "Relevant Records" shall mean all books and records of Provider related directly or indirectly to the goods and services furnished under the terms of this Agreement. Provider shall maintain such Relevant Records for the period of time required by applicable federal and state statutes, but in no event less than ten (10) years. This provision shall survive termination of the Agreement. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

2. Confidentiality. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

3. Hold Harmless. Provider agrees that under no circumstance shall a subscriber or enrollee be liable to the Provider for any sums owed by Health Plan to the Provider. (42 CFR 422.504(g)(1)(i).

4. Delegation. If Provider is delegated any of the activities or functions of Health Plan as required in the CMS Agreement, Provider agrees to comply with all applicable contractual provisions in the same manner as if Provider had executed such contract with CMS directly. The activities or functions delegated to Provider are set forth in the Agreement. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. Health Plan shall monitor the performance of such delegated activities on an ongoing basis, and Provider shall cooperate with all reasonable requests made by Health Plan in order to accomplish such monitoring. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or

terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(3)(iii), 422.504(i)(4)) and 422.504(i)(5).

5. Medicare Claims Payment. Health Plan and Provider agree that Health Plan shall pay all Clean Claims within sixty (60) days of the date such claim is delivered by Provider to Health Plan and Health Plan determines such claim is complete/clean. Any claims that are not submitted to Health Plan within six (6) months of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. Health Plan shall pay interest on Clean Claims that are not paid within sixty (60) days for the period beginning on the day after the required payment date and ending on the date on which payment is made. Interest shall be computed at the rate of interest provided under 41 U.S.C. §611. (42 CFR 422.520(b)).
6. Reporting. Provider shall comply with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 422.257. (42 CFR 504(a)(8)).
7. Accountability. Provider acknowledges and agrees that Health Plan is accountable to CMS for overseeing any functions or responsibilities delegated to Provider. (42 CFR 422.504(i)(3)(ii)(A)).
8. Medicare Compliance. Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).
9. Benefit Continuation. Notwithstanding the termination of the Provider Agreement, Provider shall not abandon any Medicare patients, and shall continue to see and treat those patients requiring ongoing medical care (including, but not limited to, patients that are hospitalized on the termination date of the Provider Agreement) on the same terms and conditions as prior to termination, and shall continue to see and treat such ongoing patients until such time as such patients may be transitioned to another appropriate medical provider (or, if applicable, such patients are discharged from the hospital). (42 CFR 422.504(g)(2)(I), 422.504(g)(2)(ii), and 422.504(g)(3)).

ATTACHMENT I

DISCLOSURE FORM

(Welfare and Institutions Code Section 14452 (a))
HealthSmart Pacific, Inc., dba

Name of Subcontractor **Pacific Hospital of Long Beach**

The undersigned hereby certifies that the following information regarding **Pacific Hospital of Long Beach** (the "Organization") is true and correct as of the date set forth below.

1. Officers/Directors General Partners: Please see attachment
2. Co-Owner(s):
3. Stockholders owning more than ten percent (10%) of the stock of the Organization:

   Abraws Healthcare, Inc.
4. Major creditors holding more than five percent (5%) of Organization's debt:

   East West Bank, Future Opportunities, LLC
5. Form of Organization (Corporation, Partnership, Sole Proprietorship, Individual):

   Corporation
6. If not already disclosed above, is Organization, either directly or indirectly, related to or affiliated with the Contracting Health Plan? Explain:

   Yes. Faustino Bernadette

Date: 4/11/09

By: /s/ M. Drobot
Print Name: M. Drobot
Title: CEO

HealthSmart Pacific, Inc. dba
Pacific Hospital of Long Beach

Officers/Directors/General Partners:

Chairman of the Board	**Faustino Bernadett, M.D.**
Chief Executive Officer	**Michael D. Drobot**
President	**Clark Todd**
Treasurer	**G. William Hammer**
Secretary	**Michael J. Tichon**

1

ATTACHMENT J

CERTIFICATE OF OWNERSHIP

I, Drobot, an authorized representative of **Pacific Hospital of Long Beach**, do certify that, to the best of my knowledge, the individuals or entities listed below have a five percent or more ownership, direct or indirect, or control interest in the aforementioned entity as defined under 42 U.S. C. Section 1320 a 3 (2). This form is to be submitted annually to the organization contracting with the Managed Risk Medical Insurance Board for the Healthy Families Program and/or Access to Infants and Mothers Program.

Name of Individual/Entity	Employer Identification Number	Social Security Number
/s/ Tino Bernadett		

☐ No one is listed because there are no individuals or entities with a five (5%) percent or more interest

☐ No one is listed because the plan is under government ownership.

☐ No one is listed because the provider of services is a non-profit, public benefit corporation for which there are no outside controlling interests.

/s/ Michael D. Drobot CEO — 4/16/09

Signature of Authorized Representative and Title — Date

HSA — Hospital Services Agreement

Molina ECMS ref# 729
MCH v122706 / MHI v091707
Pacific Hospital of Long Beach

Provider or authorized representative's initials:

HOSPITAL SERVICES AGREEMENT

This Hospital Services Agreement ("Agreement") is entered by and between Molina Healthcare of California, a California corporation ("Health Plan"), and HealthSmart Pacific, Inc., dba Pacific Hospital of Long Beach ("Provider").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE — DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B.

Pending DMHC approval

ARTICLE TWO — PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall provide hospital inpatient and/or outpatient services to Members, as are specifically set forth in Attachment C. Provider agrees that its practice information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Facility Information includes, but is not limited to, name, address, telephone number, hours of operation, and services. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member as an inpatient or outpatient, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Provider shall notify Health Plan or its agent within twenty-four (24) hours of admission and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan's notification procedures described in Provider Manual for all inpatient (acute, rehabilitation, mental health and SNF) and outpatient admission on the same day of admission or at a maximum within twenty-four (24) hours of admission.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("participating providers").

Prescriptions. Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

g. **Availability of Services.** Provider shall make Covered Services available 24 hours a day, 7 days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

2.3 **Standards for Hospital Providers**

a. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Provider's contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information.** Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(c) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious

deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.

e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's contracted providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider's medical staff and the bylaws, rules and regulations of Provider.

f. **Notification.** Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider's notification to Health Plan shall state Provider's actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping**

a. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

e. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of

state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 **Program Participation**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.

e. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Promotional Activities.** At the request of Health Plan, Provider shall (1) display Health Plan promotional materials in its offices and facilities as practical, and (2) shall cooperate with and participate in all reasonable Health Plan's marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2 **icensure and Standing**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Provider shall deliver copies of such insurance policies to Health Plan within five business days of a written request by Health Plan.

2.9 **Claims Payment**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within 180 days of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider does not waive any AB-1455 right to payment.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments and deductibles, if any.

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.

e. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan, who receives a global capitation from Health Plan for both professional and facility services and is responsible for arranging for Covered Services through subcontractual arrangements ("Capitated Provider"), that Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

2.10 **Claims Review**

a. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider's intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider's operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in more than a one (1) day admission, Health Plan reserves the right to retrospectively review such claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition. Health Plan will not retrospectively deny payment for any services rendered by Provider in good faith pursuant to the prior authorization of Health Plan.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless Provider's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.

c. **Reporting Requirements.** Provider's failure to comply with Health Plan's requirements regarding Provider's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.

d. **Offset.** In the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days notice in which to exercise Provider's appeal rights under this Agreement. As a material condition to Health Plan's obligations under this Agreement, Provider agrees

that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider. Health Plan may not offset any claim that date-of-services is older than 360 days, unless Health Plan can show just cause for delay of submission from provider, according to AB-1455 regulations.

e. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

2.11 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to applicable state licensing statutes and regulations. Accordingly, Provider shall abide by those provisions set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.

2.12 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Provider Services Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.13 **Fraud and Abuse Reporting.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to and during the course of any such investigations.

2.14 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

ARTICLE THREE — HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be in the interest of the Member.

3.5 **Provider Directory.** Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of the scientific, technical, and medical aspects of Health Plan.

ARTICLE FOUR — TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the first day of the month immediately following the date this Agreement is signed by Health Plan (Effective Date) and shall continue in effect for one year; it shall automatically renew for successive one year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state licensing statutes and regulations set forth in Attachment E and Attachment F.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least 120 days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have 30 days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this 30-day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such 30-day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority:

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

e. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

f. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise is terminated as a provider by any state or federal health care program;

g. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement.

h. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety

ARTICLE FIVE — GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is

intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The contract between the state and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement. Health Plan may otherwise materially amend this Agreement only after 45 business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Arbitration.** Any controversy between Health Plan and Provider shall be resolved, to the extent possible, within forty-five (45) days by informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining controversies or claims which, when determined on a cumulative basis, exceed $10,000 or more, arising from or related to this Agreement and the rendition of services to Members pursuant to this Agreement, shall be settled by binding arbitration; provided, however, that binding arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be

available as a mechanism for appeal of any determinations made as to such matters. The arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules then in effect, and shall be conducted by a single arbitrator in Long Beach, California. The arbitrator shall be an attorney with at least fifteen years of experience, including at least five in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law. Nor shall the arbitrator have the authority to award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept the arbitrator's decision as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction hereof. Any arbitration must be initiated within one year after the controversy or claim arises, is discovered or should have been discovered with reasonable diligence; if not so initiated, any such claim shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement:

Attachment A — Provider Identification Sheet
Attachment B — Definitions
Attachment C — Products/Programs
Attachment D — Compensation Schedule
Attachment E — Licensing Provisions
Attachment F — Medicaid Program Provisions
Attachment G — Acknowledgment of Receipt of Provider Manual
Attachment H — Division of Financial Responsibility — Medicare Advantage

/s/ David C. Zembik
Molina Healthcare of California

David C. Zembik
Name (printed)

Executive Director
Title

Date 6/19/06

SIGNATURE AUTHORIZATION

The individual signing below on behalf of Provider-acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

HealthSmart Pacific Inc.
dba Pacific Hospital of Long Beach

"Provider"

/s/ Faustino Bernadett
By

CEO
Title

Faustino Bernadett
Name (printed)

Date 6/1/06

Page 16

ATTACHMENT A
Provider Identification Sheet

(Initial applicable category)

_____ Primary Care Physician

_____ Specialist: type _____

_____ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)

__X__ Hospital

_____ Ancillary Provider: type _____

_____

_____ Pharmacy

_____ Other: type _____

Provider Name	HealthSmart Pacific, Inc. dba Pacific Hospital of Long Beach	Address	2776 Pacific Avenue, Long Beach, CA 90806
Telephone No.	(562) 595-1911		
Facsimile No.	(562) 492-1363		
Tax I.D. No.			
License No.			
UPIN			
DEA No.			

Capitated managed care activities are administered by:
HealthSmart Management Services Organization, Inc.
P.O. Box 7110
Newport Beach, CA 92658-7110
Attn: President

Tel: (949) 999-3700
Fax: (949) 999-3806

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

/s/ Faustino Bernadett Date: 6/1/06
Provider Signature

Faustino Bernadett
(Name)

CEO
(Title)

Page 17

ATTACHMENT B

Definitions

Agreement means this Provider Services Agreement, all Attachments, and incorporated documents or materials.

1. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.
2. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
3. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.
4. **Credentialing Payment Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event Provider is dedelegated responsibility for credentialing.
5. **Emergency Services** are Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid/Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.
6. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.
7. **Health Plan** means Molina Healthcare of California
8. **HEDIS Studies** means Health Employer Data and Information Set.
9. **IPA** means Independent Practice Association.

10. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

11. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

12. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a Group/IPA or Hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Group/IPA or Hospital. All of said persons are bound by the terms of this Agreement.

13. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

14. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

15. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

16. **Utilization Management Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event that Provider is de-delegated responsibility for utilization management.

ATTACHMENT C

Products/Benefits Inventory

Provider hereby elects to participate as a panel provider for each of the Health Plan products initialed below.

____ 1. Medi-Cal Primary Care Case Manager
(Description of benefits appended as Attachment C-1)

____ 2. Medi-Cal Prepaid Health Plan
(Description of benefits appended as Attachment C-2)

____ 3. Medi-Cal Geographic Managed Care
(Description of benefits appended as Attachment C-3)

____ 4. Medi-Cal Two-Plan Model
(Description of benefits appended as Attachment C-4)

____ 5. Healthy Families
(Description of benefits appended as Attachment C-5)

____ 6. Commercial
(Description of benefits appended as Attachment C-6)

__X__ 7. Medicare
(Description of benefits appended as Attachment C-7)

____ 8. Other Products
Provider agrees that Health Plan may from time to time add additional products for which provider agrees to participate as a contracted provider

Provider hereby acknowledges receipt of a description of the benefits for each of the Health Plan products initialed above.

Initials of authorized
representative of Provider:

ATTACHMENT D

Compensation Schedule

Pacific Hospital of Long Beach (Capitated Hospital) full risk with Pacific Healthcare IPA Medical Associates, Inc.

Medicare Advantage (Special Needs Program) Capitation Payment Amount:

43% of the CMS Premium*

Capitation Payments to Provider shall be made to the Provider by the 10th day of each month.

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* The gross revenue Molina receives each month from CMS, as determined by CMS for Parts A, B and Medi-Cal portion only, as determined by CMS, for the medical coverage of each member, including the Medicare rebates and retro-active payments. The revenue shall not be deducted to pay for any or all broker fees nor deducted from the gross revenue prior to the capitation split.

Initials of authorized
representative of Provider:

ATTACHMENT E

REQUIRED PROVISIONS
(HEALTH CARE SERVICE PLANS)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

1. In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan. Provider shall not collect or attempt to collect from an Member or subscriber any sums owed to Provider by the Health Plan. Provider may not and will not maintain any action at law against an Member or subscriber to collect sums owed to the Provider by Health Plan (Health and Safety Code section 1379)
2. To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system. (Rule 1300.51, J-5)
3. Provider is responsible for coordinating the provision of health care services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))
4. Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))
5. Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))
6. To the extent Provider has any role in rendering emergency health care services, Provider shall make such emergency health care services available and accessible 24 hours a day, seven days a week. (Rule 1300.67.2(c))

Initials of authorized
representative of Provider:

7. Provider shall participate in Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or inability to maintain Health Plan's access standards. (Rule 1300.67(f))

8. Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 the Health and Safety Code), and the Regulations promulgated hereunder (subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulation that is required to be in this Agreement shall bind the Health Plan whether or not expressly set forth in this Agreement. (Rule 1300.67.4(a)(9))

9. Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Section 1345 of the Health and Safety Code) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code section 1373.96) (Rule 1300.67.4(a)(10))

10. Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f)

11. Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least two years: this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code section 1381) (Rule 1300.67.8(b))

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12. Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c))
13. Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services, Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and offsetting the cost of the same against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))
14. Upon Health Plan's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code section 1385)
15. To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)
16. Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Provider Services Department, Molina Medical Centers, Third Floor, One Golden Shore Drive, Long Beach, CA 90802 (800) 526-8196, ext. 1249. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)
17. Provider shall display in each reception and waiting area a notice informing Members how to contact their health plan, file a complaint with their plan, obtain assistance from the DMHC, and seek an independent medical review. (Rule 1300.67.8(f))

Initials of authorized
representative of Provider:

18. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68(b))

19. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code section 3040.

20. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon 45 business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend the Provider Manual only after 45 business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party.

21. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider is not the primary payer under coordination of benefits, Provider may submit claims to Health Plan or Health Plan's capitated provider within 90 days from the date of payment or date of contest, denial or notice from the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within 90 days from the date of payment or date of contest, denial or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

Initials of authorized
representative of Provider:

22. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider denies a claim because it was filed beyond the claim filing deadline, Health Plan will, upon Provider's submission of a provider dispute pursuant to Title 28, California Code of Regulations, section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to California Health & Safety Code section 1371 or 1371.35, which ever is applicable, and the California Code of Regulations.

23. In the event Provider participates in Molina Advantage, the following provisions shall apply:

    a. Provider shall make all of its "Relevant Records" available for inspection, examination and copying by all federal and state agencies with regulatory authority over the subject matter of this Agreement. Provider shall permit such inspection at Provider's place of business and at all reasonable times. "Relevant Records" shall mean all books and records of Provider related directly or indirectly to the goods and services furnished under the terms of this Agreement. Provider shall maintain such Relevant Records for the period of time required by applicable federal and state statutes, but in no event less than ten (10) years. This provision shall survive termination of the Agreement. (42 CFR 422.504(e)(2), 422.504(c)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

    b. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

    c. Provider agrees that under no circumstance shall a subscriber or enrollee in Molina Advantage be liable to the Provider for any sums owed by Health Plan to Provider. (42 CFR 422.504(g)(1)(i).

Initials of authorized
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d. If Provider is delegated any of the activities or functions of Health Plan as required in its contract with CMS, Provider agrees to comply with all applicable contractual provisions in the same manner as if Provider had executed such contract with CMS directly. The activities or functions delegated to Provider are set forth in the Agreement. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. The performance of such delegated activities shall be monitored by Health Plan on an ongoing basis, and Provider shall cooperate with all reasonable requests made by Health Plan in order to accomplish such monitoring. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).

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ATTACHMENT E-1

DMHC Financial Solvency Provisions

This Attachment is required to comply with the financial standards and reporting requirements Rules 1300.75.4 through 1300.75.4.8. References to the term "Rule" identity regulatory citations in Title 28 of the California Code of Regulations.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

I. DEFINITIONS

1.1 **"Cash-to-Claims Ratio"** is Provider's cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by Provider's unpaid claims liability. Unpaid claims liability is claims payable plus incurred but not reported claims ("IBNR").

1.2 **"Contracted Plans"** means all full-service health care service plans as defined in Section 1345(f) of the California Health & Safety Code with which Provider has contracts involving a Risk Arrangement.

1.3 **"Corrective Action Plan"** ("CAP") means a plan reflected in a document containing requirements for correcting and monitoring Provider's efforts to correct any financial solvency deficiencies in the Grading Criteria, financial deficiencies or other claims payment deficiencies, determined through the DMHC's review or audit process, indicating that Provider may lack the capacity to meets its contractual obligations consistent with the requirements of Rule 1300.70(b)(2)(H)(1).

1.4 **"DMHC"** means the California Department of Managed Health Care. Whenever the Solvency Regulations reference the Department, that reference includes the DMHC or its External Party.

Initials of authorized
representative of Provider:

1.5 **"External Party"** means the DMHC or its designated agent, which may be contracted or appointed to fulfill the functions stated in these Solvency Regulations.

1.6 **"Grading Criteria"** means the four grading/reviewing criteria specified in Health and Safety Code sections 1375.4(b)(1)(A)(i), (ii), (iii), and (iv) and the Cash-to-Claims Ratio as defined above.

1.7 **"Risk Arrangement"** is defined to include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(a) Risk-Sharing Arrangement means any compensation arrangement between Provider and Health Plan under which Provider shares the risk of financial gain or loss with Health Plan.

(b) Risk-Shifting Arrangement means a contractual arrangement between Provider and Health Plan under which Health Plan pays Provider on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by Provider.

1.8 **"Solvency Regulations"** means Rules 1300.75.4 through 1300.75.4.8.

II. OBLIGATIONS OF HEALTH PLAN

2.1 Monthly Membership Reports. Notwithstanding any different provisions of the Agreement, Health Plan will provide the following information to Provider on a monthly basis for members assigned to Provider, within ten (10) calendar days following the start of each month:

(a) Membership information containing at least the following elements for each member: i) identification number; ii) name; iii) birth date; iv) gender; v) address (including zip code); vi) benefit plan selected; vii) employer group identification (name and number); viii) identity of other third party coverage (if known); ix) dates of enrollment/disenrollment from Provider; x) Provider number; xi) primary care physician selected; xii) primary care physician effective date; xiii) type of change to coverage; xiv) co-payment amounts; xv) deductible (if applicable); xvi) amount of monthly capitation payment.

Initials of authorized
representative of Provider:

(b) The following additional information: i) member additions and terminations for the month (including at least: member name, member identification number); ii) number of additional members under each managed care plan; iii) number of terminated members under each managed care plan.

Health Plan shall submit the information from Section 2.1(a) and 2.1(b) to Provider electronically, unless both Health Plan and Provider agree in writing that hard copy reports will be submitted instead.

(d) If the information from Section 2.1(a) and 2.1(b) above is provided to Provider in more than one report, all reports shall be processed by Health Plan on the same date.

(e) Within forty-five (45) calendar days of the close of each calendar quarter, Health Plan shall disclose to Provider a reconciliation of any variances between the reports for information listed in sections 2.1(a) and 2.1(b) above through electronic transmission, or in hard copy if mutually agreed upon by Provider and Health Plan.

2.2 Intentionally Left Blank.

2.3 Intentionally Left Blank.

2.4 Annual Financial Risk Disclosure. On the Agreement anniversary date each year, Health Plan shall disclose to Provider the financial risk assumed under the Agreement by providing to Provider the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under the Agreement:

(a) A matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Provider, a hospital(s) or Health Plan under the Risk Arrangement.

(b) Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

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representative of Provider:

2.5 Annual Disclosure of Capitation Payments. On the Agreement anniversary date each year, Health Plan shall disclose to Provider the amount of capitation payments to be paid per member per month.

2.6 Capitation Deduction Detail. Health Plan shall provide to Provider sufficient details to allow Provider to verify the accuracy and appropriateness of any deductions from capitation payments made by Health Plan including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

III. OBLIGATIONS OF MEDICAL GROUP

3.1 Cash-to-Claims Ratio. Provider shall maintain at least the following Cash-to-Claims Ratio:

(a) 0.60 — January 1, 2006 through June 30, 2006
(b) 0.65 — July 1, 2006 through December 31, 2006
(c) 0.75 — January 1, 2007 and thereafter

3.2 Quarterly Financial Survey. No later than forty-five (45) calendar days following the close of each quarter of its fiscal year beginning on or after July 1, 2005, Provider agrees to submit a quarterly financial survey report in an electronic format to the DMHC as required by Rule 1300.41.8 of Title 28 of the California Code of Regulations as set forth below:

(a) The quarterly financial survey report shall include the following if Provider has at least 10,000 covered lives under all Risk Arrangements as of December 31 of the preceding calendar year:

Initials of authorized
representative of Provider:

(i) A Financial survey report, (including a balance sheet, an income statement and a statement of cash flows), or comparable financial statements if Provider is a nonprofit entity, and supporting schedule information (including, but not limited to, aging of receivable information), reflecting the results of operations for the immediately preceding quarter, prepared in accordance with Generally Accepted Accounting Principles ("GAAP"). Financial survey reports must be on a combining basis with an affiliate, if Provider or such Provider affiliate is legally or financially responsible for payment of Provider's claims. Any affiliated entity included in this financial survey report must be separately identified in a combining schedule format. For the purposes of this section, Provider's use: (1) of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial - obligation to pay Provider's claims liability.

(ii) A claims report, which includes the percentage of claim's that have been timely reimbursed, contested or denied during the quarter by Provider in accordance with the requirements of sections 1371 and 1371.35 of the California Health & Safety Code, Rule 1300.71, and any other applicable state and federal laws and regulations. If less than ninety-five percent (95%) of all complete claims have been reimbursed, contested or denied on a timely basis, the claims report must also describe the reasons why Provider's claims adjudication process is not meeting the requirements of applicable law, any actions taken to correct the deficiency, and any results of the actions. This claims report is for the purpose of monitoring the financial solvency of Provider and is not intended to change or alter existing state and federal laws and regulations relating to claims payment settlement practices and timeliness.

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representative of Provider:

(iii) A statement as to whether or not Provider has estimated and documented, on a monthly basis, its liability for ("IBNR") claims in accordance with Rule 1300.77.2 ("IBNR Statement") and that these estimates are the basis for the quarterly financial survey report submitted to the DMHC. If the estimated and documented liability is not in compliance with Rule 1300.77.2 in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider's failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and records on an accrual accounting basis shall result in Provider's failure to maintain, at all times, positive tangible net equity ("TNE") and positive working capital as set forth in section 3.2(a)(iv) below.

(iv) A statement as to whether or not Provider has maintained at all times throughout the quarter (1) a positive TNE as defined in Rule 1300.76(e) and (2) a positive level of working capital, calculated according to GAAP ("TNE/Working Capital Statement"). If either the required TNE or the required working capital has not been maintained at all times, a statement must be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider may reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital and Cash-to-Claim Ratio in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B) so long as the sponsoring organization has filed with the DMHC: (1) its audited annual financial statements within one hundred twenty (120) calendar days of the end of the sponsoring organization's fiscal year and (2) a copy of the written guarantee meeting the requirements of Health and Safety Code Rule 1375.4(b)(1)(B). For purposes of the Health and Safety Code Rule 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or TNE in a lesser amount approved by the DMHC, in situations where Provider can demonstrate to the DMHC's satisfaction that a lesser amount of TNE is sufficient. If Provider has a sponsoring organization, Provider shall provide a statement demonstrating the capacity of the sponsoring organization to guarantee Provider's debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code Section 1375.4(b)(1)(B).

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(v) For the quarter beginning on or after January 1, 2006, a statement as to whether or not Provider has, at all times during the quarter, maintained a Cash-to-Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(b) The quarterly financial survey report shall include the following if Provider has fewer than 10,000 covered lives under all Risk Arrangements as of December 31 of the preceding calendar year:

(i) The disclosure statements set forth in sections 3.2(a)(ii),(iii), (iv) and (v) above.

(ii) In the event Provider serves fewer than 10,000 covered lives under all Risk Arrangements and it: (i) fails to satisfactorily demonstrate its compliance with the Grading Criteria; (ii) experiences an event that materially alters its ability to remain compliant with the Grading Criteria; (iii) is found, by the DMHC's (or the DMHC's designee's) review or audit activities, to potentially lack sufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of Rule 1300.70(b)(2)(H)(1); or (iv) is found, through the DMHC's HMO Help Center, medical audits and surveys, or any other source, to be delaying referrals, authorizations, or access to basic health care services based on financial considerations, Provider shall, within thirty (30) calendar days of the DMHC's written request, begin submitting all quarterly financial survey reports set forth in sections 3.2(a) above.

3.3 Annual Financial Survey. Provider agrees to submit to the DMHC on a yearly basis, not more than one hundred fifty (150) calendar days after the close of Provider's fiscal year beginning on or after January 1, 2005, annual financial survey reports, in an electronic format determined by the DMHC as required by Rule 1300.41.8, based upon Provider's annual audited financial statement prepared in accordance with generally accepted auditing standards and containing all of the following:

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representative of Provider:

(a) An annual financial survey report, based upon Provider's annual audited financial statements, (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures) or comparable financial statements if Provider is a nonprofit entity, and supporting schedule information, (including, but not limited to, aging of receivable information and debt maturity information) for the immediately preceding fiscal year, prepared by an independent certified public accountant in accordance with GAAP. For the purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16 of the California Code of Regulations) shall apply.

(b) The financial survey reports of Provider shall be on a combining basis with an affiliate if Provider or such affiliate is legally or financially responsible for the payment of Provider's claims. Any affiliated entity included in the report shall be separately identified. Provider's use of: (1) a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay Provider's claims liability. When combined financial statements are required, the independent accountant's report or opinion must address all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, Provider shall also file the report or opinion issued by the other auditor.

(c) Opinion of an independent certified public accountant indicating whether Provider's annual audited statements present fairly, in all material respects, the financial position of Provider and whether the financial statements were prepared in accordance with GAAP. If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.

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(d) An IBNR Statement consistent with the requirements outlined in section 3.2(a)(iii) of this Amendment. If the estimated and documented liability is not in compliance with Rule 1300.77.2 in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider's failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and records on an accrual accounting basis shall result in Provider's failure to maintain, at all times, positive tangible net equity ("TNE") and positive working capital as set forth in section 3.3(e) below.

(e) A TNE/Working Capital Statement consistent with the TNE reporting requirements as outlined in Section 3.2(a)(iv) of this Amendment. If either the required TNE or the required working capital has not been maintained at all times, the TNE/Working Capital Statement shall describe in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider may reduce its liabilities for purposes of calculating its TNE and working capital in a manner as required by Rule 1300.41.8 and as outlined in section 3.2(a)(iv) of this Amendment.

(f) For fiscal years beginning on or after January 1, 2006, a statement as to whether or not Provider has at all times during the year maintained a Cash-to Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(g) A statement as to whether Provider maintains reinsurance and/or professional stop-loss coverage.

(h) A copy of Provider's complete annual audited financial statement, including footnotes and the certificate or opinion of the independent certified public accountant.

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3.4 Annual Statement of Organization Survey. Provider shall submit to the DMHC a "Statement of Organization," in an electronic format determined by the DMHC to be filed with Provider's annual financial survey report, Such Statement of Organization shall include the following information as of December 31 of each calendar year prior to the filing:

(a) Name and address of Provider;

(b) Financial and public contact person, with title, address, telephone, fax and e-mail address;

(c) A list of all health plans with which Provider has Risk Arrangements;

(d) Type of Provider: Independent Practice Association (IPA), Medical Group, Foundation or other entity, or some combination. If Provider is a foundation, identify each and every medical group within the foundation and whether any of those medical groups independently qualifies as a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g).

(e) Corporate status: professional corporation, partnership, not-for-profit corporation, sole proprietor or other form of business;

(f) The name, address and principal officer of each of Provider's affiliates as defined in Rule 1300.45(c)(1) and (2);

(g) Whether Provider is partially or wholly owned by a hospital or hospital system;

(h) A matrix listing all major categories of medical care offered by Provider, including but not limited to anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology, and radiology, and next to each listed category in the matrix a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by Provider to compensate the majority of providers of that category of care;

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(i) An approximation of the number of enrollees served by Provider through Risk Arrangements, pursuant to a list of ranges developed by the DMHC;

The name of any Management Services Organization ("MSO") that Provider contracts with for administrative services;

Total number of contracted physicians in employment and/or contractual arrangements with Provider;

(l) Disclosure by California county or counties of Provider's primary service area (excluding out-of-area tertiary facilities and providers);

(m) Provider's address, telephone number and website link, if available, where providers may access written information and instructions for filing of provider disputes with Provider's dispute resolution mechanism consistent with requirements of Rule 1300.71.38;

(n) Any other information which the DMHC deems reasonable and necessary, as permitted by law, to understand the operational structure and finances of Provider.

3.5 Attestation. Provider shall submit a written verification for each report made under Sections 3.2, 3.3, and 3.4 of this Amendment stating that the report is true and correct to the best knowledge and belief of a principal officer of Provider, and signed by a principal officer, as defined by Rule 1300.45(o).

3.6 Notification to DMHC & Health Plan. Provider agrees to notify the DMHC and Health Plan no later than five (5) business days from discovering that Provider has experienced any event that materially alters its financial situation or threatens its solvency.

3.7 DMHC Evaluation of Provider. Provider shall:

(a) Permit the DMHC to make any examination that it deems reasonable and necessary to implement section 1375.4 of the Health and Safety Code, and provide to the DMHC for inspection and copying, upon request, any books or records that the DMHC deems relevant or useful in such examination, as permitted by law.

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(b) Comply with the DMHC's review and audit process that is used to determine Provider's compliance with the Grading Criteria.

(c) Permit the DMHC to obtain and evaluate supplemental financial information pertaining to Provider when:

(i) Provider fails to satisfactorily demonstrate its compliance with the Grading Criteria;

(ii) Provider experiences an event that materially alters its ability to remain compliant with the Grading Criteria;

(iii) The External Party's review or audit process indicates that Provider may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of Rules 1300.70(b)(2)(H)(1);

(iv) The DMHC receives information from complaints submitted to the HMO Help Center, Health Plan reporting, medical audits and surveys or any other source that indicates Provider may be delaying referrals or authorizations or failing to meet access standards for basic health care services based on financial considerations.

IV. OBLIGATIONS OF MEDICAL GROUP & HEALTH PLAN

4.1 Corrective Action Plans. Provider and Health Plan shall comply with the DMHC's Corrective Action Plan ("CAP") process as set forth below.

(a) Beginning with the financial survey submission filed for the third quarter of calendar year 2005, in the event Provider has deficiencies in any of the Grading Criteria, it shall simultaneously submit a self-initiated CAP proposal, in an electronic format developed by the DMHC, to the DMHC and Health Plan that meets the following requirements:

(i) Identifies the Grading Criteria that Provider has failed to meet;

(ii) Identifies the amount by which Provider has failed to meet the Grading Criteria;

(iii) Identifies Health Plan and other Contracted Plans, including the identification of the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at Health Plan and each Contracted Plan for monitoring compliance with the CAP;

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Exhibit 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2009	2008(1)	2007(1)	2006	2005
	(Dollars in thousands)				
Earnings:					
Income before income taxes	$43,616	$ 99,374	$ 92,722	$73,458	$43,851
Add fixed charges:					
Interest expense, including amortization of debt discount and exp	13,777	13,231	5,605	2,353	1,529
Estimated interest portion of rental expense	5,181	4,370	3,988	2,682	2,852
Total fixed charges	18,958	17,601	9,593	5,035	4,381
Total earnings available for fixed charges	$62,574	$116,975	$102,315	$78,493	$48,232
Fixed Charges from above	$18,958	$ 17,601	$ 9,593	$ 5,035	$ 4,381
Ratio of Earnings to Fixed Charges	3.3	6.6	10.7	15.6	11.0
Total rent expense	$20,723	$ 17,481	$ 18,127	$12,193	$ 9,505
Interest factor	25%	25%	22%	22%	30%
Interest component of rental expense	$ 5,181	$ 4,370	$ 3,988	$ 2,682	$ 2,852

(1) The Registrant's condensed statements of income for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1 of the notes to consolidated financial statements).

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Nevada, Inc.	Nevada
Molina Healthcare Insurance Company	Ohio
Alliance for Community Health LLC, dba Molina Healthcare of Missouri	Missouri
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Virginia, Inc.	Virginia
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the Registration Statements (Forms S-8, No. 333-108317, No. 333-138552 and No. 333-153246) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan, and 2002 Employee Stock Purchase Plan, and in the Registration Statement (Form S-3, No. 333-155995) and related Prospectus of Molina Healthcare, Inc. for the registration of $300,000,000 of its securities, of our reports dated March 16, 2010, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2009.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2010

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2009 of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ JOSEPH M. MOLINA

Joseph M. Molina
Chief Executive Officer and President

March 16, 2010

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2009, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ JOHN C. MOLINA

John C. Molina, J.D.
Chief Financial Officer and Treasurer

March 16, 2010

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2009 as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOSEPH M. MOLINA

Joseph M. Molina, M.D.
Chief Executive Officer and President

March 16, 2010

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2009 as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN C. MOLINA

John C. Molina, J.D.
Chief Financial Officer and Treasurer

March 16, 2010

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

Attachment 17-3 -
2010 Audited Financial Report

Attachment 17-3 -
2010 Audited Financial
Report

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐ Yes ☑ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☐ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☑ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2010, the last business day of our most recently completed second fiscal quarter, was approximately $324 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2010).

As of March 2, 2011, approximately 30,523,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2010 Annual Meeting of Stockholders to be held on April 27, 2011, are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

Table of Contents
Form 10-K

PART I

Item 1: *Business*

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business focuses exclusively on government-sponsored health care programs, and includes our Health Plans segment, our Molina Medicaid Solutions℠ segment, and our smaller direct delivery line of business. Our Health Plans segment consists of licensed health maintenance organizations serving Medicaid populations in ten states. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. Our direct delivery line of business consists of 16 primary care community clinics in California and two primary care community clinics in Washington, and we also manage three county-owned primary care community clinics under a contract with Fairfax County, Virginia. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today we remain a provider-focused company led by his son, Dr. J. Mario Molina.

Our Health Plans segment operates Medicaid managed care plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin that serve a total of approximately 1.6 million members. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our Health Plans segment derives its revenue principally in the form of premiums paid under Medicaid contracts with the states in which our health plans operate. While the health plans receive fixed per-member per-month, or PMPM, premium payments from the states, the health plans are at risk for the medical costs associated with their members' health care. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements which limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS, a core information technology tool used to support the administration of state Medicaid and other health care entitlement programs. Our Molina Medicaid Solutions segment currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in May 2010 to expand our product offerings to include support of state Medicaid agency administrative needs; to reduce the variability in our earnings resulting from fluctuations in medical care costs; to improve our operating profit margin percentages; and to improve our cash flow by adding a business for which there are no restrictions on dividend payments.

From a strategic perspective, we believe our two business segments and our direct delivery business line allow us to participate in an expanding sector of the economy and continue our mission of serving low-income families and individuals eligible for government-sponsored health care programs. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is *www.molinahealthcare.com.*

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to "Molina Healthcare," the "Company," "we," "our," and "us" herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge on our website, *www.molinahealthcare.com*, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, Corporate Governance and Nominating Committee, and Compliance Committee Charters, are also available on our website. Such information is also available in print upon the request

of any stockholder to our Investor Relations department at the address of our executive offices set forth above. In accordance with New York Stock Exchange, or NYSE, rules, on June 2, 2010, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Molina Healthcare, the Molina Healthcare logo, Molina Medicaid Solutions℠, motherhood matters!℠, breathe with ease!℠, and Healthy Living with Diabetes℠ are registered servicemarks of Molina Healthcare, Inc.

Our Industry

The Medicaid and CHIP Programs. The Medicaid program is a federal entitlement program administered by the states. Medicaid provides health care and long-term care services and support to low-income Americans. Subject to federal rules, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states prior to FY 2009 was 57 percent, but ranged from a federally established FMAP floor at 50 percent to as high as 76 percent. With the passage of the American Recovery and Reinvestment Act, or ARRA, stimulus package in 2009, FMAP rates for all states increased by a minimum of 6.2 percentage points between October 1, 2009 and December 31, 2010, plus an additional increase adjusted quarterly based on the state's unemployment rate. Congress has extended through June 2011 the increased FMAP, but at a reduced rate from the previous ARRA enhancement.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced "TAN-if"). Another common state-administered Medicaid program is for the aged, blind or disabled, or ABD, Medicaid members. In addition, the Children's Health Insurance Program, or CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.

As a result of recently enacted health care reform legislation, the Patient Protection and Affordable Care Act, the Medicaid and CHIP population is expected to grow from approximately 60 million people today to approximately 82 million people by 2019. Over that same period, total Medicaid and CHIP expenditures are expected to grow from approximately $427 billion to approximately $896 billion.

Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. The federal government typically reimburses the states for 90% of the costs incurred in the

design, development, and implementation of an MMIS and for 50% of the costs incurred in operating an MMIS. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we now actively participate in this market.

In certain instances, states have elected to provide medical benefits to individuals and families who are not served by Medicaid. In New Mexico and Washington, our health plan segment participates in programs that are administered in a manner similar to Medicaid and CHIP, but without federal matching funds.

Medicare Advantage Plans. During 2010, each of our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, and Washington operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name, Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name, Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operate a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans at December 31, 2010 was approximately 24,500 members. Our 2010 premium revenues from Medicare across all health plans represented approximately 6.6% of our total premium revenues.

Overall, approximately 82% of our members are TANF, 9% are CHIP, 8% are ABD, and 1% are Medicare.

Our Strengths

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. Additionally, we support state Medicaid agencies by providing them with comprehensive solutions to their MMIS development and operating needs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, and cost management through our Health Plans segment, to state-level MMIS administration through our Molina Medicaid Solutions segment, to the direct delivery of health care services at our clinics. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. Our Molina Medicaid Solutions platform is based upon commercial off-the-shelf technology, or COTS. As a result, we believe that our Molina Medicaid Solutions platform has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our health plan segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The successful acquisition of our New Mexico, Missouri, and Wisconsin health plans demonstrated our ability to expand into new states. The establishment of our health plans in Utah, Ohio, Texas, and Florida reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Recognition for Quality of Care. The National Committee for Quality Assurance, or NCQA, has accredited eight of our ten Medicaid managed care plans. Our Missouri health plan is currently seeking NCQA accreditation, and our recently acquired Wisconsin plan will be seeking NCQA accreditation in the future. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our Company in 1980 to serve the Medicaid population in Southern California through a small network of primary care clinics, we have increased our membership to 1.6 million members, expanded our Health Plans segment to ten states, and added our Molina Medicaid Solutions segment. Our experience over the last 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Our Strategy

Our objective is to provide a comprehensive suite of Medicaid-related services to meet the health care needs of low-income families and individuals and the state Medicaid agencies that serve them. To achieve our objective, we intend to:

Continue to expand within existing markets. We plan to continue our growth in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, extending our services to new populations (including the aged, blind, or disabled), maintaining positive provider relationships, and integrating members from other health plans.

Continue to enter new strategic markets. We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. For example, on September 1, 2010, we acquired for approximately $15.5 million Abri Health Plan, a provider of Medicaid managed care services in Wisconsin. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size and, where practicable, mandated Medicaid managed care enrollment.

Continue to provide quality cost-effective care. We plan to use our strong provider networks and the knowledge gained through the operation of our clinics to further develop and utilize effective medical management and other coordinated programs that address the distinct needs of our members and improve the quality and cost-effectiveness of their care.

Leverage operational efficiencies. We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost.

Deliver administrative value to state Medicaid agencies. As Medicaid expenditures increase, we believe that an increasing number of states will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. For example, we can apply analytics to improve the functionality of care management processes. We believe that we can help strengthen these tools in ways that translate into both better care and cost containment. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs.

Open additional primary care clinics. During 2010, we became more diversified and more efficient by expanding our involvement in the direct delivery of primary care. The community clinic model offers an integrated approach that helps us improve both the quality and cost-effectiveness of the care our members receive. In 2010 we opened two clinics in Washington so that we can serve our members' needs for primary and behavioral health services in one place. We also expanded the capacity of our existing clinics in California in anticipation of increases in the numbers of ABD members in our plans. Approximately 20% of our California health plan's membership is now being served by the health plan's 16 primary care clinics. The growth and aging of the population of the United States foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to

worsen this shortage. We believe the shortage will be felt most acutely among already underserved populations, such as the low income families and individuals we serve. We therefore intend to expand on the direct delivery component of our business by developing additional community care clinics at certain of our health plans during 2011. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging this capability selectively we can improve access for our plan members in areas that are most underserved by primary care providers.

Pursue opportunities presented by ICD-10 conversion requirements. Over the next three years, health insurance plans are required to upgrade their systems for diagnosis, medical procedure coding, and claims processing under the tenth revisions of the International Statistical Classification of Diseases, or ICD-10. The United States Department of Health and Human Services will require payers and providers to transition to ICD-10 by October 2013. For many smaller health plans with less than one million members, the costs of making the necessary systems upgrades will be substantial. For companies like ours, the benefits of scale in this environment will be significant. We believe we will be positioned to reduce the cost per member for compliance with ICD-10. At the same time, the new requirements will create revenue opportunities for Molina Medicaid Solutions.

Prepare for health care reform. In preparation for the large scale changes associated with federal health care reform, we have organized a dedicated business unit to address issues of strategy, policy, reform readiness, and implementation. Health care reform opportunities include an estimated 16 million more members eligible for Medicaid by 2019, 30 million more individuals covered by health insurance exchanges, and increasing demand for long-term care and behavioral health services. In the next three years, we anticipate that many states will be offering new Medicaid RFP expansions in order to avoid disruptions in 2014 in connection with the full implementation of health care reform. For instance, several states are currently evaluating transitioning their ABD populations into managed care. Pursuant to a Section 1115 waiver expansion in California, we will be enrolling new ABD members in California by year end 2011.

Medicaid Contracts

With the exception of our Missouri health plan, which does not serve ABD or Medicare members, and our Wisconsin health plan, which does not serve Medicare members, all of our health plans serve TANF, CHIP, ABD, and Medicare members. For its Medicare members, each health plan enters into a one-year annually renewable contract with the Centers for Medicare and Medicaid Services, or CMS. For its other members, each health plan enters into a contract with the state's Medicaid agency. The contractual relationship with the state is generally for a period of one- to two-years and renewable on an annual or biannual basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

Our contracts with the state determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and disenrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

We are usually paid a negotiated PMPM amount, with the PMPM amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also

paid an additional amount for each newborn delivery from the Medicaid programs in all of our state health plans, except with respect to our New Mexico health plan.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations, or IPAs. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California health plan operates 16 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a non-licensed subsidiary in Virginia which manages three health care clinics for Fairfax County, and our Washington health plan operates two Company-owned primary care clinics.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*[sm] is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*[sm] is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*[sm] is a diabetes

disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/Submit Authorizations.
- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/PCP.
- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (such as those that may be required by the Health Insurance Portability and Accountability Act of 1996, or HIPAA, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness Data and Information Set, or HEDIS, and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Eight of our ten health plans are accredited by the NCQA.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 3.4 system), with the exception of our newly acquired Wisconsin plan which we expect will be migrated to the Molina standard platform in January 2012.

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan's ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- *Medicaid HMOs* — National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- *Prepaid Health Plans* — Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- *Primary Care Case Management Programs* — Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, or CSC, and CNSI.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules can occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and

rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organization, including those operating in the Medicaid and Medicare programs.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC, and are administered by the states. Our Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin health plans are subject to RBC requirements. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established in 1965 under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state governments jointly fund it, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states award contracts to any applicant demonstrating that it meets the state's requirements. Other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;

- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services, or CMS. Medicare beneficiaries have the option to enroll in a Medicare Advantage plan. Under Medicare Advantage, managed care plans contract with CMS to provide benefits that are comparable to original Medicare in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, made numerous changes to the Medicare program, including expanding the Medicare program to include a prescription drug benefit. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan. Plans are not required to offer the same benefits, but are required to provide coverage that is at least actuarially equivalent to the standard drug coverage delineated in the MMA.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, or MIPPA, became law and, in September 2008, CMS promulgated implementing regulations. MIPPA impacts a broad range of Medicare activities and impacts all types of Medicare managed care plans. MIPPA and subsequent CMS guidance place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. MIPPA also establishes certain restrictions on agent and broker compensation.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- Afford privacy to patient health information, and
- Protect the privacy of patient health information through physical and electronic security measures.

The Patient Protection and Affordable Care Act of 2010, or ACA, created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers. On September 23, 2010, CMS issued proposed regulations designed to implement these requirements. It is not clear at this time the degree to which managed care providers would have to comply with these new requirements, many of which resemble procedures that we already have in place.

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), a part of the ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. The U.S. Department of Health and Human Services, as required by the HITECH Act, has issued interim final rules that set forth the breach notification obligations applicable to covered entities and their business associates (the "HHS Breach Notification Rule"). The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are

in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as *"qui tam"* actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Action of 2005 ("DRA") encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2010, we had approximately 4,200 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Executive Officers of the Registrant

J. Mario Molina, M.D., 52, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 46, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 30 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He was recently named to the Los Angeles branch of the Federal Reserve Bank of San Francisco's board of directors. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Terry P. Bayer, 60, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has 26 years of health care management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President

and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University.

Joseph W. White, 52, has served as our Chief Accounting Officer since 2003. In his role as Chief Accounting Officer, Mr. White is responsible for oversight of the Company's accounting, reporting, forecasting, budgeting, actuarial, procurement, treasury and facilities functions. Mr. White has 25 years of financial management experience in the health care industry. Prior to joining the Company in 2003, Mr. White worked for Maxicare Health Plans, Inc. from 1987 through 2002. Mr. White holds a Master's degree in Business Administration and a Bachelor's degree in Commerce from the University of Virginia. Mr. White is a Certified Public Accountant.

James W. Howatt, 64, served as our Chief Medical Officer from May 2007 to February 2011. Effective February 17, 2011, Dr. Howatt was reassigned to the position of medical director of MMS. As medical director of MMS, Dr. Howatt will serve as the clinical leader for existing and future MMS product offerings, and will direct efforts to incorporate care coordination solutions into the government health care programs served by MMS. Prior to joining Molina Healthcare in February 2006, Dr. Howatt was Western Regional Medical Director for Humana. Dr. Howatt received B.S. and M.D. degrees from the University of California, San Francisco, and also holds a Master of Business Administration degree with an emphasis in Health Management from the University of Phoenix.

Item 1A: ***Risk Factors***

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This annual report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Business

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs are continuing to increase at the same time that state budgets are suffering from unprecedented deficits. In June 2010, 50.3 million members were enrolled in the Medicaid program throughout the nation, over three million more than in June 2009. Because governmental health care programs account for such a large portion of state budgets, efforts to contain overall government spending and to achieve a balanced budget often result in significant political pressure being directed at the funding for these health care programs. For fiscal year 2011, 46 states have reported budget gaps of a total of $130 billion as of December 2010, and that gap could reach an estimated $160 billion. Resolving the budget shortfalls is now particularly difficult since program reductions and one-time strategies to plug the gaps have already been used in most states. Headed into fiscal year 2012, states do not expect revenue collections to recover to a level sufficient to avoid additional budget cuts. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it will likely be a prime target for cost-containment efforts. All of the states in which we currently operate our health plans are currently facing significant budgetary pressures. The mandate of health reform adding millions of individuals to Medicaid and CHIP will put further pressures on state Medicaid programs.

As part of ARRA, the federal government increased the amount of funding for federal Medicaid matching by approximately $87 billion for the period between October 1, 2008 and December 31, 2010. In August 2010, the President signed a bill extending the ARRA enhanced FMAP on a phased-down basis for two additional quarters through June 30, 2011. The unemployment adjustment remained in the extension, but the law phased down the across-the-board base increase of 6.2 percentage points to 3.2 percentage points from January 1, 2011 to March 31, 2011, and to 1.2 percentage points from April 1, 2011 to June 30, 2011. Almost every state legislature had enacted its 2011 budgets prior to enactment of the extension, and with the uncertainty about whether Congress would extend the enhanced FMAP, each state was forced to make an assumption about whether the higher FMAP would continue beyond December 2010. Even with fiscal relief provided by the extension of ARRA enhanced Medicaid matching rates and the fact that economists pegged June 2009 as the official "end" of the recession, state budgets remain under considerable stress in fiscal year 2011, and without exception state policy leaders expect the fiscal stress to extend into fiscal year 2012. Unemployment remains high, and state revenues remain depressed.

Since the start of the recession, all states have implemented programmatic changes of some kind, including provider rate cuts or freezes, benefit cuts and restrictions, provider taxes and assessments, utilization controls, fraud and abuse reduction strategies and numerous administrative cuts (travel bans, hiring freezes, furloughs and layoffs) to reduce Medicaid cost growth. 20 states reduced Medicaid benefits in fiscal year 2010, more than in any year in the past decade, and 14 states planned to reduce benefits in fiscal year 2011. With the expiration of the ARRA funds on June 30, 2011, states may have no choice but to further cut or revise health care programs, optional benefits, eligibility criteria and thresholds, or health plan rates. Such actions could materially reduce the funding under one or more of our state Medicaid contracts, thereby reducing our revenues and our health plan profit margins. We expect to obtain rate increases during our fiscal year 2011 from the states of California and Ohio, and for the rates at our other health plans (with the exception of our Wisconsin health plan where we expect an 11% rate cut) to remain unchanged during the year. In the event this expectation is undermined by state budget pressures and the rates of any of our health plans are reduced, our business, financial condition, cash flows, or results of operations could be adversely affected. In addition, the timing of payments we receive may be impacted by state budget shortfalls.

Moreover, some federal deficit reduction proposals would fundamentally change the structure and financing of the Medicaid program. Recently, various proposals have been advanced to reduce annual federal deficits and to slow the increase in the national debt. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid. Some of the proposals relating to Medicaid would fundamentally change the structure and financing of the program, with major implications for providers and beneficiaries. One such proposal would be to convert Medicaid into a block grant, capping federal Medicaid payments to each state at a specified dollar amount, and limiting the growth in that dollar amount each year. Based on analysis of previous proposals to cap Medicaid, these dollar caps and growth limits would have to be set below the levels at which Medicaid is now expected to grow based on enrollment and health care inflation to save money. In the event the Medicaid program is fundamentally restructured, our business could be adversely affected.

The recently enacted health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act, commonly referred to together as the "ACA". This legislation enacts comprehensive changes to the U.S. health care system, components of which will be phased in at various stages over the next eight years. Among other things, by January 1, 2014, the Medicaid program will be expanded to provide eligibility to nearly all low-income people under age 65 with income below 133 percent of the federal poverty line. As a result, millions of low-income adults without children who currently cannot qualify for coverage, as well as many low-income parents and, in some instances, children now covered through CHIP, will be made eligible for Medicaid. In total, the Congressional Budget Office estimates that Medicaid and CHIP will cover an additional 16 million people by 2019. The legislation also imposes a franchise tax or premium excise tax of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes.

There are many parts of the legislation that will require further guidance in the form of regulations. Due to the breadth and complexity of the health reform legislation, the lack of implementing regulations and interpretive

guidance, and the phased-in nature of the implementation, the overall impact of the health reform legislation on our business over the coming years is difficult to predict and not yet fully known.

In addition, there have been a number of lawsuits filed that challenge all or part of the health care reform law. On January 31, 2011, a Florida District Court ruled that the entire health care reform law is unconstitutional. Other courts have ruled in favor of the law or have only struck down certain provisions of the law. These cases are under appeal and others are in process. We cannot predict the ultimate outcome of any of the litigation. Further, various Congressional leaders have indicated a desire to revisit some or all of the health care reform law during 2011. While the U.S House of Representatives voted to repeal the whole health care reform law, the U.S. Senate voted against such a repeal, and there have separately been a number of bills introduced that would repeal or change certain provisions of the law. Because of these challenges, we cannot predict whether any or all of the legislation will be implemented as enacted, overturned, repealed, or modified.

If we fail to effectively accommodate the growth in Medicaid enrollment anticipated under the health reform legislation, our business may be materially adversely affected. In addition, if the new insurance industry assessment is imposed as enacted, or if we are unable to obtain premium increases to offset the impact of the assessment or otherwise adjust our business model to address the assessment, our business, financial condition, cash flows, or results of operations could be materially adversely affected.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio for 2010 of 84.5% had been one percentage point higher, or 85.5%, our earnings for 2010 would have been approximately $1.14 per diluted share rather than our actual 2010 earnings of $1.98 per diluted share, a 42% reduction in our earnings.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual flu season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid," or IBNP, medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to Medicare Advantage or aged,

blind, and disabled Medicaid members, is impacted by the more limited experience we have had with those populations. Finally, with regard to the new Medicaid and CHIP members we expect to enroll in 2011 through organic growth due primarily to the recession, certain new members may be disproportionately costly due to high utilization in their first several months of Medicaid or CHIP membership as a result of their previously having been uninsured and therefore not seeking or deferring medical treatment.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

Another flu epidemic in 2011 or other kind of epidemic in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results during 2009 were significantly impacted by the widespread incidence of the H1N1 flu in the states in which we operate our health plans. The recurrence in 2011 of the H1N1 flu, another variant of the flu, or the outbreak and rapid spread of any other highly contagious and potentially virulent disease, could increase the utilization rates among our members, resulting in significantly increased outpatient, inpatient, emergency room, and pharmacy costs.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, the state contract of our Washington health plan with respect to the Healthy Options program may be subject to competitive bidding during 2011 or 2012. In the event the responsive bids of our Washington health plan or those of other health plans are not successful, we will lose our Medicaid contract in the applicable state, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of the unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. Further, most of our contracts are terminable without cause.

Our government contracts generally run for periods of one year to three years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. Although our health plans have generally been successful in obtaining the renewal and/or extension of their state contracts, there can be no guarantee that any of our state government contracts will be renewed or extended. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

There are numerous risks associated with the expansion of our Texas health plan's service area under the CHIP Rural Service Area Program, with our acquisition of Abri Health Plan in Wisconsin, and with our ABD expansion in California.

In September 2010, our Texas health plan began arranging health care services for approximately 64,000 low-income children and pregnant women in 174 predominantly rural counties through Texas' CHIP Rural Service Area Program. In addition, on September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. As of December 31, 2010, Abri Health Plan served approximately 36,000 Medicaid members. During 2011, we will begin serving additional ABD members in Texas, and we expect to begin serving additional ABD members in California. There are numerous risks associated with a health plan's initial expansion into a new service area or the provision of medical services to a new population, including pent-up demand for medical services, elevated medical care costs, and our lack of actuarial experience in setting appropriate reserve levels. In the event the medical care costs of our Texas, Wisconsin, or California health plans are higher than anticipated, we are unable to lower the medical care ratio associated with these new populations, our reserve levels are inadequate, or our enrollment projections are overestimated, the negative results of our Texas, Wisconsin, or California health plan could adversely affect our business, financial condition, cash flows, or results of operations.

States may not adequately compensate us for the value of drug rebates that were previously earned by the Company but that are now collectible by the states.

ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers are in the process of or have completed renegotiating their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours will likely decline significantly in the future. There are provisions in the ACA that require rates paid to Medicaid managed care to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from 10 state health plans. If we were unable to continue to operate in any of those ten states, or if our current operations in any portion of the states we are in were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

There are performance and other risks associated with certain provisions in the state Medicaid contracts of our Florida, New Mexico, Ohio, and Texas health plans.

The state contracts of our New Mexico, Ohio, and Texas health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, the health plan will be unable to recognize the revenue associated with that measure. Any failure of our health plan to satisfy one of these performance measure provisions could adversely affect our business, financial condition, cash flows, or results of operations.

In addition, the state contracts of our Florida, New Mexico, and Texas health plans contain provisions pertaining to medical cost floors, administrative cost and profit ceilings, and profit-sharing arrangements. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could adversely affect our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we were unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also create increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have an adverse impact on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could adversely affect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. During 2010, due to a prolonged budget impasse, some of the monthly premium payments made by the state of California to our California health plan were several months late. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse affect on our business, financial condition, cash flows, or results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets — particularly operators of large commercial health plans — have significantly greater financial resources than we do.

Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or comply with these regulatory requirements in a timely manner, if at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. For example, from July 26 to July 30, 2010, the Center for Medicare and Medicaid Services, or CMS, conducted an on-site audit with respect to our Medicare Advantage and Prescription Drug Plan contracts in the compliance areas of prescription drug formulary administration, prescription drug coverage determinations and appeals, prescription drug grievances, enrollment and disenrollment, premium billing, and an evaluation of whether we had implemented an effective compliance program. On February 25, 2011, we received from CMS the audit and inspection report. The report provides that we will be given until April 26, 2011 to develop and implement a corrective action plan to correct the deficiencies noted in the report and to demonstrate to CMS that the underlying deficiencies have been corrected and are not likely to recur. If we are unable to correct the noted deficiencies, or become subject to material fines or other sanctions, whether as a result of this most recent CMS audit or otherwise, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for

whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws which may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our financial position, results of operations and cash flows.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties, and assessments. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. Many states, including states where we currently operate, have enacted parallel legislation. In the event we are subject to liability under a *qui tam* action, our business and operating results could be adversely affected.

Federal regulations require entities subject to HIPAA to update their transaction formats for electronic data exchange from current HIPAA 4010 requirement to the new HIPAA 5010 standards, which are not only burdensome and complex, but could adversely impact administrative expense and compliance.

A federal mandate known as HIPAA 5010 will require health plans to use new standards for conducting certain operational and administrative transactions electronically beginning in January 2012. These administrative transactions include: claims, remittance, eligibility and claims status requests and responses. The HIPAA 5010 upgrade was prompted by government and industry's shared goal of providing higher-quality, lower-cost health care and the need for a comprehensive electronic data exchange environment for the ICD-10 mandate to be implemented by October 2013. Upgrading to the new HIPAA 5010 standards should increase transaction uniformity, support pay for performance, and streamline reimbursement transactions. We, along with other health plans, face significant pressure to make sure that we have installed our software and tested it for compatibility with our business partners. Because HIPAA 5010 affects electronic transactions such as patient eligibility, claims filing, claims status, and remittance advice, we must proceed proactively to achieve full functionality of HIPAA 5010 transactions before the deadline. Otherwise we may face transaction rejections and subsequent payment delays, which could have a material adverse effect on our business, cash flows, and results of operations. As the deadline approaches, we continue to upgrade and test our claims management systems to accommodate HIPAA 5010 and prevent any operational disruptions.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

The U.S. Department of Health and Human Services, or HHS, has released rules pursuant to HIPAA which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. By October 2013, the federal government will require that health care organizations, including health insurers, upgrade to updated and expanded standardized code sets used for documenting health conditions. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. While use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our cash flows, financial position, or results of operations. However, these changes may result in errors and otherwise negatively impact our service levels, and we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide, appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial position, cash flows, or results of operations.

The insolvency of a delegated provider could obligate us to pay their referral claims, which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped if the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which the Company does not participate. These actions and the resulting negative publicity could become associated with or imputed to the Company, regardless of the Company's actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which the Company does participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2010, 2009, and 2008 without approval of the regulatory authorities were approximately $18.8 million, $9.0 million, and $7.6 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our credit facility and/or our convertible senior notes.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization

of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our business, financial condition, cash flows, or results of operations.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process, and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The Health Information Technology for Economic and Clinical Health Act provisions of the ARRA further expand the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, increasing penalties for violations, and requiring public disclosure of improper disclosures of health information of more than 500 individuals.

Under ARRA, civil penalties for HIPAA violations by covered entities are increased up to an annual maximum of $1.5 million for uncorrected violations based on willful neglect. In addition, imposition of these penalties is now more likely because ARRA strengthens enforcement. For example, commencing February 2010, HHS was required to conduct periodic audits to confirm compliance. Investigations of violations that indicate willful neglect, for which penalties are mandatory beginning in February 2011, are statutorily required. In addition, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Initially monies collected will be transferred to a division of HHS for further enforcement, and within three years, a methodology will be adopted for distributing a percentage of those monies to affected individuals to fund enforcement and provide incentive for individuals to report violations. In addition, ARRA requires us to notify affected individuals, HHS, and in some cases the media when unsecured personal health information is subject to a security breach.

ARRA also contains a number of provisions that provide incentives for states to initiate certain programs related to health care and health care technology, such as electronic health records. While provisions such as these do not apply to us directly, states wishing to apply for grants under ARRA, or otherwise participating in such programs, may impose new health care technology requirements on us through our contracts with state Medicaid agencies. We are unable to predict what such requirements may entail or what their effect on our business may be.

We will continue to assess our compliance obligations as regulations under ARRA are promulgated and more guidance becomes available from HHS and other federal agencies. The new privacy and security requirements, however, may require substantial operational and systems changes, employee education and resources and there is no guarantee that we be able to implement them adequately or prior to their effective date. Given HIPAA's complexity and the anticipated new regulations, which may be subject to changing and perhaps conflicting interpretation, our ongoing ability to comply with all of the HIPAA requirements is uncertain, which may expose us to the criminal and increased civil penalties provided under ARRA and may require us to incur significant costs in order to seek to comply with its requirements.

Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third-party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could subject us to civil and criminal penalties and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Risks Related to the Operation of Our Molina Medicaid Solutions Business

MMIS operational problems in Idaho or Maine could result in reduced or withheld payments, damage assessments, increased administrative costs, or even contract termination, any of which could adversely affect our business, financial condition, cash flows, or results of operations.

From and after the MMIS operational or "go live" date of June 1, 2010 after which it began pilot operations, Molina Medicaid Solutions has experienced certain problems with the MMIS in Idaho. On October 5, 2010, Molina Medicaid Solutions received from the Idaho Department of Administration a notice to cure letter with respect to its

alleged non-compliance with certain provisions of the MMIS project agreements. Molina Medicaid Solutions and the Idaho Department of Health and Welfare ("DHW") have been working together to resolve the MMIS problems, and Molina Medicaid Solutions has developed a corrective action plan with respect to the identified problems and defects. Molina Medicaid Solutions believes it has ameliorated or corrected many of the identified problems, and that it will ultimately be successful in resolving all of the MMIS issues in Idaho. However, in the event Molina Medicaid Solutions is unsuccessful in correcting all of the identified problems, the Idaho Department of Administration may: (i) reduce or withhold its payments to Molina Medicaid Solutions, (ii) require Molina Medicaid Solutions to provide services at no additional cost to Idaho, (iii) require the payment of damages, or (iv) terminate its contract with Molina Medicaid Solutions. In addition, Molina Medicaid Solutions may incur much greater administrative costs than expected in correcting the MMIS problems, or in advancing interim payments to Idaho providers. For example, the consulting and outside service costs for Idaho following its go-live operational date have not declined from the pre-operational level as had been previously expected. Finally, Idaho DHW may not accept the MMIS developed and implemented by Molina Medicaid Solutions, or CMS may not certify such MMIS.

All of such risks are also applicable to the MMIS in Maine which became operational and began pilot operations as of September 1, 2010. The realization of any of the foregoing risks could adversely affect our business, financial condition, cash flows, or results of operations.

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently has management contracts in only six states. If we are unable to continue to operate in any of those six states, or if our current operations in any of those six states were significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, including its responsive bid in Louisiana during 2011, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, the state MMIS contract of Louisiana is currently subject to competitive bidding. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event the responsive bid in Louisiana is not successful, we will lose our fiscal agent contract in that state, and our revenues could be materially reduced as a result. In addition, in the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or unanticipated delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our overall business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business may be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have an adverse effect on our business, financial condition, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results or damage our reputation.

Experienced computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance on contracts, including those on which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties including software and hardware vendors to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenue and profitability.

Risks Related to our General Business Operations

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions or reduce our liquidity and capital resources.

We have a $150 million senior secured credit facility that imposes numerous restrictions and covenants, including prescribed consolidated leverage and fixed charge coverage ratios, net worth requirements, and acquisition limitations that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends without lender approval. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to act with complete flexibility, or our inability to use our credit facility in the manner intended. In addition, our credit facility matures in May 2012. If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, or if we are unable to renew or refinance our credit facility prior to its maturity, we may be unable to use the credit facility in the manner intended, and our operations, liquidity, and capital resources could be materially adversely affected.

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In fiscal year 2006, we had total premium revenue of $2.0 billion. In fiscal year 2010, we had total premium revenue of $4.0 billion, an increase of 100% over a five-year span. Continued rapid growth could place a significant strain on our management and on other Company resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with

members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems, could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. Providers at our 16 primary care clinics in California and two in Washington are employees of our health plans. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of their employees. We maintain medical malpractice insurance for our clinics as we believe are reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, cash flows, or results of operations, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies

in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles ("GAAP") and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

Our investments in auction rate securities are subject to risks that may cause losses and have a material adverse effect on our liquidity.

As of December 31, 2010, our investments in auction rate securities included amounts designated as available-for-sale securities amounted to $24.6 million par value (fair value of $20.4 million). As a result of the decrease in fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized losses of $0.2 million to accumulated other comprehensive loss for the fiscal year ended December 31, 2010. We deem the cumulative unrealized losses on these securities to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost. However, if we were to sell these investments before recovery of their cost, we would be required to record a charge to earnings for any accumulated losses, which would impact our earnings for the quarter in which such event occurred.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations, or the accounting reversal of any tax benefits or revenue previously recognized by us, could have an adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel, which could negatively impact our operations.

Risks Related to Our Common Stock

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $16.12 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

- state and federal budget pressures,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- changes in government payment levels,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies in the health care industry,
- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change,
- general economic conditions, including unemployment rates, inflation, and interest rates, and
- the factors set forth under "Risk Factors" in this report.

Our stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our stock does not continue to develop, securities analysts may not maintain or initiate research coverage of our Company and our shares, and this could depress the market for our shares.

Members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate own or are entitled to receive upon certain events approximately 55% of our capital stock. Our president

and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of our Company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, including securities that are convertible into or exchangeable for, or that represent the right to receive, common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 80,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2010, 30,308,616 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire our Company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our Company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

We do not anticipate paying any cash dividends in the foreseeable future.

We have never declared or paid any cash dividends. While we have in the past and may again in the future use our available cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Item 1B: ***Unresolved Staff Comments***

None.

Item 2: ***Properties***

We lease a total of 67 facilities, including our corporate headquarters at 200 Oceangate in Long Beach, California. We own a 32,000 square-foot office building in Long Beach, California, our 26,000 square-foot data center in Albuquerque, New Mexico, and one of the community clinics in Pomona, California. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3: ***Legal Proceedings***

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 4: ***Reserved***

PART II

Item 5: ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of February 15, 2011, there were 115 holders of record of our common stock. The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2010		
First Quarter	$26.39	$20.02
Second Quarter	$31.20	$25.00
Third Quarter	$31.80	$25.28
Fourth Quarter	$28.28	$24.65
2009		
First Quarter	$22.74	$16.22
Second Quarter	$25.75	$18.11
Third Quarter	$25.05	$19.36
Fourth Quarter	$23.49	$17.05

Dividends

We have never paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our business, and we do not anticipate paying any cash dividends in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Any future determination to pay dividends will be at the discretion of our Board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 — Management's Discussion and Analysis of Financial Condition and Results of Operations — Regulatory Capital and Dividends Restrictions.

Unregistered Issuances of Equity Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2010)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	513,614(1)	$30.59	3,744,530(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and Incentive Plan have been suspended.

(2) Includes only shares remaining available to issue under the 2002 Equity Incentive Plan (the "2002 Incentive Plan") and the 2002 Employee Stock Purchase Plan (the "ESPP"). The 2002 Incentive Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares available for issuance under the 2002 Incentive Plan automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. The 400,000 share increase on January 1, 2011 increased the total number of shares reserved for issuance under the 2002 Incentive Plan to 4,800,000 shares. The ESPP initially allowed for the issuance of 600,000 shares of common stock. Beginning December 31, 2003, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares reserved for issuance under the ESPP automatically increased by 1% of total outstanding capital stock.

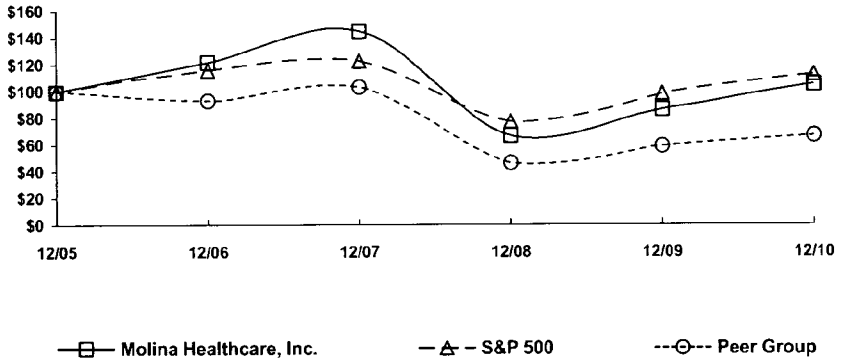
STOCK PERFORMANCE GRAPH

The following discussion shall not be deemed to be "soliciting material" or to be "filed" with the SEC nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500") and a peer group index for the five-year period from December 31, 2005 to December 31, 2010. The graph assumes an initial investment of $100 in Molina Healthcare, Inc. common stock and in each of the indices.

The peer group index consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN*
Among Molina Healthcare, Inc, The S&P 500 Index
And A Peer Group



* $100 invested on 12/31/05 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.

Item 6. ***Selected Financial Data***

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics") for the five years ended December 31, 2010 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data. The data under the caption "Operating Statistics" has not been audited.

	Year Ended December 31,				
	2010(1)(3)	2009(2)(3)	2008(2)(3)	2007(2)(8)	2006(2)(9)
Statements of Income Data:					
Revenue:					
Premium revenue	$ 3,989,909	$ 3,660,207	$ 3,091,240	$ 2,462,369	$ 1,985,109
Service revenue(1)	89,809	—	—	—	—
Investment income	6,259	9,149	21,126	30,085	19,886
Total revenue	4,085,977	3,669,356	3,112,366	2,492,454	2,004,995
Expenses:					
Medical care costs	3,370,857	3,176,236	2,621,312	2,080,083	1,678,652
Cost of service revenue(1)	78,647	—	—	—	—
General and administrative expenses(2)	345,993	276,027	249,646	205,057	168,280
Premium tax expenses(2)(3)	139,775	128,581	100,165	81,020	60,777
Depreciation and amortization	45,704	38,110	33,688	27,967	21,475
Total expenses	3,980,976	3,618,954	3,004,811	2,394,127	1,929,184
Gain on purchase of convertible senior notes	—	1,532	—	—	—
Operating income	105,001	51,934	107,555	98,327	75,811
Interest expense	(15,509)	(13,777)	(13,231)	(5,605)	(2,353)
Income before income taxes	89,492	38,157	94,324	92,722	73,458
Provision for income taxes(3)	34,522	7,289	34,726	34,996	27,731
Net income	$ 54,970	$ 30,868	$ 59,598	$ 57,726	$ 45,727
Net income per share:					
Basic	$ 2.00	$ 1.19	$ 2.15	$ 2.04	$ 1.64
Diluted	$ 1.98	$ 1.19	$ 2.15	$ 2.03	$ 1.62
Weighted average number of common shares outstanding	27,449,000	25,843,000	27,676,000	28,275,000	27,966,000
Weighted average number of common shares and potential dilutive common shares outstanding	27,754,000	25,984,000	27,772,000	28,419,000	28,164,000
Operating Statistics:					
Medical care ratio(4)	84.5%	86.8%	84.8%	84.5%	84.6%
General and administrative expense ratio(5)	8.5%	7.5%	8.0%	8.2%	8.4%
Premium tax ratio(6)	3.5%	3.5%	3.2%	3.3%	2.3%
Members(7)	1,613,000	1,455,000	1,256,000	1,149,000	1,077,000

	As of December 31,				
	2010(1)	2009	2008	2007(8)	2006(9)
Balance Sheet Data:					
Cash and cash equivalents	$ 455,886	$ 469,501	$ 387,162	$ 459,064	$403,650
Total assets	1,509,214	1,244,035	1,148,068	1,170,016	864,475
Long-term debt (including current maturities)	164,014	158,900	164,873	160,166	45,000
Total liabilities	790,157	701,297	616,306	655,640	444,309
Stockholders' equity	719,057	542,738	531,762	514,376	420,166

(1) Service revenue and cost of service revenue represent revenue and costs generated by our Molina Medicaid Solutions segment. Because we acquired this business on May 1, 2010, results for the year ended December 31, 2010 include eight months of results for this segment.

(2) Prior to 2010, general and administrative expenses have included premium tax expenses. Beginning in 2010, we have reported premium tax expenses on a separate line in the statements of income data. Prior periods have been reclassified to conform to this presentation.

(3) Effective January 1, 2008 through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax. For the years ended December 31, 2009, and 2008, amounts for premium tax expense and income tax expense have been reclassified to conform to this presentation. The MGRT amounted to $6.2 million, $5.5 million, and $5.1 million for the years ended December 31, 2010, 2009, and 2008, respectively.

(4) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See *Management's Discussion and Analysis of Financial Condition and Results of Operations* for further discussion.

(5) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(6) Premium tax ratio represents such expenses as a percentage of premium revenue.

(7) Number of members at end of period.

(8) The balance sheet and operating results of the Mercy CarePlus acquisition, relating to our Missouri health plan, have been included since November 1, 2007, the effective date of the acquisition.

(9) The balance sheet and operating results of the Cape Health Plan acquisition, relating to our Michigan health plan, have been included since May 15, 2006, the effective date of the acquisition.

Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax, or MGRT, as a premium tax and not as an income tax. Prior periods have been reclassified to conform to this presentation.

In prior periods, general and administrative, or G&A, expenses have included premium tax expenses. Beginning in 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business processing solutions to Medicaid agencies in an additional five states. Our direct delivery business currently consists of 16 primary care community clinics in California and two primary care community clinics in Washington, and we also manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of December 31, 2010. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010, we terminated operations at our small Medicare health plan in Nevada.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*[SM]. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We paid $131.3 million to acquire Molina Medicaid Solutions. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility.

With the addition of Molina Medicaid Solutions, we have added a segment to our internal financial reporting structure in 2010. We now report our financial performance based on the following two reportable segments: (i) Health Plans; and (ii) Molina Medicaid Solutions.

Fiscal Year 2010 Overview and Highlights

During 2010, we experienced diversified revenue growth thanks to increased enrollment in our health plans, our successful entry into the Medicaid health information management business, and an acquisition that established us in a new state. Meanwhile, stronger medical management and disciplined cost control helped us realize improvements in our health plan medical margins. Many of these factors contributed to our Company's strong financial performance in 2010. For the year, our net income rose to $55.0 million, or $1.98 per diluted share, an increase of 78% over 2009. We earned premium revenues of $4.0 billion, up 9% over the previous year. Meanwhile, during a year when costs continued to rise for the health care industry, we achieved a medical care ratio of 84.5%, compared with a medical care ratio of 86.8% for fiscal year 2009.

During 2010, we continued to pursue the expansion of our Medicaid health plan business. In September 2010, we completed the $15.5 million acquisition of Abri Health Plan of Milwaukee, which served approximately 36,000 Medicaid beneficiaries as of December 31, 2010. We also expanded our growing presence in Texas, where we were already serving patients in the Houston, San Antonio, and Laredo service areas. In May 2010, we were awarded a contract to serve Medicaid managed care patients in the seven-county Dallas service area starting in February 2011. In September 2010, we won an additional contract to administer the CHIP program (including the CHIP Perinatal program) in 174 predominately rural counties across the state. As of December 31, 2010, we served approximately 63,000 children and pregnant women under this contract. The new contracts not only provide increased scale for leveraging our resources in Texas, they make Molina an increasingly important player in a state where the potential revenue opportunity will grow as new Medicaid beneficiaries qualify for coverage under health care reform.

In addition, during 2010 we expanded our operation of community-based primary care clinics — the business field in which Molina began over 30 years ago — so that we can serve the needs of our patients while also serving the states that pay for their health care.

Finally, on May 1, 2010, we acquired Molina Medicaid Solutions, an acquisition which has complemented our core business model of serving government programs, expanded our service offerings diversified our revenue base, and expanded our level of participation in the Medicaid program.

2010 Financial Performance Summary

The following table briefly summarizes our financial performance for the years ended December 31, 2010, 2009, and 2008. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Year Ended December 31,		
	2010	2009	2008
	(Dollar amounts in thousands, except per-share data)		
Earnings per diluted share	$ 1.98	$ 1.19	$ 2.15
Premium revenue	$3,989,909	$3,660,207	$3,091,240
Service revenue	$ 89,809	$ —	$ —
Operating income	$ 105,001	$ 51,934	$ 107,555
Net income	$ 54,970	$ 30,868	$ 59,598
Total ending membership	1,613,000	1,455,000	1,256,000
Premium revenue	97.6%	99.8%	99.3%
Service revenue	2.2	—	—
Investment income	0.2	0.2	0.7
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	84.5%	86.8%	84.8%
General and administrative expense ratio	8.5%	7.5%	8.0%
Premium tax ratio	3.5%	3.5%	3.2%
Operating income	2.6%	1.4%	3.5%
Net income	1.3%	0.8%	1.9%
Effective tax rate	38.6%	19.1%	36.8%

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. The majority of medical costs associated with premium revenues are risk-based costs — while the health plans receive fixed per-member per-month, or PMPM, premium payments from the states, the health plans are at risk for the costs of their members' health care. Our Health Plans segment operates

in a highly regulated environment with stringent capitalization requirements. These capitalization requirements, among other things, limit the health plans' ability to pay dividends to us without regulatory approval.

As of December 31, 2010, our health plans were located in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. Additionally, we operate three county-owned primary care clinics in Virginia.

Molina Medicaid Solutions Segment

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. Among the principle differences between the Molina Medicaid Solutions segment and the Health Plans segment are:

- The Molina Medicaid Solutions segment, unlike the Health Plans segment, does not assume risk for medical costs. We believe that over time the Molina Medicaid Solutions segment will experience less volatility in profits than the Health Plans segment because the costs incurred for the provision of business process outsourcing services are less volatile than those incurred for the provision of medical care.
- Revenue earned by the Molina Medicaid Solutions segment will be much less than that earned by the Health Plans segment. The revenue earned by our Health Plans segment is intended to include the cost of the medical care actually provided to our health plan membership. Such costs typically amount to approximately 85% of the revenue of the health plans segment. The revenue received by the Molina Medicaid Solutions segment is intended only to pay for certain administrative costs (plus profit) of the Medicaid program — not the actual cost of services provided to Medicaid members.
- In general, we expect the operating profit margin percentage generated by the Molina Medicaid Solutions segment to be higher than the operating profit margin percentage generated by the Health Plans segment. While total profit is likely to be lower for the Molina Medicaid Solutions segment than for the Health Plans segment, the percentage of revenue that we retain as profit is likely to be higher for the Molina Medicaid Solutions segment.
- The capital requirements of the Molina Medicaid Solutions segment are — except in the case of new contract start-ups — considerably less than those of our Health Plans segment.
- Regulatory approval is not required for the Molina Medicaid Solutions segment to pay dividends to us.

While we believe that the acquisition of the Molina Medicaid Solutions segment diversifies our risk profile, we also believe that the two segments are complementary from strategic and operating perspectives. From a strategic perspective, both segments allow us to participate in an expanding sector of the economy while continuing our mission to serve low-income families and individuals eligible for government-sponsored health care programs. Operationally, the segments share a common systems platform — allowing for efficiencies of scale — and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market various cost containment and quality practices used by our Health Plans segment (such as care management and care coordination programs) to state MMIS customers who wish to incorporate certain aspects of managed care programs into their own fee-for-service programs.

Composition of Revenue and Membership

Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the year ended December 31, 2010, we received approximately 94% of our premium revenue as a fixed PMPM amount, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the year ended December 31, 2010, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for CHIP members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $230 in Missouri. Among our Medicaid ABD membership, PMPM premiums range from approximately $320 in Utah to $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare premiums are almost $1,100 PMPM, with Medicare revenue totaling $265.2 million, $135.9 million, and $95.1 million, for the years ended December 31, 2010, 2009, and 2008, respectively.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2010	2009	2008
Total Ending Membership by Health Plan:			
California	344,000	351,000	322,000
Florida	61,000	50,000	—
Michigan	227,000	223,000	206,000
Missouri	81,000	78,000	77,000
New Mexico	91,000	94,000	84,000
Ohio	245,000	216,000	176,000
Texas	94,000	40,000	31,000
Utah	79,000	69,000	61,000
Washington	355,000	334,000	299,000
Wisconsin(1)	36,000	—	—
Total	1,613,000	1,455,000	1,256,000
Total Ending Membership by State for our Medicare Advantage Plans(1):			
California	4,900	2,100	1,500
Florida	500	—	—
Michigan	6,300	3,300	1,700
New Mexico	600	400	300
Texas	700	500	400
Utah	8,900	4,000	2,400
Washington	2,600	1,300	1,000
Total	24,500	11,600	7,300
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	13,900	13,900	12,700
Florida	10,000	8,800	—
Michigan	31,700	32,200	30,300
New Mexico	5,700	5,700	6,300
Ohio	28,200	22,600	19,000
Texas	19,000	17,600	16,200
Utah	8,000	7,500	7,300
Washington	4,000	3,200	3,000
Wisconsin(1)	1,700	—	—
Total	122,200	111,500	94,800

(1) We acquired the Wisconsin health plan on September 1, 2010. As of December 31, 2010, the Wisconsin health plan had approximately 3,000 Medicare Advantage members covered under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

Our Molina Medicaid Solutions segment provides technology solutions to state Medicaid programs that include system design, development, implementation, and technology outsourcing services. In addition, this segment offers business process outsourcing services such as claims processing, provider enrollment, pharmacy drug rebate services, recipient eligibility management, and pre-authorization services to state Medicaid agencies.

Molina Medicaid Solutions has contracts with five states to design, develop, implement, maintain, and operate Medicaid Management Information Systems (MMIS). These contracts extend over a number of years, and cover the life of the MMIS from inception through at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds. In some circumstances, revenue recognition may be delayed for long periods while we await formal customer acceptance of our products and/or services. In those circumstances, recognition of a portion of our costs may also be deferred.

Under our contracts in Louisiana, New Jersey, and West Virginia, we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue on a straight-line basis over the remaining term of the contract. In Maine, we completed the DDI phase of our contract effective September 1, 2010. In Idaho, we expect to complete the DDI phase of our contract during 2011. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in 2011.

Additionally, Molina Medicaid Solutions provides pharmacy rebate administration services under a contract with the state of Florida.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with the providers. We pay hospitals on a fee-for-service basis in a variety of ways, including by per diem amounts, by diagnostic-related groups, or DRGs, as a percentage of billed charges, and by case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract; under certain circumstances, we pay escalated charges in connection with these stop-loss agreements. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.
- *Capitation* — Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management,

and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy* — Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Other* — Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance costs, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2010, 2009 and 2008, medically related administrative costs were approximately $85.5 million, $74.6 million and $75.9 million, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Louisiana, Maine, New Jersey, West Virginia and Florida, as well as certain selling, general and administrative expenses. Additionally, certain indirect costs incurred under our contracts in Maine (prior to exiting the DDI phase of that contract in September, 2010) and Idaho are also expensed to cost of services.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contact costs during 2011, in a manner consistent with our anticipated recognition of revenue.

Results of Operations

Year Ended December 31, 2010 Compared with the Year Ended December 31, 2009

Health Plans Segment

Premium Revenue

Premium revenue grew 9.0% in the year ended December 31, 2010, compared with the year ended December 31, 2009, due to a membership increase of 10.9%. On a PMPM basis, however, consolidated premium revenue decreased 2.1% because of declines in premium rates. The decrease in PMPM revenue was due to the transfer of the pharmacy benefit to the state fee-for-service programs in Ohio (effective February 1, 2010) and Missouri (effective October 1, 2009). Exclusive of the transfer of the pharmacy benefit in Ohio and Missouri, Medicaid premium revenue PMPM increased approximately 1.5% over the year ended December 31, 2009. Medicare enrollment exceeded 24,000 members at December 31, 2010, and Medicare premium revenue was $265.2 million for the year ended December 31, 2010, compared with $135.9 million for the year ended December 31, 2009.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$2,360,858	$128.73	70.0%	$2,077,489	$126.14	65.4%
Capitation	555,487	30.29	16.5	558,538	33.91	17.6
Pharmacy	325,935	17.77	9.7	414,785	25.18	13.1
Other	128,577	7.01	3.8	125,424	7.62	3.9
Total	$3,370,857	$183.80	100.0%	$3,176,236	$192.85	100.0%

The medical care ratio decreased to 84.5% for the year ended December 31, 2010, compared with 86.8% for the year ended December 31, 2009.

The medical care ratio of the California health plan decreased to 83.5% for the year ended December 31, 2010, compared with 92.2% for the year ended December 31, 2009, primarily due to lower inpatient facility fee-for-service costs resulting from provider network restructuring and improved medical management.

The medical care ratio of the Florida health plan increased to 95.4% for the year ended December 31, 2010, from 93.8% for the year ended December 31, 2009, primarily due to higher capitation costs and higher fee-for-service costs in the outpatient and physician categories.

The medical care ratio of the Michigan health plan increased to 83.7% for the year ended December 31, 2010, from 81.5% for the year ended December 31, 2009, primarily due to higher inpatient facility fee-for-service costs.

The medical care ratio of the New Mexico health plan decreased to 80.6% for the year ended December 31, 2010, from 85.7% for the year ended December 31, 2009, primarily due to reduced fee-for-service costs which more than offset decreased premium revenue PMPM.

The medical care ratio of the Ohio health plan decreased to 79.1% for the year ended December 31, 2010, from 86.1% for the year ended December 31, 2009, primarily due to an increase in Medicaid premium PMPM of approximately 6% effective January 1, 2010 (exclusive of the reduction related to pharmacy benefits), partially offset by higher inpatient facility fee-for-service costs.

The medical care ratio of the Utah health plan decreased to 91.3% for the year ended December 31, 2010, from 91.8% for the year ended December 31, 2009, due to improved financial performance in the second half of 2010. That improved financial performance was the result of reduced fee-for-service costs in the second half of 2010 and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010.

The medical care ratio of the Washington health plan decreased to 83.9% for the year ended December 31, 2010 from 84.5% for the year ended December 31, 2009, primarily due to reduced fee-for-service costs which more than offset decreased premium revenue PMPM. Premium revenue PMPM decreased for all of 2010 compared with 2009 because the rate increase of approximately 2.5% effective July 1, 2010 was not enough to offset decreases received during the second half of 2009.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	4,197	$ 506,871	$120.77	$ 423,021	$100.79	83.5%	$ 6,912
Florida	664	170,683	256.87	162,839	245.07	95.4	1
Michigan	2,708	630,134	232.66	527,596	194.80	83.7	39,187
Missouri	946	210,852	222.98	180,291	190.66	85.5	—
New Mexico	1,104	366,784	332.02	295,633	267.61	80.6	9,300
Ohio	2,817	860,324	305.42	680,802	241.69	79.1	67,358
Texas	708	188,716	266.72	162,714	229.97	86.2	3,251
Utah	921	258,076	280.27	235,576	255.84	91.3	—
Washington	4,141	758,849	183.27	636,617	153.75	83.9	13,513
Wisconsin(2)	134	30,033	224.75	27,574	206.35	91.8	—
Other(3)	—	8,587	—	38,194	—	—	253
	18,340	$3,989,909	$217.56	$3,370,857	$183.80	84.5%	$139,775

	Year Ended December 31, 2009						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	4,135	$ 481,717	$116.49	$ 443,892	$107.34	92.2%	$ 16,446
Florida	386	102,232	264.94	95,936	248.62	93.8	16
Michigan	2,523	557,421	220.94	454,431	180.12	81.5	36,482
Missouri	927	230,222	248.25	191,585	206.59	83.2	—
New Mexico	1,042	404,026	387.67	346,044	332.03	85.7	11,043
Ohio	2,411	803,521	333.33	691,402	286.82	86.1	47,849
Texas	402	134,860	335.69	110,794	275.78	82.2	2,513
Utah	793	207,297	261.43	190,319	240.02	91.8	—
Washington	3,847	726,137	188.77	613,876	159.58	84.5	14,175
Wisconsin(2)	—	—	—	—	—	—	—
Other(3),(4)	—	12,774	—	37,957	—	—	57
	16,466	$3,660,207	$222.24	$3,176,236	$192.85	86.8%	$128,581

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

(4) As of December 31, 2009, our Nevada health plan no longer served members. Premium revenue and medical care costs for the Nevada health plan have been included in "Other."

Days in Medical Claims and Benefits Payable

Beginning January 1, 2010, and for all prior periods presented, we are reporting days in medical claims and benefits payable relating to fee-for-service medical claims only. This computation includes only fee-for-service

medical care costs and related liabilities, and therefore calculates the extent of reserves for those liabilities that are most subject to estimation.

The days in medical claims and benefits payable amount previously reported included *all* medical care costs (fee-for-service, capitation, pharmacy, and administrative), and *all* medical claims liabilities, including those liabilities that are typically paid concurrently, or shortly after the costs are incurred, such as capitation costs and pharmacy costs. Medical claims liabilities in this calculation do not include accrued costs — such as salaries — associated with the administrative portion of medical costs. By including only fee-for-service medical costs and liabilities in this computation, our days in claims payable metric is more indicative of the size of our reserves for liabilities subject to a substantial degree of estimation. The days in medical claims and benefits payable, excluding our Wisconsin health plan which was acquired September 1, 2010, were as follows:

	December 31,		
	2010	2009	2008
Days in claims payable — fee-for-service only	42 days	44 days	51 days
Number of claims in inventory at end of period	143,600	93,100	87,300
Billed charges of claims in inventory at end of period (in thousands)	$218,900	$131,400	$115,400

Molina Medicaid Solutions Segment

Molina Medicaid Solutions contributed $2.6 million to operating income for the year ended December 31, 2010, but reported an operating loss of $3.6 million for the quarter ended December 31, 2010. The operating loss for the fourth quarter of 2010 was primarily the result of system stabilization costs incurred for two of Molina Medicaid Solutions' contracts.

Performance of the Molina Medicaid Solutions segment for the year ended December 31, 2010 was as follows:

	(In thousands)
Service revenue before amortization	$98,125
Less: amortization of contract backlog recorded as contra-service revenue	(8,316)
Service revenue	89,809
Cost of service revenue	78,647
General and administrative costs	5,135
Amortization of customer relationship intangibles recorded as amortization	3,418
Operating income	$ 2,609

Consolidated Expenses

General and Administrative Expenses

General and administrative, or G&A, expenses, were $346.0 million, or 8.5% of total revenue, for the year ended December 31, 2010 compared with $276.0 million, or 7.5% of total revenue, for the year ended December 31, 2009. The increase in the G&A ratio was the result of higher administrative expenses for the Health Plans segment, driven in part by the cost of our Medicare expansion, higher variable compensation expense as a result of substantially improved financial performance in 2010, employee severance and settlement costs, and costs relating to the acquisitions of Molina Medicaid Solutions and the Wisconsin health plan.

	Year Ended December 31,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 30,254	0.7%	$ 18,564	0.5%
Non Medicare-related administrative costs:				
Health Plans segment administrative payroll, including employee incentive compensation	239,146	5.9	204,432	5.6
Molina Medicaid Solutions segment administrative expenses	5,135	0.1	—	—
Employee severance and settlement costs	5,548	0.1	1,257	—
Molina Medicaid Solutions and Wisconsin plan acquisition costs	2,957	0.1	—	—
All other Health Plans segment administrative expense	62,953	1.6	51,774	1.4
	$345,993	8.5%	$276,027	7.5%

Premium Tax Expense

Premium tax expense relating to Health Plans segment premium revenue was 3.5% of revenue for both years ended December 31, 2010, and 2009.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different captions in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization in "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of service revenue; and
- Depreciation is recorded as cost of service revenue.

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue, and reconciles that amount to the consolidated statements of cash flows.

	Year Ended December 31,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Depreciation	$27,230	0.7%	$25,172	0.7%
Amortization of intangible assets	18,474	0.4	12,938	0.3
Depreciation and amortization reported in the consolidated statements of income	45,704	1.1	38,110	1.0
Amortization recorded as reduction of service revenue	8,316	0.2	—	—
Depreciation recorded as cost of service revenue	6,745	0.2	—	—
Depreciation and amortization reported in the consolidated statements of cash flows	$60,765	1.5%	$38,110	1.0%

Interest Expense

Interest expense increased to $15.5 million for the year ended December 31, 2010, from $13.8 million for the year ended December 31, 2009. We incurred higher interest expense relating to the $105 million draw on our credit facility (beginning May 1, 2010) to fund the acquisition of Molina Medicaid Solutions. Amounts borrowed to fund this acquisition were repaid in the third quarter using proceeds from our equity offering in the third quarter of 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $5.1 million and $4.8 million for the years ended December 31, 2010, and 2009, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 38.6% for the year ended December 31, 2010 compared with 19.1% for the year ended December 31, 2009. The lower rate in 2009 was primarily due to discrete tax benefits recorded in 2009 as a result of settling tax examinations, and higher than previously estimated tax credits.

For the year ended December 31, 2009, amounts for premium tax expense and income tax expense have been reclassified to conform to the 2010 presentation of MGRT as a premium tax. The MGRT amounted to $6.2 million and $5.5 million for the years ended December 31, 2010, and 2009, respectively. There was no impact to net income for either period presented relating to this change.

Year Ended December 31, 2009 Compared with the Year Ended December 31, 2008

Health Plans Segment

Premium Revenue

Premium revenue grew approximately 18% in the year ended December 31, 2009 compared with the same period in 2008. During 2009, membership grew 16% overall, with Florida, California, Washington, and Ohio gaining the most members. Consolidated premium revenue increased 5.3% on a PMPM basis. Increased membership contributed 71% of the growth in premium revenue, and increases in PMPM revenue, as a result of both rate changes and shifts in member mix, contributed the remaining 29%.

We received PMPM premium reductions in 2009 that were in many cases correlated with reductions in the Medicaid fee schedule that also reduced our medical costs. However, PMPM premium reductions in Washington and Missouri in 2009 were not fully commensurate with changes in the Medicaid fee schedule in those states, and thus decreases in premiums were not matched by lower medical costs. In Washington, premium reductions not

linked to decreases in the Medicaid fee schedule lowered our medical margin by approximately $13 million in 2009. In Missouri, the transfer of the pharmacy benefit to the state fee-for-service program effective October 1, 2009 reduced our medical margin by approximately $1.2 million in 2009.

Medical care costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2009			2008		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$2,077,489	$126.14	65.4%	$1,709,806	$116.69	65.2%
Capitation	558,538	33.91	17.6	450,440	30.74	17.2
Pharmacy	414,785	25.18	13.1	356,184	24.31	13.6
Other	125,424	7.62	3.9	104,882	7.16	4.0
Total	$3,176,236	$192.85	100.0%	$2,621,312	$178.90	100.0%

Medical care costs, in the aggregate, increased 8% on a PMPM basis for the year ended December 31, 2009 compared with the same period in 2008. The medical care ratio was 86.8% for the year ended December 31, 2009, compared with 84.8% for the same period in 2008. Increased expenses were generally the result of higher utilization rather than higher unit costs (except in the case of outpatient costs, where both utilization and unit costs increased) and were most pronounced in connection with physician and outpatient emergency room facility services. Influenza-related illnesses and the costs associated with more recently enrolled members were key factors in the higher utilization. We estimate that the incremental costs associated with influenza-related illnesses were approximately $35 million, or $0.83 per diluted share, in the year ended December 31, 2009 compared with the year ended December 31, 2008.

Physician and outpatient costs exhibited the most significant unfavorable cost trend in the year ended December 31, 2009. Together, these costs increased approximately 13% on a PMPM basis compared with the same period in 2008. Consistent with our experience throughout 2009, emergency room utilization (up approximately 9%) and cost per visit (up approximately 8%) were the primary drivers of increased cost in the year ended December 31, 2009.

Inpatient costs were flat on a PMPM basis year-over-year despite increased utilization.

Pharmacy costs (including the benefit of rebates) increased 6% on a PMPM basis year-over-year, excluding the Missouri health plan, where the pharmacy benefit was transferred to the sate fee-for-service program effective October 1, 2009. Pharmacy utilization increased approximately 6% year-over-year, while unit costs (excluding rebates) were flat.

Capitated costs increased approximately 10% PMPM year-over-year, primarily as a result of rate increases received for members capitated on a percentage of premium basis at the New Mexico health plan, and the transition of members into capitated arrangements in California.

Health Plans Segment Operating Data

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2009						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	4,135	$ 481,717	$116.49	$ 443,892	$107.34	92.2%	$ 16,446
Florida(2)	386	102,232	264.94	95,936	248.62	93.8	16
Michigan	2,523	557,421	220.94	454,431	180.12	81.5	36,482
Missouri	927	230,222	248.25	191,585	206.59	83.2	—
New Mexico	1,042	404,026	387.67	346,044	332.03	85.7	11,043
Ohio	2,411	803,521	333.33	691,402	286.82	86.1	47,849
Texas	402	134,860	335.69	110,794	275.78	82.2	2,513
Utah	793	207,297	261.43	190,319	240.02	91.8	—
Washington	3,847	726,137	188.77	613,876	159.58	84.5	14,175
Other(3),(4)	—	12,774	—	37,957	—	—	57
	16,466	$3,660,207	$222.24	$3,176,236	$192.85	86.8%	$128,581

	Year Ended December 31, 2008						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	3,721	$ 417,027	$112.06	$ 363,776	$ 97.75	87.2%	$ 12,503
Florida(2)	—	—	—	—	—	—	—
Michigan	2,526	509,782	201.86	405,683	160.64	79.6	31,760
Missouri	910	225,280	247.62	184,298	202.58	81.8	—
New Mexico	970	348,576	359.45	286,004	294.92	82.1	11,713
Ohio	1,998	602,826	301.76	549,182	274.91	91.1	30,505
Texas	348	110,178	316.32	84,324	242.09	76.5	1,995
Utah	659	155,991	236.75	139,011	210.98	89.1	—
Washington	3,514	709,943	202.02	575,085	163.64	81.0	11,668
Other(3),(4)	—	11,637	—	33,949	—	—	21
	14,646	$3,091,240	$210.97	$2,621,312	$178.90	84.8%	$100,165

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) The Florida health plan began enrolling members in December 2008.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

(4) As of December 31, 2009, our Nevada health plan no longer served members. Premium revenue and medical care costs for the Nevada health plan have been included in "Other."

General and administrative expenses

G&A expenses were 7.5% of revenue in the year ended December 31, 2009, compared with 8.0% for the year ended December 31, 2008. Year-over-year, premium revenue grew faster than administrative costs, causing administrative costs, as a percentage of revenue, to decrease. On a PMPM basis, G&A decreased to $16.76 in 2009, from $17.04 for the same period in 2008.

	Year Ended December 31,			
	2009		2008	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 18,857	0.5%	$ 18,451	0.6%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	205,396	5.6	190,932	6.1
Florida health plan start up expenses	—	—	2,495	0.1
All other administrative expense	51,774	1.4	37,768	1.2
G&A expenses	$276,027	7.5%	$249,646	8.0%

Depreciation and Amortization

Depreciation and amortization expense increased $4.4 million for the year ended December 31, 2009 compared with 2008, primarily due to depreciation expense associated with investments in infrastructure. The following table presents the components of depreciation and amortization:

	Year Ended December 31,			
	2009		2008	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Depreciation	$25,172	0.7%	$20,718	0.7%
Amortization of intangible assets	12,938	0.3	12,970	0.4
Depreciation and amortization reported in the consolidated statements of cash flows	$38,110	1.0%	$33,688	1.1%

Gain on Retirement of Convertible Senior Notes

In February 2009, we purchased and retired $13.0 million face amount of our convertible senior notes. In connection with the purchase of the notes, we recorded a pretax gain of $1.5 million in 2009. There was no comparable transaction in 2008.

Interest Expense

Interest expense was $13.8 million for the year ended December 31, 2009, a slight increase over interest expense of $13.2 million for the year ended December 31, 2008. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $4.8 million, and $4.7 million for the years ended December 31, 2009, and 2008, respectively.

Income Taxes

Income taxes were recorded at an effective rate of 19.1% for the year ended December 31, 2009, compared with 36.8% in the prior year. The decrease in the effective tax rate was primarily due to discrete tax benefits recognized during the year relating to settling tax examinations, and higher than previously estimated California enterprise zone tax credits.

For the years ended December 31, 2009 and 2008, amounts for premium tax expense and income tax expense have been reclassified to conform to the presentation of MGRT as a premium tax. The MGRT amounted to $5.5 million and $5.1 million for the years ended December 31, 2009, and 2008, respectively. There was no impact to net income for either period presented relating to this change.

Acquisitions

Wisconsin Health Plan. On September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. As of December 31, 2010, we expect the final purchase price for the acquisition to be approximately $15.5 million, subject to adjustments. As of December 31, 2010, we had paid $8.5 million of the total purchase price. In the first quarter of 2011 we will compute the final purchase price based on the plan's membership on that date.

Molina Medicaid Solutions. On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*[SM] as described in "Overview," above.

Florida Health Plan. On December 31, 2009, we acquired 100% of the voting equity interests in Florida NetPASS, LLC, or NetPASS. The final purchase price totaled $29.6 million.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our premium revenue or our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2010, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $6.3 million for the year ended December 31, 2010, compared with $9.1 million for year ended December 31, 2009. This decline was primarily due to lower interest rates in 2010. The annualized portfolio yields for the years ended December 31, 2010, 2009, and 2008, were 0.7%, 1.2%, and 3.0%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect to incur significantly losses due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the year ended December 31, 2010 was $161.6 million compared with $155.4 million for the year ended December 31, 2009, an increase of $6.2 million. Deferred revenue, which was a use of operating cash totaling $41.9 million in 2010, was a source of operating cash totaling $88.2 million in 2009. In 2009, the state of Ohio typically paid premiums in advance of the month the premium was earned. In 2010, the state of Ohio delayed its premium payments to mid-month for the month premium is earned. Therefore, we did not receive advance payments for the Ohio health plan's premiums during 2010. The change in deferred revenue was offset by increases in net income, depreciation and amortization, and other current liabilities.

Cash used in investing activities increased significantly in 2010 compared with 2009, due chiefly to the acquisition of Molina Medicaid Solutions, which totaled $131.3 million.

Cash provided by financing activities increased due to funds generated by our equity offering in the third quarter of 2010, which totaled $111.1 million, net of issuance costs. Amounts borrowed under our credit facility to fund the acquisition of Molina Medicaid Solutions in the second quarter of 2010 were repaid in the third quarter using proceeds from the equity offering.

Reconciliation of Non-GAAP(1) to GAAP Financial Measures

EBITDA(2)

	Year Ended December 31,	
	2010	2009
	(In thousands)	
Operating income	$105,001	$51,934
Add back:		
Depreciation and amortization reported in the consolidated statements of cash flows	60,765	38,110
EBITDA	$165,766	$90,044

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) We calculate EBITDA consistently on a quarterly and annual basis by adding back depreciation and amortization to operating income. Operating income includes investment income. EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At December 31, 2010, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $65.1 million, including $6.0 million in non-current auction rate securities, compared with $45.6 million of cash and investments at December 31, 2009.

On a consolidated basis, at December 31, 2010, we had working capital of $392.4 million compared with $321.2 million at December 31, 2009. At December 31, 2010 and December 31, 2009, cash and cash equivalents were $455.9 million and $469.5 million, respectively. At December 31, 2010, investments were $315.8 million, including $20.4 million in non-current auction rate securities, and at December 31, 2009, investments were $234.5 million, including $59.7 million in non-current auction rate securities.

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. We borrowed $105 million under the Credit Facility to acquire Molina Medicaid Solutions in the second quarter of 2010. During the third quarter of 2010, we repaid this amount using proceeds from our equity offering, described in Note 14 to the accompanying audited consolidated financial statements for the year ended December 31, 2010. As of December 31, 2010, and 2009, there was no outstanding principal debt balance under the Credit Facility. However, as of December 31, 2010, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the contract of MMS with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2010, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio set forth pursuant to the Credit Facility was 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first and second quarters of 2010, and through August 14, 2010. Effective as of August 15, 2010, the consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We also paid an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through August 15, 2010.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering. As a result of the offering described below, we may now offer up to $182.5 million of our securities from time to time under the shelf registration statement.

In August 2010, we sold 4,350,000 shares of common stock covered by this registration statement. The public offering price for this sale was $25.65 per share, net of the underwriting discount. Our proceeds from the sales totaled approximately $111.1 million, net of the issuance costs. We used the proceeds from these sales to repay the Credit Facility and for general corporate purposes. Also in August 2010, the Molina Siblings Trust, as a selling stockholder, sold 250,000 shares of outstanding common stock covered by this registration statement.

Securities Purchase Programs

Under securities purchase programs announced in 2009, we purchased and retired $13.0 million face amount of our convertible senior notes. Also during 2009, we purchased approximately 1,352,000 shares of our common stock for $28 million.

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). During 2009, we purchased and retired $13.0 million face amount of the Notes. As of December 31, 2010, the remaining aggregate principal amount of the Notes was $187.0 million. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $397.8 million at December 31, 2010, and $368.7 million at December 31, 2009.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At December 31, 2010, our health plans had aggregate statutory capital and surplus of approximately $416.6 million, compared to the required minimum aggregate statutory capital and surplus of approximately $278.0 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2010. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2011.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;

- The deferral of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Certain components of premium revenue of our Health Plans segment are subject to accounting estimates, and are therefore subject to retroactive revision. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At December 31, 2010, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.
- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2010, we had recorded a liability of $5.6 million under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the

existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. The state of New Mexico's fiscal year ends June 30, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending June 30, 2011, our New Mexico health plan has received $5.4 million in at-risk revenue as of December 31, 2010. To date, we have recognized $3.5 million of that amount as revenue, and recorded a liability of approximately $1.9 million as of December 31, 2010, for the remainder. If the state of New Mexico disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. Effective February 1, 2010 an additional 0.25% of the Ohio health plan's revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Ohio's fiscal year ends June 30, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending June 30, 2011, our Ohio health plan has received $13.8 million in at-risk revenue as of December 31, 2010. To date, we have recognized $4.5 million of that amount as revenue and recorded a liability of approximately $9.3 million as of December 31, 2010, for the remainder. If the state of Ohio disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required. During the third quarter of 2010, we reversed the recognition of approximately $3.3 million of at-risk revenue previously recognized.

- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at December 31, 2010.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas there is a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of December 31, 2010, we had an aggregate liability of approximately $0.6 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2010 and 2011 contract years (ending August 31 of each year). We paid $2.6 million to the state under the terms of this profit sharing agreement during the year ended December 31, 2010, for the 2009 and 2010 contract years. Because the final settlement

calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, an adjustment to the amounts owed may be required.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Texas's fiscal year ends August 31, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending August 31, 2011, our Texas health plan has received $2.2 million in at-risk revenue, all of which has been recognized as revenue, as of December 31, 2010. If the state of Texas disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns we have recorded a liability of approximately $1.2 million related to the potential recoupment of Medicare premium revenue at December 31, 2010. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

Deferral of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solution segment contracts are multiple-element arrangements. We have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services. While all contracts support the system of record for state MMIS, the actual services and products we provide vary significantly between contracts; and

- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. Although the length of the DDI phase for any MMIS contract can vary considerably, the DDI phase typically takes about two years to complete. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all

revenue will be recognized over the period that BPO services and training and IT support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services or training and IT support services) until the contingency had been removed. In these circumstances we would also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the contract (whether DDI, BPO services or training and IT support services) on which revenue recognition is being deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

We began to recognize revenue (and related deferred costs) associated with our Maine contract in September 2010. In Idaho, we expect to begin recognition of deferred contact costs during 2011, in a manner consistent with our anticipated recognition of revenue. Unamortized deferred contract costs relating to the Molina Medicaid Solutions segment at December 31, 2010 were $28.4 million.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	December 31,		
	2010	2009	2008
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$275,259	$246,508	$236,492
Capitation payable	49,598	39,995	28,111
Pharmacy	14,649	20,609	18,837
Other	14,850	8,204	9,002
	$354,356	$315,316	$292,442

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately

pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $275.3 million of our total medical claims and benefits payable of $354.4 million as of December 31, 2010. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at December 31, 2010 was $268.3 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2010 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2010, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 80,667
(4)%	53,778
(2)%	26,889
2%	(26,889)
4%	(53,778)
6%	(80,667)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2010 that would have resulted had we altered our trend factors by the

percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$(64,958)
(4)%	(43,305)
(2)%	(21,653)
2%	21,653
4%	43,305
6%	64,958

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 27.8 million diluted shares outstanding for the year ended December, 2010. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2010, net income for the year ended December 31, 2010 would increase or decrease by approximately $8.5 million, or $0.31 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2010, net income for the year ended December 31, 2010 would increase or decrease by approximately $6.8 million, or $0.25 per diluted share, net of tax. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $42.4 million, or $1.53 per diluted share, and $34.1 million, or $1.23 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $8.5 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously

reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2010, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 15.7%.

As shown in greater detail in the table below, the amounts ultimately paid out on our prior period liabilities in fiscal years 2009 and 2010 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

For the year ended December 31, 2010, we recognized a benefit from prior period claims development in the amount of $49.4 million (see table below). This amount represents our estimate as of December 31, 2010 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2009 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2009 was due primarily to the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

We recognized a benefit from prior period claims development in the amount of $51.6 million in the year ended December 31, 2009 (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2008. The overestimation of claims liability at December 31, 2008 was the result of the following factors:

- In New Mexico, we overestimated at December 31, 2008 the ultimate amounts we would need to pay to resolve certain high dollar provider claims.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008.
- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt

of paper claims would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

In estimating our claims liability at December 31, 2010, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The rapid growth of membership in our Medicare line of business between December 31, 2009 and December 31, 2010.
- Our assumption of risk for new populations in Texas (rural CHIP members) and Wisconsin (Medicaid members) effective September 1, 2010.
- An increase in claims inventory at our Florida, Michigan, New Mexico, Ohio and Texas health plans between September 30, 2010 and December 31, 2010.
- A decrease in claims inventory at our Utah health plan between September 30, 2010 and December 31, 2010.
- The transition of claims processing for our Missouri health plan from a third party service provider to our internal claims processing platform effective April 1, 2010.
- Changes to the Medicaid fee schedule in Utah effective July 1, 2010.
- Changes to provider reimbursement rates (primarily for outpatient facility costs) in New Mexico effective November 1, 2010.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2009 and 2010, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "*Components of medical care costs related to:* Prior years" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2010	2009
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of year	$ 315,316	$ 292,442
Balance of acquired subsidiary	3,228	—
Components of medical care costs related to:		
Current year	3,420,235	3,227,794
Prior years	(49,378)	(51,558)
Total medical care costs	3,370,857	3,176,236
Payments for medical care costs related to:		
Current year	3,085,388	2,920,015
Prior years	249,657	233,347
Total paid	3,335,045	3,153,362
Balances at end of year	$ 354,356	$ 315,316
Benefit from prior years as a percentage of:		
Balance at beginning of year	15.7%	17.6%
Premium revenue	1.2%	1.4%
Medical care costs	1.5%	1.6%
Claims Data(1):		
Days in claims payable, fee for service only	42	44
Number of members at end of period	1,613,000	1,455,000
Fee-for-service claims processing and inventory information:		
Number of claims in inventory at end of period	143,600	93,100
Billed charges of claims in inventory at end of period	$ 218,900	$ 131,400
Claims in inventory per member at end of period	0.09	0.06
Billed charges of claims in inventory per member at end of period	$ 135.71	$ 90.31
Number of claims received during the period	14,554,800	12,930,100
Billed charges of claims received during the period	$11,686,100	$ 9,769,000

(1) "Claims Data" does not include our Wisconsin health plan acquired September 1, 2010.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2010, our lease obligations for the next five years and thereafter were as follows: $28.0 million in 2011, $23.8 million in 2012, $20.3 million in 2013, $17.4 million in 2014, $13.7 million in 2015, and an aggregate of $30.6 million thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 18 to the accompanying audited consolidated financial statements for the year ended December 31, 2010.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2010. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2011	2012-2013	2014-2015	2016 and Beyond
Medical claims and benefits payable	$354,356	$354,356	$ —	$ —	$ —
Principal amount of long-term debt(1)	187,000	—	—	187,000	—
Operating leases	133,806	28,004	44,143	31,037	30,622
Interest on long-term debt	26,297	7,012	14,025	5,260	—
Purchase commitments	28,557	13,401	14,828	328	—
Total contractual obligations	$730,016	$402,773	$72,996	$223,625	$30,622

(1) Represents the principal amount due on our 3.75% Convertible Senior Notes due 2014.

As of December 31, 2010, we have recorded approximately $11.0 million of unrecognized tax benefits. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 13 to the accompanying audited consolidated financial statements for the year ended December 31, 2010 for further information.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Inflation

Although the general rate of inflation has remained relatively stable and health care cost inflation has stabilized in recent years, the national health care cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. While we currently believe our strategies will mitigate health care cost inflation, competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2010 and 2009, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2010. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2010 and 2009, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2010, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 8, 2011 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 8, 2011

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31, 2010	December 31, 2009
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 455,886	$ 469,501
Investments	295,375	174,844
Receivables	168,190	136,654
Income tax refundable	—	6,067
Deferred income taxes	15,716	8,757
Prepaid expenses and other current assets	22,772	14,383
Total current assets	957,939	810,206
Property and equipment, net	100,537	78,171
Deferred contract costs	28,444	—
Intangible assets, net	105,500	80,846
Goodwill and indefinite-lived intangible assets	212,228	133,408
Investments	20,449	59,687
Restricted investments	42,100	36,274
Receivable for ceded life and annuity contracts	24,649	25,455
Other assets	17,368	19,988
	$1,509,214	$1,244,035
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 354,356	$ 315,316
Accounts payable and accrued liabilities	137,930	71,732
Deferred revenue	60,086	101,985
Income taxes payable	13,176	—
Total current liabilities	565,548	489,033
Long-term debt	164,014	158,900
Deferred income taxes	16,235	12,506
Liability for ceded life and annuity contracts	24,649	25,455
Other long-term liabilities	19,711	15,403
Total liabilities	790,157	701,297
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 30,309 shares at December 31, 2010 and 25,607 shares at December 31, 2009	30	26
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	251,627	129,902
Accumulated other comprehensive loss	(2,192)	(1,812)
Retained earnings	469,592	414,622
Total stockholders' equity	719,057	542,738
	$1,509,214	$1,244,035

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2010	2009	2008
	(In thousands, except per-share data)		
Revenue:			
Premium revenue	$3,989,909	$3,660,207	$3,091,240
Service revenue	89,809	—	—
Investment income	6,259	9,149	21,126
Total revenue	4,085,977	3,669,356	3,112,366
Expenses:			
Medical care costs	3,370,857	3,176,236	2,621,312
Cost of service revenue	78,647	—	—
General and administrative expenses	345,993	276,027	249,646
Premium tax expenses	139,775	128,581	100,165
Depreciation and amortization	45,704	38,110	33,688
Total expenses	3,980,976	3,618,954	3,004,811
Gain on purchase of convertible senior notes	—	1,532	—
Operating income	105,001	51,934	107,555
Interest expense	(15,509)	(13,777)	(13,231)
Income before income taxes	89,492	38,157	94,324
Provision for income taxes	34,522	7,289	34,726
Net income	$ 54,970	$ 30,868	$ 59,598
Net income per share:			
Basic	$ 2.00	$ 1.19	$ 2.15
Diluted	$ 1.98	$ 1.19	$ 2.15
Weighted average shares outstanding:			
Basic	27,449	25,843	27,676
Diluted	27,754	25,984	27,772

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
				(In thousands)			
Balance at January 1, 2008	28,444	$28	$210,310	$ 272	$324,156	$(20,390)	$514,376
Comprehensive income:							
Net income	—	—	—	—	59,598	—	59,598
Other comprehensive income, net of tax:							
Unrealized loss on investments	—	—	—	(7,025)	—	—	(7,025)
Other-than-temporary impairment of available-for-sale securities	—	—	—	4,443	—	—	4,443
Total comprehensive income	—	—	—	(2,582)	59,598	—	57,016
Purchase of treasury stock	—	—	—	—	—	(49,940)	(49,940)
Retirement of treasury stock	(1,943)	(1)	(49,939)	—	—	49,940	—
Stock issued in business purchase transaction	48	—	1,262	—	—	—	1,262
Stock options exercised, employee stock grants and employee stock plan purchases	176	—	9,340	—	—	—	9,340
Tax deficiency from employee stock compensation	—	—	(292)	—	—	—	(292)
Balance at December 31, 2008	26,725	27	170,681	(2,310)	383,754	(20,390)	531,762
Comprehensive income:							
Net income	—	—	—	—	30,868	—	30,868
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	498	—	—	498
Total comprehensive income	—	—	—	498	30,868	—	31,366
Purchase of treasury stock	—	—	—	—	—	(27,712)	(27,712)
Retirement of treasury stock	(1,352)	(1)	(48,101)	—	—	48,102	—
Retirement of convertible debt	—	—	(476)	—	—	—	(476)
Employee stock grants and employee stock plan purchases	234	—	8,516	—	—	—	8,516
Tax deficiency from employee stock compensation	—	—	(718)	—	—	—	(718)
Balance at December 31, 2009	25,607	26	129,902	(1,812)	414,622	—	542,738
Comprehensive income:							
Net income	—	—	—	—	54,970	—	54,970
Other comprehensive income, net of tax:							
Unrealized loss on investments	—	—	—	(380)	—	—	(380)
Total comprehensive income	—	—	—	(380)	54,970	—	54,590
Common stock issued, net of issuance costs	4,350	4	111,127	—	—		111,131
Employee stock grants and employee stock plan purchases	352	—	11,271	—	—	—	11,271
Tax deficiency from employee stock compensation	—	—	(673)	—	—	—	(673)
Balance at December 31, 2010	30,309	$30	$251,627	$(2,192)	$469,592	$ —	$719,057

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Operating activities:			
Net income	$ 54,970	$ 30,868	$ 59,598
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	60,765	38,110	33,688
Unrealized (gain) loss on trading securities	(4,170)	(3,394)	399
Loss (gain) on rights agreement	3,807	3,100	(6,907)
Other-than-temporary impairment on available-for-sale securities	—	—	7,166
Deferred income taxes	(4,092)	(1)	(3,404)
Stock-based compensation	9,531	7,485	7,811
Non-cash interest on convertible senior notes	5,114	4,782	4,707
Gain on purchase of convertible senior notes	—	(1,532)	—
Amortization of deferred financing costs	1,780	1,872	1,435
Tax deficiency from employee stock compensation	(968)	(749)	(335)
Loss on disposal of property and equipment	—	—	142
Changes in operating assets and liabilities, net of effects of business combinations:			
Receivables	(7,539)	(8,092)	(17,025)
Prepaid expenses and other current assets	(9,756)	383	(2,245)
Medical claims and benefits payable	34,363	22,874	(19,164)
Accounts payable and accrued liabilities	40,482	(26,467)	10,830
Deferred revenue	(41,899)	88,181	(26,300)
Income taxes	19,258	(2,049)	(9,965)
Net cash provided by operating activities	161,646	155,371	40,431
Investing activities:			
Purchases of equipment	(48,538)	(35,870)	(34,690)
Purchases of investments	(302,842)	(186,764)	(263,229)
Sales and maturities of investments	225,106	204,365	246,524
Net cash paid in business combinations	(130,743)	(11,294)	(1,000)
Increase in deferred contract costs	(29,319)	—	—
(Increase) decrease in restricted investments	(5,566)	1,928	(9,183)
Change in other noncurrent assets and liabilities	2,830	(10,078)	(2,942)
Net cash used in investing activities	(289,072)	(37,713)	(64,520)
Financing activities:			
Proceeds from common stock offering, net of issuance costs	111,131	—	—
Amount borrowed under credit facility	105,000	—	—
Repayment of amount borrowed under credit facility	(105,000)	—	—
Treasury stock purchases	—	(27,712)	(49,940)
Purchase of convertible senior notes	—	(9,653)	—
Credit facility fees paid	(1,671)	—	—
Proceeds from employee stock plans	4,056	2,015	2,084
Excess tax benefits from employee stock compensation	295	31	43
Net cash provided by (used in) financing activities	113,811	(35,319)	(47,813)
Net (decrease) increase in cash and cash equivalents	(13,615)	82,339	(71,902)
Cash and cash equivalents at beginning of year	469,501	387,162	459,064
Cash and cash equivalents at end of year	$ 455,886	$ 469,501	$ 387,162

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (Continued)

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 18,299	$ 23,480	$ 46,088
Interest	$ 10,951	$ 8,205	$ 7,797
Schedule of non-cash investing and financing activities:			
Retirement of treasury stock	$ —	$ 48,102	$ 49,940
Details of business combinations:			
Fair value of assets acquired	$(159,916)	$ (34,594)	$ (2,262)
Release of escrow and other deposits	—	18,000	—
Common stock issued to seller	—	—	1,262
Less payable to seller	4,723	5,300	—
Fair value of liabilities assumed	24,450	—	—
Net cash paid in business purchase transactions	$(130,743)	$ (11,294)	$ (1,000)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of December 31, 2010. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010, we terminated operations at our small Medicare health plan in Nevada.

Our Molina Medicaid Solutions, which we acquired during 2010, segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. All significant intercompany transactions and balances have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition. Our operating results for the year ended December 31, 2010, include the results of the following businesses acquired during 2010:

- *Molina Medicaid Solutions.* On May 1, 2010, we acquired a health information management business which now operates under the name, *Molina Medicaid Solutions*SM. See Note 4, "Business Combinations," for more information relating to this acquisition.
- *Wisconsin Health Plan.* On September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. See Note 4, "Business Combinations," for more information relating to this acquisition.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure 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. Principal areas requiring the use of estimates include:

- The determination of revenue to be recognized by our Health Plans segment under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;
- The determination of medical claims and benefits payable of our Health Plans segment;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;

- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax as a premium tax and not as an income tax. For the years ended December 31, 2009, and 2008, amounts for premium tax expense and income tax expense have been reclassified to conform to this presentation. See Note 2, "Significant Accounting Policies."

In prior periods, general and administrative expenses have included premium tax expenses. Beginning in 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

We have reclassified certain other prior year balance sheet amounts to conform to the 2010 presentation.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income.

The cost of securities sold is determined using the specific-identification method, on an amortized cost basis. Fair values of securities are generally based on quoted prices in active markets.

Our investment policy requires that all of our investments have final maturities of five years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be two years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. Our auction rate securities are classified as non-current assets. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," and Note 6, "Investments" and Note 10, "Restricted Investments."

Receivables

Receivables consist primarily of amounts due from the various states in which we operate, and are subject to potential retroactive adjustment. Because such receivables are readily determinable and our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables." Additionally, we cede 100% of the financial responsibility for Medicare members covered by our Wisconsin health plan to third a party health reinsurer. In connection with the arrangement, as of December 31, 2010, we have recorded a receivable from the third party reinsurer of $5.0 million along with a corresponding current liability of $5.0 million.

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years. See Note 8, "Property and Equipment."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software, which may be ultimately transferred to our clients under fixed-price contracts, are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Deferral of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO, arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solution segment contracts are multiple-element arrangements. We have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services. While all contracts support the system of record for state MMIS, the actual services and products we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and IT support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase

of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services or training and IT support services) until the contingency had been removed. In these circumstances we would also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the contract (whether DDI, BPO services or training and IT support services) on which revenue recognition is being deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

We began to recognize revenue (and related deferred costs) associated with our Maine contract in September 2010. In Idaho, we expect to begin recognition of deferred contact costs during 2011, in a manner consistent with our anticipated recognition of revenue. Unamortized deferred contract costs relating to the Molina Medicaid Solutions segment at December 31, 2010 were $28.4 million.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are amortized on a straight-line basis over the expected period to be benefited (generally between one and 15 years). See Note 9, "Goodwill and Intangible Assets."

Goodwill and indefinite-lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. We use a discounted cash flow methodology to assess the fair values of our reporting units. If the carrying values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill and indefinite-lived asset balance derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite-lived asset balance. Based on the results of our impairment testing, no adjustments were required for the years ended December 31, 2010, 2009 and 2008.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships.

The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to the acquisition. The contract backlog intangible has been developed on a contract-by-contract basis. The amortization of that portion of the contract backlog intangible associated with contracts for which revenue recognition has not yet commenced is deferred until revenue recognition has begun. Because each acquired contract constitutes a single revenue stream, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a straight-line basis for each specific contract over periods generally ranging from one to six years.

The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

The determination of the value of identifiable intangible assets requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. In addition to annual impairment testing, we continually evaluate whether events and circumstances have occurred that indicate the balance of identifiable intangible assets may not be recoverable. In evaluating impairment, we compare the estimated fair value of the intangible asset to its underlying book value. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event occurs that would cause us to revise our estimates and assumptions used in analyzing the value of our identifiable intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different captions in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization in "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of service revenue; and
- Depreciation is recorded as cost of service revenue.

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue, and reconciles that amount to the consolidated statements of cash flows.

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Depreciation	$27,230	$25,172	$20,718
Amortization of intangible assets	18,474	12,938	12,970
Depreciation and amortization reported in our consolidated statements of income	45,704	38,110	33,688
Amortization recorded as reduction of service revenue	8,316	—	—
Depreciation recorded as cost of service revenue	6,745	—	—
Depreciation and amortization reported in our consolidated statements of cash flows	$60,765	$38,110	$33,688

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted expected cash flows associated with that asset. In such circumstances, the asset is deemed to be impaired. We review material long-lived assets for impairment when events or changes in business conditions suggest potential impairment. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that

these contracts will continue to be renewed. Impaired assets are written down to fair value. We have determined that no long-lived assets were impaired in the years ended December 31, 2010, 2009, and 2008.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Receivable/Liability for Ceded Life and Annuity Contracts

We report a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts.

Other Assets

Significant items included in other assets include deferred financing costs associated with our convertible senior notes and with our credit facility, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see Note 17, "Related Party Transactions"). The deferred financing costs are being amortized on a straight-line basis over the seven-year term of the convertible senior notes and the five year term of the credit facility.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2010, or December 31, 2009.

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2010 we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These

premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue by health plan for the periods indicated:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
California	$ 506,871	$ 481,717	$ 417,027
Florida(1)	170,683	102,232	—
Michigan	630,134	557,421	509,782
Missouri	210,852	230,222	225,280
New Mexico	366,784	404,026	348,576
Ohio	860,324	803,521	602,826
Texas	188,716	134,860	110,178
Utah	258,076	207,297	155,991
Washington	758,849	726,137	709,943
Wisconsin(2)	30,033	—	—
Other	8,587	12,774	11,637
	$3,989,909	$3,660,207	$3,091,240

(1) The Florida health plan began enrolling members in December 2008.

(2) We acquired the Wisconsin health plan on September 1, 2010.

For the year ended December 31, 2010, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates, and therefore are subject to retroactive revision. The most significant of these estimates involve:

- The recognition of premium revenue at our Florida, New Mexico, and Texas health plans, where we are subject to a number of requirements, that, among other things, require us to expend a minimum amount of revenue on certain defined medical costs, expend a maximum amount of revenue on certain defined administrative costs, and share our profits (as defined) above a certain percentage of revenue with the state;
- The recognition of premium revenue due to the achievement of certain performance measures (generally linked to quality of care and administrative efficiency) included in our contracts with the states of New Mexico, Ohio, and Texas;
- The recognition of premium revenue due to the achievement of certain medical cost savings (as measured against state fee-for-service costs) under our contract with the state of Utah; and
- The amount of Medicare premium revenue that we recognize, which may be retroactively adjusted to reflect the acuity of care required by our members.

Medical Care Costs

Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. Most hospitals are paid on a fee-for-service basis in a

variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. As discussed below, we also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed per-member per-month, or PMPM, payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2010, 2009, and 2008, medically related administrative costs were approximately $85.5 million, $74.6 million, and $75.9 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2010			2009			2008		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for- service..	$2,360,858	$128.73	70.0%	$2,077,489	$126.14	65.4%	$1,709,806	$116.69	65.2%
Capitation.....	555,487	30.29	16.5	558,538	33.91	17.6	450,440	30.74	17.2
Pharmacy	325,935	17.77	9.7	414,785	25.18	13.1	356,184	24.31	13.6
Other	128,577	7.01	3.8	125,424	7.62	3.9	104,882	7.16	4.0
Total.....	$3,370,857	$183.80	100.0%	$3,176,236	$192.85	100.0%	$2,621,312	$178.90	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been

paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates. See Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Our California, Florida, Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in premium tax expense.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2010, or 2009.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers. For further discussion and disclosure, see Note 13, "Income Taxes."

Through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax, and prior years have been reclassified to conform to this presentation. We will continue to record the BIT as an income tax. The MGRT amounted to $6.2 million, $5.5 million and $5.1 million for the years ended December 31, 2010, 2009, and 2008 respectively.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers is defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of our Michigan plan's receipts and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2010, and 2009, our investments with PFM totaled $327 million and $296 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2010, we operated health plans in 10 states, primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements

Revenue Recognition. In late 2009, the Financial Accounting Standards Board, or FASB, issued the following new accounting guidance which is first applicable for our January 1, 2011 reporting:

- *ASU No. 2009-14, Software (ASC Topic 985) — Certain Revenue Arrangements That Include Software Elements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies the scope of ASC Subtopic 985-605 — *Software-Revenue Recognition* to exclude from its requirements (a) non-software components of tangible products and (b) software components of tangible products that are sold, licensed or leased with tangible products when the software components and non-software components of the tangible product function together to deliver the tangible product's essential functionality. We do not expect the update to impact our consolidated financial position, results of operations or cash flows.

- *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies previous requirements by allowing the use of the "best estimate of selling price" in the absence of vendor-specific objective evidence ("VSOE") or verifiable objective evidence ("VOE") (now referred to as "TPE" or third-party evidence) for determining the selling price of a deliverable. A vendor is now required to use its best estimate of the selling price when more objective evidence of the selling price cannot be determined. In addition, the residual method of allocating arrangement consideration is no longer permitted. As of December 31, 2010, we do not expect the update to impact our consolidated financial position, results of operations or cash flows; however, the future impact of the update will be dependent on future contracts and modifications to existing contracts.

Fair Value Measurements. In January 2010, the FASB issued the following guidance which expanded the required disclosures about fair value measurements. Effective for interim and annual reporting beginning after December 15, 2009, with one new disclosure effective beginning after December 15, 2010, we adopted this guidance in full during the interim period ended March 31, 2010.

- *ASU No. 2010-6, Fair Value Measurements and Disclosures (Topic 820) — Improving Disclosures about Fair Value Measurements.* This guidance requires (a) separate disclosure of the amounts of significant transfers in and out of Level 1 and Level 2 fair value measurements along with the reasons for such transfers, (b) information about purchases, sales, issuances and settlements to be presented separately in the reconciliation for Level 3 fair value measurements, (c) fair value measurement disclosures for each class of assets and liabilities and (d) disclosures about the valuation techniques and inputs used to measure fair value for both recurring and nonrecurring fair value measurements for fair value measurements that fall in either Level 2 or Level 3. The adoption of this guidance did not impact our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the AICPA, and the SEC did not, or are not believed by management to have a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Shares outstanding at the beginning of the year	25,607	26,725	28,444
Weighted-average number of shares:			
Issued under equity offering	1,671	—	—
Purchased	—	(988)	(871)
Issued under employee stock plans	171	106	103
Denominator for basic earnings per share	27,449	25,843	27,676
Dilutive effect of employee stock options and stock grants(1)	305	141	96
Denominator for diluted earnings per share(2)	27,754	25,984	27,772

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2010, 2009 and 2008, there were approximately 478,000, 620,000, and 532,000 anti-dilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the

periods presented. For the years ended December 31, 2010, 2009 and 2008, anti-dilutive weighted restricted shares were insignificant.

(2) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2010, 2009 and 2008.

4. Business Combinations

Wisconsin Health Plan

On September 1, 2010, Molina acquired 100% of the voting equity interests in Avatar Partners, LLC, which is the sole shareholder of Abri Health Plan, Inc. ("Abri"), a Medicaid managed care organization based in Milwaukee, Wisconsin. This acquisition is consistent with our stated strategy to enter markets with competitive provider communities, supportive regulatory environments, significant size and, where practicable, mandated Medicaid managed care enrollment.

We expect the final purchase price for the Abri acquisition to be approximately $15.5 million, subject to adjustments. As of December 31, 2010, we had paid $8.5 million of the total purchase price. We expect to finalize the amount due to the sellers based on the final membership reconciliation in the first quarter of 2011. Additionally, $2.8 million of the purchase price represents contingent consideration based on the plan's minimum surplus requirements as of February 1, 2011, which will also be computed in the first quarter of 2011. Any adjustments to the estimated amount of contingent consideration will be recorded to operations in the first quarter of 2011. Following the final membership reconciliation, 10% of the final purchase price for the membership acquired will be deposited to an escrow account payable at the later of 12 months or the resolution of all unresolved claims. We incurred approximately $0.5 million in acquisition costs relating to this acquisition in 2010, recorded to general and administrative expenses.

In connection with this acquisition, we recorded $5.5 million in goodwill, which is not deductible for tax purposes, and $3.4 million in various definite-lived identifiable intangible assets, with a weighted average useful life of 6.4 years. Accumulated amortization totaled approximately $0.4 million as of December 31, 2010, which reflects amortization recorded since the acquisition date. We expect to record amortization relating to this acquisition in future years as follows— 2011: $0.9 million, 2012: $0.4 million, 2013: $0.3 million, 2014: $0.3 million, and 2015: $0.2 million.

Molina Medicaid Solutions

On May 1, 2010, we acquired a health information management business that was previously an operating unit of Unisys Corporation. This business now operates under the name *Molina Medicaid Solutions*[SM], or Molina Medicaid Solutions. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. As a result of this acquisition, we are diversifying our core health plan business, and we believe that the use of a common claims processing platform across our health plans and our new MMIS business will enable us to achieve synergies in the operations of both.

We paid $131.3 million to acquire Molina Medicaid Solutions. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility. In connection with the closing, both the fourth amendment and the fifth amendment to our credit facility became effective (see Note 12, "Long-Term Debt"). We incurred approximately $2.5 million in acquisition costs relating to this acquisition in 2010, recorded to general and administrative expenses. Additionally, effective on the acquisition date, we entered into a transition services

agreement with Unisys Corporation. Under this agreement, Unisys is providing Molina Medicaid Solutions various systems and infrastructure support services until April 30, 2011. During 2010, we recorded approximately $4.7 million to cost of service revenue relating to this agreement.

Recording of assets acquired and liabilities assumed: The transaction has been accounted for using the acquisition method of accounting which requires, among other things, that most assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date.

The following table summarizes the acquisition-date fair values of the assets acquired and liabilities assumed:

	(In thousands)
Assets	
Accounts receivable	$ 17,128
Other current assets	3,901
Equipment and other long-term assets	783
Identifiable intangible assets	48,150
Goodwill	72,367
	142,329
Less: liabilities	
Accounts payable and accrued liabilities	11,079
Net assets acquired	$131,250

A single estimate of fair value results from a complex series of judgments about future events and uncertainties and relies heavily on estimates and assumptions. Results that differ from the estimates and judgments used to determine the estimated fair value assigned to each class of assets acquired and liabilities assumed, as well as asset lives, can materially impact our results of operations.

Accounts receivable: Accounts receivable are stated at fair value, based on the gross contractual amounts receivable. We have collected substantially all of the accounts receivable as of the acquisition date.

Identifiable intangible assets: The following table is a summary of the fair value estimates of the identifiable intangible assets and their weighted-average useful lives:

	Estimated Fair Value	Weighted Average Useful Life
	(In thousands)	(Years)
Customer relationships	$24,550	5.3
Contract backlog	23,600	2.4
	$48,150	

Accumulated amortization totaled approximately $11.7 million as of December 31, 2010, which reflects total amortization recorded since the acquisition date. For identifiable intangible assets recorded as of December 31, 2010, we expect to record amortization in future years as follows — 2011: $13.2 million, 2012: $7.6 million, 2013: $7.6 million, 2014: $5.6 million, and 2015: $0.8 million.

Goodwill: Goodwill in the amount of $72.4 million was recognized for this acquisition, all of which is expected to be deductible for tax purposes. The total goodwill amount was calculated as the excess of the consideration transferred over the net assets recognized and represents the future economic benefits arising from

other assets acquired that could not be individually identified and separately recognized. The goodwill recorded as part of the acquisition of Molina Medicaid Solutions includes:

- Expected synergies and other benefits that we believe will result from combining the operations of Molina Medicaid Solutions with the operations of Molina;
- Any intangible assets that do not qualify for separate recognition such as the assembled workforce; and
- The value of the going-concern element of Molina Medicaid Solutions' existing businesses (the higher rate of return on the assembled collection of net assets versus acquiring all of the net assets separately).

Accounts payable and accrued liabilities: Accounts payable and accrued liabilities include $1.3 million payable to the seller of Molina Medicaid Solutions, which represented a working capital adjustment provided in the purchase agreement. This working capital adjustment was paid to the seller in August 2010. The working capital adjustment provided that the net working capital, or current assets minus current liabilities, on Molina Medicaid Solutions' opening balance sheet would equal $10 million. To the extent the final net working capital conveyed by the seller exceeded $10 million, the amount would be payable back to the seller; conversely, to the extent that net working capital conveyed by the seller was less than $10 million, the shortage would be a receivable from the seller. Thus, the $1.3 million amount described above represented the amount payable to the seller for net working capital in excess of $10 million on the opening balance sheet.

Pro-forma impact of the acquisition: The unaudited pro-forma results presented below include the effects of the acquisition as if it had been consummated as of January 1, 2010, 2009 and 2008. The pro-forma results include the amortization associated with the acquired intangible assets and interest expense associated with debt used to fund the acquisition. To better reflect the combined operating results, material non-recurring charges directly attributable to the transaction have been excluded. In addition, the pro-forma results do not include any anticipated synergies or other expected benefits of the acquisition. Accordingly, the unaudited pro forma financial information below is not necessarily indicative of either future results of operations or results that might have been achieved had the acquisition been consummated as of January 1, 2010, January 1, 2009, or January 1, 2008.

	Year Ended December 31,		
	2010	2009	2008
Revenue	$4,124,058	$3,767,888	$3,202,581
Net income	$ 57,800	$ 26,192	$ 54,228
Diluted earnings per share	$ 2.08	$ 1.01	$ 1.95

Florida Health Plan

On December 31, 2009, we acquired 100% of the voting equity interests in Florida NetPASS, LLC, or NetPASS. The final purchase price for this acquisition totaled $29.6 million. As of the final membership reconciliation in the second quarter of 2010, we transitioned approximately 49,600 members from NetPASS to our Florida health plan, and have recorded $18.0 million in goodwill, and $11.6 million in intangible assets relating to these members.

On April 15, 2010, the former owners of NetPASS filed suit in federal court stating that we had not paid $12 million of the purchase price that was owed and based on a formula in the purchase agreement. Because the purchase agreement contained an arbitration clause, the Florida health plan filed a demand for arbitration seeking a declaration that the full purchase price had been paid and the purchase agreement had been fulfilled. The former owners of NetPASS filed a counter-demand for an additional $10 million and seeking a declaration regarding the anti-competition clause in the purchase agreement. The parties have exchanged documents and will start to take depositions. Arbitration is scheduled to commence June 10, 2011. We continue to believe that their claims do not have any merit and that we will prevail in this action.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

As described in Note 12, "Long-Term Debt," the carrying amount of the convertible senior notes was $164.0 million, and $158.9 million as of December 31, 2010, and 2009, respectively. Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was approximately $188.4 million, and $160.8 million as of December 31, 2010, and 2009, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of December 31, 2010, we held certain assets that are required to be measured at fair value on a recurring basis. These included investments as follows:

Balance Sheet Classification	Description
Current assets:	
Investments	Investment-grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1). See Note 6, "Investments," for further information regarding fair value.
Non-current assets:	
Investments	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).

As of December 31, 2010, $24.6 million par value (fair value of $20.4 million) of our investments consisted of auction rate securities, all of which were collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2010. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, 2009, and continued to be unavailable as of December 31, 2010. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of December 31, 2010. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As of December 31, 2010, all of our auction rate securities were designated as available-for-sale securities. As a result of the decrease in fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized losses of $0.2 million to accumulated other comprehensive loss for the year ended December 31, 2010. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to

accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Until July 2, 2010, we held certain auction rate securities (designated as trading securities) with an investment securities firm. In the fourth quarter of 2008, we entered into a rights agreement with this firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. On June 30, 2010, and July 1, 2010, all of the eligible auction rate securities remaining at that time were settled at par value.

During 2010, the aggregate auction rate securities (designated as trading securities) settled amounted to $40.9 par value (fair value $36.7 million). For the years ended December 31, 2010, 2009, and 2008, we recorded pretax gains (losses) of $4.2 million, $3.4 million, and ($0.4) million, respectively, on the auction rate securities underlying the Rights.

We accounted for the Rights as a freestanding financial instrument and, until July 2, 2010, recorded the value of the Rights under the fair value option. When the remaining eligible auction rate securities were sold at par value on July 1, 2010, the value of the Rights was zero. For the years ended December 31, 2010, 2009, and 2008, we recorded pretax (losses) gains of ($3.8) million, ($3.1) million and $6.9 million, respectively, on the Rights.

Our assets measured at fair value on a recurring basis at December 31, 2010, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$177,929	$177,929	$—	$ —
Government-sponsored enterprise securities	59,713	59,713	—	—
Municipal securities	30,563	30,563	—	—
U.S. treasury notes	23,918	23,918	—	—
Certificates of deposit	3,252	3,252	—	—
Auction rate securities (available-for-sale)	20,449	—	—	20,449
	$315,824	$295,375	$—	$20,449

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3) (In thousands)
Balance at December 31, 2009	$ 63,494
Total gains (realized or unrealized):	
Included in earnings:	
Gain on auction rate securities designated as trading securities	4,170
Loss on change in fair value of Rights	(3,807)
Included in other comprehensive income	(208)
Settlements	(43,200)
Balance at December 31, 2010	$ 20,449
The amount of total losses for the period included in other comprehensive income attributable to the change in unrealized gains relating to assets still held at December 31, 2010	$ (208)

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

As described in Note 4, "Business Combinations," we have recorded a $2.8 million liability for contingent consideration related to the acquisition of our Wisconsin health plan. We have estimated the fair value of this liability based on our expectations regarding the Wisconsin health plan's statutory net worth as of January 31, 2011 as well as the Wisconsin health plan's minimum required statutory net worth as of that date. The liability for contingent consideration related to this acquisition was measured at fair value on a recurring basis using significant unobservable inputs (Level 3). The following table presents a roll forward of this liability for 2010:

	(Level 3) (In thousands)
Balance at December 31, 2009	$ —
Addition through acquisition — 2010	2,800
Balance at December 31, 2010	$2,800

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2010			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$179,124	$193	$1,388	$177,929
Government-sponsored enterprise securities (GSEs)	59,790	293	370	59,713
Municipal securities (including non-current auction rate securities)	55,247	78	4,313	51,012
U.S. treasury notes	23,864	114	60	23,918
Certificates of deposit	3,252	—	—	3,252
	$321,277	$678	$6,131	$315,824

	December 31, 2009			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 32,543	$ 206	$ 185	$ 32,564
GSEs	89,451	504	281	89,674
Municipal securities (including non-current auction rate securities)	82,009	3,120	4,154	80,975
U.S. treasury notes	28,052	92	84	28,060
Certificates of deposit	3,258	—	—	3,258
	$235,313	$3,922	$4,704	$234,531

The contractual maturities of our investments as of December 31, 2010 are summarized below.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$168,948	$167,856
Due one year through five years	127,549	127,144
Due after five years through ten years	930	990
Due after ten years	23,850	19,834
	$321,277	$315,824

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $124.5 million, $60.3 million, and $55.3 million for the years ended December 31, 2010, 2009 and 2008, respectively. Net realized investment gains for the years ended December 31, 2010, 2009 and 2008 were $110,000, $267,000, and $342,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at December 31, 2010 and 2009 are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we do not intend to sell these securities prior to maturity, we are unlikely to experience gains or losses. In the unlikely event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Approximately 40% of our investment in municipal securities consists of auction rate securities. As described in Note 5, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at December 31, 2010.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months and those that have been in a loss position for 12 months or more as of December 31, 2010.

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2010		In a Continuous Loss Position for 12 Months or More as of December 31, 2010		Total as of December 31, 2010	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
			(In thousands)			
Corporate debt securities	$103,225	$1,060	$10,490	$ 328	$113,715	$1,388
GSEs	13,014	71	7,539	299	20,553	370
Municipal securities	18,884	117	25,271	4,196	44,155	4,313
U.S. treasury notes	5,480	40	6,806	20	12,286	60
	$140,603	$1,288	$50,106	$4,843	$190,709	$6,131

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2009. At December 31, 2009, we previously reported only those available-for-sale investments in an unrealized loss position for at least two consecutive months. To conform to the current year presentation, we have

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

included all available-for-sale investments in an unrealized loss position at December 31, 2009. This presentation change increased the total amount of unrealized losses reported in the following table by $113,000 at December 31, 2009. The accompanying increase to the estimated fair value of the underlying investments amounted to $42.9 million at December 31, 2009.

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2009		In a Continuous Loss Position for 12 Months or More as of December 31, 2009		Total as of December 31, 2009	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
			(In thousands)			
Corporate debt securities	$13,513	149	$ 1,203	$ 36	$ 14,716	$ 185
GSEs	30,460	187	7,297	94	37,757	281
Municipal securities	12,460	78	24,031	3,902	36,491	3,980
U.S. treasury notes	21,824	84	—	—	21,824	84
	$78,257	$498	$32,531	$4,032	$110,788	$4,530

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	December 31,	
	2010	2009
	(In thousands)	
Health Plans Segment:		
California	$ 46,482	$ 34,289
Michigan	13,596	14,977
Missouri	22,841	19,670
New Mexico	18,310	11,919
Ohio	21,622	37,004
Utah	1,589	6,107
Washington	14,486	9,910
Wisconsin	5,437	—
Other	3,598	2,778
Total Health Plans	147,961	136,654
Molina Medicaid Solutions Segment	20,229	—
	$168,190	$136,654

8. Property and Equipment

A summary of property and equipment is as follows:

	December 31, 2010	December 31, 2009
	(In thousands)	
Land	$ 3,524	$ 3,524
Building and improvements	49,735	41,476
Furniture and equipment	60,074	54,898
Capitalized computer software costs	90,003	66,526
	203,336	166,424
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(54,341)	(50,911)
Less: accumulated amortization for capitalized computer software costs	(48,458)	(37,342)
	(102,799)	(88,253)
Property and equipment, net	$ 100,537	$ 78,171

Depreciation expense recognized for building and improvements, and furniture and equipment was $13.9 million, $11.0 million, and $9.0 million for the years ended December 31, 2010, 2009 and 2008, respectively. Amortization expense recognized for capitalized computer software costs was $20.1 million, $14.2 million, and $11.7 million for the years ended December 31, 2010, 2009, and 2008, respectively.

9. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 11 years, for customer relationships is approximately 5 years, for backlog is approximately 2 years, and for provider networks is approximately 10 years. Based on the balances of our identifiable intangible assets as of December 31, 2010, we estimate that our intangible asset amortization will be $27.5 million in 2011, $19.0 million in 2012, $15.8 million in 2013, $12.8 million in 2014, and $7.0 million in 2015. The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses (Health Plans segment)	$120,920	$64,201	$ 56,719
Customer relationships (Molina Medicaid Solutions segment)	24,550	3,418	21,132
Backlog (Molina Medicaid Solutions segment)	23,600	8,316	15,284
Provider networks (Health Plans segment)	18,622	6,257	12,365
Balance at December 31, 2010	$187,692	$82,192	$105,500
Intangible assets:			
Contract rights and licenses	$119,101	$51,246	$ 67,855
Provider networks	17,146	4,155	12,991
Balance at December 31, 2009	$136,247	$55,401	$ 80,846

The changes in the carrying amount of goodwill and indefinite-lived intangible assets were as follows (in thousands):

Balance as of December 31, 2009	$133,408
Goodwill recorded for acquisition of Molina Medicaid Solutions on May 1, 2010	72,367
Goodwill recorded for acquisition of the Wisconsin health plan on September 1, 2010	5,474
Goodwill adjustment related to the 2009 acquisition of the Florida health plan	979
Balance at December 31, 2010	$212,228

10. Restricted Investments

Pursuant to the regulations governing our health plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the carrying value of restricted investments by health plan, and by our insurance company:

	December 31,	
	2010	2009
	(In thousands)	
California	$ 372	$ 368
Florida	4,508	2,052
Insurance Company	4,689	4,686
Michigan	1,000	1,000
Missouri	508	503
New Mexico	15,881	15,497
Ohio	9,066	9,036
Texas	3,501	1,515
Utah	1,279	578
Washington	151	151
Wisconsin	260	—
Other	885	888
	$42,100	$36,274

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2010 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$40,757	$40,792
Due one year through five years	1,218	1,216
Due after five years through ten years	125	158
	$42,100	$42,166

11. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2010 and 2009. The negative amounts displayed for "*Components of medical care costs related to: Prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2010	2009
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of year	$ 315,316	$ 292,442
Balance of acquired subsidiary	3,228	—
Components of medical care costs related to:		
Current year	3,420,235	3,227,794
Prior years	(49,378)	(51,558)
Total medical care costs	3,370,857	3,176,236
Payments for medical care costs related to:		
Current year	3,085,388	2,920,015
Prior years	249,657	233,347
Total paid	3,335,045	3,153,362
Balances at end of year	$ 354,356	$ 315,316
Benefit from prior years as a percentage of:		
Balance at beginning of year	15.7%	17.6%
Premium revenue	1.2%	1.4%
Total medical care costs	1.5%	1.6%

For the year ended December 31, 2010, we recognized a benefit from prior period claims development in the amount of $49.4 million. This amount represents our estimate as of December 31, 2010 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2009 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

For the year ended December 31, 2009, we recognized a benefit from prior period claims development in the amount of $51.6 million. This amount represented our estimate as of December 31, 2009 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2008 exceeded the amount that was ultimately be paid out in satisfaction of that liability. The overestimation of the claims liability at our Michigan, New Mexico, Ohio, and Washington health plans was principally the cause of the recognition of a benefit from prior period claims development. This was partially offset by the underestimation of our claims liability at December 31, 2008 at our California health plan.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or over-estimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. In 2010 and 2009 the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations as the amount of benefit recognized in each your was roughly consistent with that recognized in the previous year.

12. Long-Term Debt

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As described below and in Note 4, "Business Combinations," we borrowed $105 million under the Credit Facility to acquire Molina Medicaid Solutions in the second quarter of 2010. During the third quarter of 2010, we repaid this amount using proceeds from our equity offering, described in Note 14, "Stockholders' Equity." As of December 31, 2010, and 2009, there was no outstanding principal balance under the Credit Facility. However, as of December 31, 2010, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the contract of MMS with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2010, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio set forth pursuant to the Credit Facility was 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.00 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.00 for the first and second quarters of 2010, and through August 14, 2010. Effective as of August 15, 2010, the consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.00. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We also paid an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through August 15, 2010.

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, so the remaining aggregate principal amount totaled $187.0 million as of December 31, 2010 (see further discussion below regarding the purchase program). The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, the conversion rate will increase in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of December 31, 2010, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 45 months. The Notes' if-converted value did not exceed their principal amount as of December 31, 2010. At December 31, 2010, the equity component of the Notes, net of the

impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	December 31,	
	2010	2009
	(In thousands)	
Details of the liability component:		
Principal amount	$187,000	$187,000
Unamortized discount	(22,986)	(28,100)
Net carrying amount	$164,014	$158,900

	Years Ended December 31,		
	2010	2009	2008
		(In thousands)	
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate of 3.75%	$ 7,012	$ 7,076	$ 7,500
Amortization of the discount on the liability component	5,114	4,782	4,707
Total interest cost recognized	$12,126	$11,858	$12,207

Securities Purchase Program. Under the $25 million securities purchase program announced in January 2009, we purchased and retired $13.0 million face amount of the Notes during the first quarter of 2009. We purchased the Notes at an average price of $74.25 per $100 principal amount, for a total of $9.8 million, including accrued interest. The gain recognized during 2009 on the purchase of the Notes was $1.5 million.

In March 2009, our board of directors authorized the purchase of up to an additional $25 million in aggregate of either our common stock or the Notes. The purchase program was funded with working capital, and common stock purchases were made from time to time on the open market or through privately negotiated transactions during 2009. The purchase program extended through December 31, 2009. See the details regarding the common stock purchases at Note 14, "Stockholders' Equity."

13. Income Taxes

The provision for income taxes consisted of the following:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Current:			
Federal	$36,395	$ 9,421	$32,972
State	2,144	(1,558)	1,866
Total current	38,539	7,863	34,838
Deferred:			
Federal	(4,717)	1,924	378
State	700	(2,498)	(490)
Total deferred	(4,017)	(574)	(112)
Total provision for income taxes	$34,522	$ 7,289	$34,726

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

A reconciliation of the effective income tax rate to the statutory federal income tax rate is as follows:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Taxes on income at statutory federal tax rate (35)%	$31,323	$13,355	$33,014
State income taxes, net of federal benefit	1,849	(2,637)	894
(Benefit) liability for unrecognized tax benefits	(57)	(3,315)	450
Other	1,407	(114)	368
Reported income tax expense	$34,522	$ 7,289	$34,726

Through December 31, 2009, the Company's income tax expense included both the Michigan business income tax, or BIT, and the Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, the Company has recorded the MGRT as a premium tax and not as an income tax. The Company will continue to record the BIT as an income tax. For the years ended December 31, 2009 and December 31, 2008, premium tax expense and income tax expense have been reclassified to conform to this presentation.

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California enterprise zone credits.

During 2010, 2009, and 2008, tax-related deficiencies on share-based compensation were $673,000, $718,000, and $292,000, respectively. Such amounts were recorded as adjustments to income taxes payable with a corresponding decrease to additional paid-in capital.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2010 and 2009 were as follows:

	December 31,	
	2010	2009
	(In thousands)	
Accrued expenses	$ 12,618	$ 2,494
Reserve liabilities	877	285
State taxes	(120)	1,151
Other accrued medical costs	2,126	1,628
Net operating losses	27	27
Unrealized (gains) losses	(254)	(408)
Unearned premiums	3,517	6,554
Prepaid expenses	(3,006)	(2,894)
Other, net	(69)	(80)
Deferred tax asset, net of valuation allowance — current	15,716	8,757
Accrued expenses	791	(281)
Reserve liabilities	3,071	2,501
State taxes	1,960	—
Other accrued medical costs	(358)	(866)
Net operating losses	1,362	237
Unrealized losses	1,559	1,480
Unearned premiums	(135)	(264)
Depreciation and amortization	(20,110)	(10,415)
Deferred compensation	6,829	6,817
Debt basis	(9,673)	(11,555)
Other, net	(337)	(160)
Valuation allowance	(1,194)	—
Deferred tax liability, net of valuation allowance — long term	(16,235)	(12,506)
Net deferred income tax liability	$ (519)	$ (3,749)

At December 31, 2010, we had federal and state net operating loss carryforwards of $475,000 and $28 million, respectively. The federal net operating loss begins expiring in 2018, and state net operating losses begin expiring in 2015. The utilization of the net operating losses is subject to certain limitations under federal law.

At December 31, 2010, we had California enterprise zone tax credit carryovers of $3 million which do not expire.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2010, $1.2 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state tax operating loss carryforwards. We increased our valuation allowance from zero at December 31, 2009 to $1.2 million as of December 31, 2010.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These

reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Gross unrecognized tax benefits at beginning of period	$ (4,128)	$(11,676)	$(10,278)
Increases in tax positions for prior years	(6,891)	(3,748)	(3,310)
Decreases in tax positions for prior years	—	6,804	2,682
Increases in tax positions for current year	—	—	(2,061)
Decreases in tax positions for current year	—	—	892
Settlements	—	4,355	—
Lapse in statute of limitations	57	137	399
Gross unrecognized tax benefits at end of period	$(10,962)	$ (4,128)	$(11,676)

As of December 31, 2010, we had $11.0 million of unrecognized tax benefits of which $7.8 million, if fully recognized, would affect our effective tax rate. We anticipate a decrease of $499,000 to our liability for unrecognized tax benefits within the next twelve-month period due to normal expiration of tax statutes.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2010, December 31, 2009, and December 31, 2008, we had accrued $82,000, $75,000 and $1.4 million, respectively, for the payment of interest and penalties.

We may be subject to examination by the Internal Revenue Service ("IRS") for calendar years 2007 through 2010. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Missouri, and Michigan, for the years 2004 through 2010. Our subsidiary, HCLB, entered into a closing agreement with the IRS in December 2009 that successfully concluded with certainty the IRS examination of HCLB for the year ended May 2006.

14. Stockholders' Equity

In August 2010, we commenced an underwritten public offering of 4,000,000 shares of our common stock, conducted pursuant to an effective registration statement filed with the Securities and Exchange Commission on December 8, 2008. In connection with the offering, we granted the underwriters an overallotment option to purchase up to 350,000 shares, and the single selling stockholder, the Molina Siblings Trust, granted the underwriters an option to purchase up to 250,000 shares. The overallotment option was subsequently exercised in August 2010. Our chief financial officer, John Molina, is the trustee of the Molina Siblings Trust, with sole voting and investment power. Dr. J. Mario Molina, our president and chief executive officer and the brother of John Molina, is a beneficiary of the Molina Siblings Trust, as is John Molina and each of his other three siblings.

We issued 4,350,000 shares in connection with the offering, including the overallotment option. Net of the issuance costs, proceeds from the offering totaled $111.1 million, or approximately $25.55 per share, resulting in an increase to additional paid-in capital. We used the net proceeds of the offering to repay the outstanding indebtedness under the Credit Facility and for general corporate purposes. We did not receive any proceeds from the sale of shares by the selling stockholder.

In connection with the plans described in Note 16, "Stock Plans," we issued approximately 352,000 shares and 234,000 shares of common stock, net of shares retired to settle employees' income taxes, for the years ended

December 31, 2010 and 2009, respectively. This resulted in increases to additional paid-in capital of $10.6 million, and $7.8 million, both net of deferred taxes, as of December 31, 2010, and December 31, 2009, respectively.

Under the purchase program described in Note 12, "Long-Term Debt," we purchased approximately 1.4 million shares of our common stock for $27.7 million (average cost of approximately $20.49 per share) during 2009. These purchases increased diluted earnings per share for the year ended December 31, 2009 by $0.04. In 2009, we retired the $27.7 million of treasury shares purchased in 2009, and we also retired $20.4 million of treasury shares that were purchased prior to 2009 ($48.1 million in aggregate), which reduced additional paid-in capital.

15. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $5.9 million, $4.7 million and $3.9 million in the years ended December 31, 2010, 2009, and 2008, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

16. Stock Plans

In 2002, we adopted the 2002 Equity Incentive Plan (the "2002 Plan"), which provides for the award of stock options, restricted stock, performance shares, and stock bonuses to the company's officers, employees, directors, consultants, advisors, and other service providers. The 2002 Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares eligible for issuance automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. There were 4.4 million shares reserved for issuance under the 2002 Plan as of January 1, 2010.

Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our 2002 Employee Stock Purchase Plan (the "ESPP"), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. Under the ESPP, we issued 109,800 and 120,300 shares of our common stock during the years ended December 31, 2010 and 2009, respectively. Beginning January 1, 2004, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares available for issuance under the ESPP automatically increased by 1% of total outstanding capital stock. The aggregate number of unissued common shares available for future grants under the 2002 Plan and the ESPP combined was 3.7 million as of December 31, 2010, and 3.8 million as of December 31, 2009.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table illustrates the components of our stock-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2010		2009		2008	
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Pretax Charges	Pretax Charges	Net-of-Tax Amount
Restricted stock awards	$8,007	$5,044	$5,789	$3,589	$5,171	$3,206
Stock options (including expense relating to our ESPP)	1,524	960	1,696	1,052	2,640	1,637
Total	$9,531	$6,004	$7,485	$4,641	$7,811	$4,843

For both restricted stock and stock option awards, the expense is recognized over the vesting period, generally straight-line over four years. As of December 31, 2010, there was $12.5 million of unrecognized compensation cost related to unvested restricted stock awards, which we expect to recognize over a weighted-average period of 2.5 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 7.8% as of December 31, 2010. Also as of December 31, 2009, there was $0.2 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 0.3 years.

The total fair value of restricted shares vested during the years ended December 31, 2010, 2009, and 2008 was $6.4 million, $3.2 million, and $2.5 million, respectively. Unvested restricted stock activity for the year ended December 31, 2010 was as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested balance as of December 31, 2009	687,630	$24.64
Granted	554,475	$22.95
Vested	(271,381)	$25.95
Forfeited	(134,975)	$23.26
Unvested balance as of December 31, 2010	835,749	$23.32

The total intrinsic value of stock options exercised during the year ended December 31, 2010 was $0.3 million. No stock options were exercised during the year ended December 31, 2009; the total intrinsic value of stock options exercised during the year ended December 31, 2008 was nominal. Stock option activity for the year ended December 31, 2010 was as follows:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value (000s)
Outstanding at December 31, 2009	650,739	$30.25		
Exercised	(64,662)	$24.16		
Forfeited	(72,463)	$33.24		
Outstanding at December 31, 2010	513,614	$30.59	4.9	$528
Exercisable and expected to vest at December 31, 2010	512,381	$30.59	4.9	$528
Exercisable at December 31, 2010	468,564	$30.47	4.7	$528

The following is a summary of information about stock options outstanding and exercisable at December 31, 2010:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$16.98 - $28.66	243,889	4.1	$26.13	243,889	$28.66
$29.17 - $32.58	174,950	6.0	$31.33	135,200	$31.23
$33.56 - $44.29	94,775	4.7	$40.71	89,475	$39.73
	513,614			468,564	

17. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2010, and 2009, our carrying amount for this investment totaled $4.4 million, and $4.1 million, respectively. For the years ended December 31, 2010, 2009 and 2008, we paid $22.0 million, $21.8 million, and $15.4 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Until October 2010, Pacific Hospital was owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $1.0 million, $0.7 million, and $0.2 million, for the years ended December 31, 2010, 2009 and 2008, respectively. As of October 2010, Pacific Hospital is no longer owned by Abrazos Healthcare, Inc. or any other related party to the Company.

18. Commitments and Contingencies

Leases

We lease office space, clinics, equipment, and automobiles under agreements that expire at various dates through 2018. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases consist of the following approximate amounts:

Year ending December 31,	(In thousands)
2011	$ 28,004
2012	23,794
2013	20,349
2014	17,366
2015	13,671
Thereafter	30,622
Total minimum lease payments	$133,806

Rental expense related to these leases amounted to $25.1 million, $20.8 million, and $17.5 million for the years ended December 31, 2010, 2009, and 2008, respectively.

Employment Agreements

In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which have been amended and restated as of December 31, 2009. These employment agreements had initial terms of one to three years and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for 18 months. If the executives are terminated for cause, no further payments are due under the contracts.

If termination occurs within two years following a change of control, the executives will receive two times their base salary and termination bonus, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for three years.

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered through our clinics in California, Virginia and Washington. Claims-made coverage under the policies for California and Washington is $1.0 million per occurrence with an annual aggregate limit of $3.0 million for Washington, beginning in 2010, and for California, each of the years ended December 31, 2010, 2009 and 2008. Claims-made coverage under the Virginia policy is $2.0 million per occurrence with an annual aggregate limit of $6.0 million for each of the years ended December 31, 2010 and 2009, and beginning July 1, 2008. We also carry claims-made managed care errors and omissions professional liability insurance for our health plan operations. This insurance is subject to a coverage limit of $15.0 million per occurrence and $15.0 million in the aggregate for each policy year.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $397.8 million at December 31, 2010, and $368.7 million at December 31, 2009. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2010, our health plans had aggregate statutory capital and surplus of approximately $416.6 million compared with the required minimum aggregate statutory capital and surplus of approximately $278.0 million. All of our HMOs were in compliance with the minimum capital requirements at December 31, 2010. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

19. Segment Reporting

Our reportable segments are consistent with how we manage the business and view the markets we serve. In the second quarter of 2010, we added a segment to our internal financial reporting structure as a result of the acquisition of Molina Medicaid Solutions described in Note 4, "Business Combinations." We now report our financial performance based on the following two reportable segments — Health Plans and Molina Medicaid Solutions. The Health Plans segment represents our former single-segment health plan operations. The Molina Medicaid Solutions segment represents the operations of our new MMIS solutions business.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment. Operating segment revenues and profitability were as follows:

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
Year ended December 31, 2010			
Premium revenue	$3,989,909	$ —	$3,989,909
Service revenue	—	89,809	89,809
Investment income	6,259	—	6,259
Total revenue	$3,996,168	$89,809	$4,085,977
Operating income	$ 102,392	$ 2,609	$ 105,001
Year ended December 31, 2009			
Premium revenue	$3,660,207	$ —	$3,660,207
Service revenue	—	—	—
Investment income	9,149	—	9,149
Total revenue	$3,669,356	$ —	$3,669,356
Operating income	$ 51,934	$ —	$ 51,934
Year ended December 31, 2008			
Premium revenue	$3,091,240	$ —	$3,091,240
Service revenue	—	—	—
Investment income	21,126	—	21,126
Total revenue	$3,112,366	$ —	$3,112,366
Operating income	$ 107,555	$ —	$ 107,555

Reconciliation to Income before Income Taxes

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Segment operating income	$105,001	$ 51,934	$107,555
Interest expense	(15,509)	(13,777)	(13,231)
Income before income taxes	$ 89,492	$ 38,157	$ 94,324

Segment Assets

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
As of December 31, 2010	$1,333,599	$175,615	$1,509,214
As of December 31, 2009	$1,244,035	$ —	$1,244,035

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

20. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2010 and 2009.

	For The Quarter Ended			
	March 31, 2010	June 30, 2010	September 30, 2010	December 31, 2010
	(In thousands)			
Premium revenue	$965,220	$976,685	$1,005,115	$1,042,889
Service revenue	—	21,054	32,271	36,484
Operating income	20,438	21,178	29,953	33,432
Income before income taxes	17,081	17,079	25,353	29,979
Net income	10,590	10,579	16,173	17,628
Net income per share(1):				
Basic	$ 0.41	$ 0.41	$ 0.58	$ 0.58
Diluted	$ 0.41	$ 0.41	$ 0.57	$ 0.58

	For The Quarter Ended			
	March 31, 2009	June 30, 2009	September 30, 2009	December 31, 2009
	(In thousands)			
Premium revenue	$857,484	$925,507	$914,805	$962,411
Service revenue	—	—	—	—
Operating income (loss)(2)	23,161	19,488	15,089	(5,804)
Income (loss) before income taxes(2)	19,746	16,265	11,810	(9,664)
Net income (loss)	12,211	14,565	8,564	(4,472)
Net income (loss) per share(1),(3):				
Basic	$ 0.46	$ 0.56	$ 0.34	$ (0.18)
Diluted	$ 0.46	$ 0.56	$ 0.33	$ (0.18)

(1) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2010 and 2009.

(2) Effective January 1, 2010, the Company has recorded the Michigan gross receipts tax as a premium tax and not as an income tax. For each of the quarters in the year ended December 31, 2009, premium tax expense and income tax expense have been reclassified to conform to this presentation.

(3) For the quarter ended December 31, 2009, no potentially dilutive options or unvested stock awards were included in the computation of our diluted loss per share because to do so would have been anti-dilutive for that period.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

21. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2010 and 2009, and our condensed statements of income and condensed statements of cash flows for each of the three years in the period ended December 31, 2010.

Condensed Balance Sheets

	December 31, 2010	December 31, 2009
	(In thousands except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 57,020	$ 26,040
Investments	2,000	3,002
Income tax receivable	1,928	—
Deferred income taxes	7,006	—
Due from affiliates	19,059	19,121
Prepaid and other current assets	11,009	11,435
Total current assets	98,022	59,598
Property and equipment, net	81,445	65,067
Goodwill	58,719	45,943
Investments	6,046	16,516
Investment in subsidiaries	702,096	545,731
Advances to related parties and other assets	16,397	16,742
	$962,725	$749,597
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 56,910	$ 24,577
Long-term debt	164,014	158,900
Deferred income taxes	8,425	10,769
Other long-term liabilities	14,319	12,613
Total liabilities	243,668	206,859
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized, outstanding 30,309 shares at December 31, 2010 and 25,607 shares at December 31, 2009	30	26
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	251,627	129,902
Accumulated other comprehensive loss	(2,192)	(1,812)
Retained earnings	469,592	414,622
Total stockholders' equity	719,057	542,738
	$962,725	$749,597

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Income

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Revenue:			
Management fees and other operating revenue	$238,883	$218,911	$190,538
Investment income	1,153	1,540	2,733
Total revenue	240,036	220,451	193,271
Expenses:			
Medical care costs	30,582	26,865	21,759
General and administrative expenses	218,834	160,792	143,709
Depreciation and amortization	27,166	25,223	18,980
Total expenses	276,582	212,880	184,448
Gain on purchase of convertible senior notes	—	1,532	—
Operating (loss) income	(36,546)	9,103	8,823
Interest expense	(15,500)	(13,770)	(13,167)
Loss before income taxes and equity in net income of subsidiaries	(52,046)	(4,667)	(4,344)
Income tax benefit	(16,936)	(3,755)	(456)
Net loss before equity in net income of subsidiaries	(35,110)	(912)	(3,888)
Equity in net income of subsidiaries	90,080	31,780	63,486
Net income	$ 54,970	$ 30,868	$ 59,598

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Operating activities:			
Cash provided by operating activities	$ 19,380	$ 40,551	$ 17,532
Investing activities:			
Net dividends from and capital contributions to subsidiaries	70,800	21,960	42,872
Purchases of investments	(2,019)	(3,844)	(25,515)
Sales and maturities of investments	14,083	12,669	56,833
Cash paid in business purchase transactions	(139,762)	(2,894)	(1,000)
Purchases of equipment	(40,419)	(32,245)	(33,047)
Changes in amounts due to and due from affiliates	(5,723)	(17,074)	(6,542)
Change in other assets and liabilities	829	(540)	3,170
Net cash (used in) provided by investing activities	102,211	(21,968)	36,771
Financing activities:			
Proceeds from common stock offering, net of issuance costs	111,131	—	—
Amount borrowed under credit facility	105,000	—	—
Repayment of amount borrowed under credit facility	(105,000)	—	—
Treasury stock purchases	—	(27,712)	(49,940)
Purchase of convertible senior notes	—	(9,653)	—
Payment of credit facility fees	(1,671)	—	—
Excess tax benefits from employee stock compensation	295	31	43
Proceeds from exercise of stock options and employee stock plan purchases	4,056	2,015	2,084
Net cash provided (used in) by financing activities	113,811	(35,319)	(47,813)
Net increase (decrease) in cash and cash equivalents	30,980	(16,736)	6,490
Cash and cash equivalents at beginning of year	26,040	42,776	36,286
Cash and cash equivalents at end of year	$ 57,020	$ 26,040	$ 42,776

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Notes to Condensed Financial Information of Registrant

Note A — Basis of Presentation

Molina Healthcare, Inc. (Registrant) was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The parent company-only financial statements should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B — Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2010, 2009, and 2008 for these services totaled $238.5 million, $218.6 million, and $190.4 million, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C — Capital Contribution and Dividends

During 2010, 2009, and 2008, the Registrant received dividends from its subsidiaries totaling $81.3 million, $76.7 million, and $91.5 million, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2010, 2009, and 2008, the Registrant made capital contributions to certain subsidiaries totaling $10.5 million, $54.7 million, and $48.6 million, respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D — Related Party Transactions

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because the Registrant has an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2010 and 2009, the Registrant's carrying amount for this investment totaled $4.4 million and $4.1 million, respectively. For the years ended December 31, 2010, 2009 and 2008, the Registrant paid $22.0 million, $21.8 million, and $15.4 million, respectively, for medical service fees to this provider.

The Registrant is a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Until October 2010, Pacific Hospital was owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $1.0 million, $0.7 million, and $0.2 million, for the years ended December 31, 2010, 2009 and 2008, respectively. As of October 2010, Pacific Hospital is no longer owned by Abrazos Healthcare, Inc. or any other related party to the Company.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting during the three months ended December 31, 2010 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2010. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework.*

Our management's evaluation did not include an assessment of the effectiveness of internal control over financial reporting at Molina Medicaid Solutions, which was acquired on May 1, 2010. The assets and net assets of Molina Medicaid Solutions at December 31, 2010 were approximately $175.6 million and $133.1 million, respectively. Total revenue and net income of Molina Medicaid Solutions included in our consolidated results of operations for the year ended December 31, 2010 were approximately $89.8 million and $1.8 million, respectively. Our management has not had sufficient time to make an assessment of this subsidiary's internal control over financial reporting.

Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2010, based on those criteria.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on page 115 of this Annual Report on Form 10-K, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2010.

Item 9B. ***Other Information***

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Molina Medicaid Solutions (acquired May 1, 2010), which is included in the 2010 consolidated financial statements of Molina Healthcare, Inc. and constituted $175.6 million and $133.1 million of total and net assets, respectively, as of December 31, 2010, and $89.8 million and $1.8 million of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of Molina Healthcare, Inc. also did not include an evaluation of the internal control over financial reporting of Molina Medicaid Solutions.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2010 and 2009, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2010 and our report dated March 8, 2011 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 8, 2011

PART III

Item 10. ***Directors, Executive Officers, and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Proposal No. 1 — Election of Three Class III Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders. Such portion of the Proxy Statement is incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Corporate Governance," "Corporate Governance and Nominating Committee," "Corporate Governance Guidelines," and "Code of Business Conduct and Ethics." These portions of our Proxy Statement are incorporated herein by reference.

(d) Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Exchange Act requires our executive officers and directors, and persons who own more than 10% of a registered class of our equity securities, to file reports of ownership and changes in ownership with the SEC, and to furnish us with copies of the forms. Purchases and sales of our equity securities by such persons are published on our website at www.molinahealthcare.com. Based on our review of the copies of such reports, on our involvement in assisting our reporting persons with such filings, and on written representations from our reporting persons, we believe that, during 2010, each of our executive officers, directors, and greater than ten percent stockholders complied with all such filing requirements on a timely basis.

Item 11. ***Executive Compensation***

The information which will appear in our Proxy Statement for our 2011 Annual Meeting under the captions "Compensation Committee Interlocks," "Non-Employee Director Compensation," and "Compensation Discussion and Analysis," is incorporated herein by reference. The information which will appear in our Proxy Statement under the caption "Compensation Committee Report" is not incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Information About Stock Ownership." This portion of the Proxy Statement is incorporated herein by reference. The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning certain relationships and related transactions will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Related Party Transactions." Information concerning director independence will appear in our Proxy Statement under "Director Independence." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Disclosure of Auditor Fees." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The Company's consolidated financial statements, the notes thereto and the report of the Independent Registered Public Accounting Firm are on pages 67 through 113 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm
Consolidated Balance Sheets — At December 31, 2010 and 2009
Consolidated Statements of Income — Years ended December 31, 2010, 2009, and 2008
Consolidated Statements of Stockholders' Equity — Years ended December 31, 2010, 2009, and 2008
Consolidated Statements of Cash Flows — Years ended December 31, 2010, 2009, and 2008
Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 8th day of March, 2011.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	March 8, 2011
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	March 8, 2011
/s/ Joseph W. White **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	March 8, 2011
/s/ Charles Z. Fedak **Charles Z. Fedak, CPA, MBA**	Director	March 8, 2011
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	March 8, 2011
/s/ Steven Orlando **Steven Orlando, CPA (inactive)**	Director	March 8, 2011
/s/ Sally K. Richardson **Sally K. Richardson**	Director	March 8, 2011
/s/ Ronna Romney **Ronna Romney**	Director	March 8, 2011
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	March 8, 2011

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

INDEX TO EXHIBITS

Number	Description	Method of Filing
2.1	Asset Purchase Agreement between Molina Healthcare, Inc. and Unisys Corporation dated as of January 18, 2010	Filed as Exhibit 2.1. to registrant's Form 8-K filed January 19, 2010.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.2 to registrant's Form 8-K filed February 17, 2009.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2007.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2007.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2007.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	Form of Stock Option Agreement under 2002 Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.4	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.5	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.6	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.10	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.

Number	Description	Method of Filing
10.11	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
10.12	Amended and Restated Employment Agreement with Mark L. Andrews dated as of December 31, 2009 (terminated July 29, 2010)	Filed as Exhibit 10.3 to registrant's Form 8-K filed January 7, 2010.
10.13	Separation Agreement, General Waiver, and Release of Claims with Mark L. Andrews entered into July 29, 2010	Filed as Exhibit 10.1 to registrant's Form 8-K filed August 2, 2010.
10.14	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
10.15	Amended and Restated Change in Control Agreement with James W. Howatt, M.D., dated as of December 31, 2009	Filed as Exhibit 10.5 to registrant's Form 8-K filed January 7, 2010.
10.16	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
10.17	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.18	Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare, Inc., as the Borrower, certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed March 10, 2005.
10.19	First Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of October 5, 2005, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed October 13, 2005.
10.20	Second Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of November 6, 2006, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 10-Q filed November 9, 2006.
10.21	Third Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of May 25, 2008, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 31, 2008.
10.22	Fourth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of April 29, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent (date to be inserted on Fourth Amendment Effective Date)	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 19, 2010.
10.23	Fifth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of April 29, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.22 to registrant's Form 10-K filed March 16, 2010.
10.24	Office Lease with Pacific Towers Associates for 200 Oceangate Corporate Headquarters.	Filed as Exhibit 10.34 to registrant's Form 10-K filed March 17, 2008.
10.25	Hospital Services Agreement (fee-for-service) by and between Molina Healthcare of California, a California corporation, and Pacific Hospital of Long Beach	Filed as Exhibit 10.24 to registrant's Form 10-K filed March 16, 2010.

Number	Description	Method of Filing
10.26	Hospital Services Agreement (capitation) by and between Molina Healthcare of California, a California corporation, and HealthSmart Pacific, Inc., dba Pacific Hospital of Long Beach	Filed as Exhibit 10.25 to registrant's Form 10-K filed March 16, 2010.
10.27	Purchase Agreement between 200 Oceangate, LLC and Molina Center LLC dated November 30, 2010 (which terminated effective as of December 30, 2010 in accordance with its terms)	Filed herewith.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.

Attachment 17-4 -
Molina of AZ Balance Sheet

Attachment 17-4 -
Molina of AZ Balance
Sheet

Molina Healthcare of Arizona, Inc.

Balance Sheet

As of January 31, 2011

	01/31/11	Statutory	Non Admit	Net STAT
Assets				
Cash and Cash Equivalents				
1051 - Cash Acct - Money Market - CADRE (concentr)	1,500,187	1,500,187	-	1,500,187
Total Cash and Cash Equivalents	1,500,187	1,500,187	-	1,500,187
Total Current Assets	1,500,187	1,500,187	-	1,500,187
Total Assets	1,500,187	1,500,187	-	1,500,187
Liabilities and Stockholders' Equity				
Shareholders' Equity				
2900 - Issued Common Stock	100	100	-	100
2910 - Paid-in-Capital	1,499,900	1,499,900	-	1,499,900
2990.. - Retained Earnings	187	187	-	187
Total Stockholders' Equity	1,500,187	1,500,187	-	1,500,187
Total Liabilities and Equity	1,500,187	1,500,187	-	1,500,187

Attachment 36-1
Molina Network Development and Management Plan

ALTCS

NETWORK DEVELOPMENT AND MANAGEMENT PLAN

MOLINA HEALTHCARE OF ARIZONA

INITIAL NETWORK PLAN

MARCH 2011

MARCH 2011

SECTION 1 - GENERAL NETWORK CONSIDERATIONS

Molina considers provider network construction and maintenance to be dynamic undertakings which must undergo continuous evaluation and refinement. In order to assure proper input into the on-going operation of the provider network, Molina has established the Network Operations Committee. The Network Operations Committee will generate Molina's strategic network direction.

Network Operations Committee (NOC)

Molina will establish a multi-disciplinary committee to review, analyze and act upon data and information obtained from network monitoring activities. This multi-disciplinary approach will ensure that inter-related issues are communicated effectively throughout the organization, analyzed from multiple perspectives, and integrated solutions developed. The Network Operations Committee will be comprised of members from Provider Services, Network Contracting, Medical Management/Utilization Management, Compliance, Finance, Quality Improvement, as well as the Chief Operating Officer or Chief Executive Officer and the Chief Medical Officer. The Network Operations Committee will serve as the key force in addressing issues within the provider network as well as developing plans to improve the network.

The Network Operations Committee will meet on a monthly basis to address issues that emerge from collected data and reports throughout the previous month. Trends that have been identified will be discussed. These may include:

- Gaps in network coverage;
- Deficiencies in network coverage;
- Limitations with the current network;
- Physician profiling;
- Quality of care issues (if significant maybe referred to the Professional Review Committee for protected deliberations;
- Provider grievance and appeals trends;
- Provider accessibility issues;
- Provider service issues (such as immunization compliance);
- Review of the annual non-contracted services report (non-contracted providers utilized more than 25 times in a year); and
- Review of the use of Letters of Agreement to secure non-contracted provider services.
- Specific Ball vs. Biedess Gap Reporting

Tools that the Network Operations Committee will utilize include, but are not limited to:

- Geo-Access reporting
- Utilization reporting
- Pharmacy reporting
- PCP panel size reports
- Membership growth projections
- PCP closed panel reports
- Membership demographic reports
- Delegation oversight reports
- Non-participating provider utilization reports
- Institutional capacity reports

The Network Operations Committee will analyze issues and discuss appropriate courses of action to intervene or take corrective measures. The Network Operations Committee will receive direction from higher level committees such as the Quality Improvement Committee, to analyze and if appropriate, affect change. The Network Operations Committee is fully charged with affecting operational changes in the provider network. This might include targeting providers for additional training, a telephone call or a visit to a provider's office, admitting new providers to the network, or termination of a provider contract. The Network Operations Committee will track deliverables and report outcomes. Molina recognizes that all of these provider issues impact the health plan as a whole, and therefore must be addressed in a cohesive and cooperative manner. Strategies for network growth and improvement will emerge from these monthly meetings to enable efficient network management and provide clear and measurable goals.

The Network Operations Committee will also track the progress of prior program or procedural changes that were implemented to determine if they are successful and meeting program goals. If measurable outcomes are falling short of goals, the issues and programs will be analyzed again to determine further improvements needed to satisfy requirements. Molina's commitment to establish and maintain a sound network will be evident in this continuing pursuit of network improvement.

The Network Operations Committee will address all aspects of the provider network, with specific emphasis on:

- Home and Community Based Services Providers
- Institutional Providers
- Behavioral Health Providers
- General Acute Care Providers
- Ancillary Providers

Network Compliance

Subject to periodic update, the following list of potential network compliance concerns and their proposed solutions will be managed by the Network Operations Committee:

- How will Molina ensure that covered services are accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those are to non-AHCCCS persons within the same service area?

  Response: Molina will incorporate specific language in provider contracts requiring providers to provide services in accordance with the levels they provide to their patients in general. Further, providers are specifically prohibited from discriminating against our members. The Molina provider manual will also speak to this concern, this manual is provided to the provider.

  Sample language:

  Standard of Care. Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

- How will Molina ensure that covered services are provided promptly and are reasonably accessible in terms of location and hours of operation? Additionally, provider services representatives will confirm operating hours with providers upon initial and subsequent on-site appointments. Accessibility requirements are described in the Molina provider manual, which is provided to the provider.

  Response: Molina will incorporate specific language in provider contracts related to this need.

  Sample language:

  Availability of Services. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

- How will Molina ensure that there shall be sufficient personnel for the provision of all covered services, including emergency care on a 24 hour a day, 7 day a week basis?

Response: Molina will incorporate specific language in provider contracts related to this need. Additionally, the Molina Healthcare Nurse Advice Line will be available to Molina Members after hours. Additionally, the Network Operations Committee will be tasked with ensuring the best possible, network of after-hours care facilities/services are included in the network. The Molina Case Management department will comply with all aspects of the required Ball vs. Biedess Gap Reporting and will work hand in hand with Creative Networks d/b/a ResCare to ensure timely response to identified gaps.

Sample language:

Availability of Services. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

- How will Molina ensure that a priority is placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative care setting. Also, that the development of home and community based services include provisions for the availability of services on a 7 day a week basis, and for extended hours, as dictated by member needs.

  Response: Molina will ensure a robust network of services to support the needs of members who reside in their homes. Case Management staff members are encouraged to immediately notify the Provider Services area of any difficulty in securing such service in the course of business. Case Management staff, are also encouraged to quickly escalate any refusal from a provider to transition a member to a less restrictive setting. The Provider Services department staff are charged with facilitating alternative service providers, on a non-contracted basis if necessary, to meet the immediate needs of the member and with enforcing the contractual requirements of the provider. In the longer term sense, all such issues are reported to the Network Operations Committee to verify that a long-term solution is established. Additionally, Molina will work closely with direct providers of these services to ensure that an adequate pool of providers is available to meet needs on a 7 days a week basis. Molina will work closely with Creative Networks d/b/a ResCare to ensure adequate resources are available in all assigned GSAs.

Network Considerations for Special Needs Populations

ALTCS Members must have providers focused on their special needs. Molina is dedicated to fostering improved care and services for elderly frail, physically disabled, and socioeconomically disadvantaged members of its communities. Molina is their advocate; providing a voice for those who cannot speak for themselves. Molina's provider network is designed to meet the needs of its assigned membership. Molina's contracting efforts focus on ensuring adequate network support for special needs individuals. Molina utilizes a multidisciplinary team, the Network Operations Committee to monitor and track, among other things, the adequacy and accessibility of services for the Molina Special Needs Populations. The Network Operations Committee includes the Chief Medical Officer, Medical Management/Utilization Management and Case Management leaders, as well as the plan CEO, and the leaders within the Network Management department.

Behavioral Health Members

Molina Healthcare is committed to developing a comprehensive continuum of behavioral health providers to effectively meet the needs of ALTCS members, including those who have serious mental illnesses. Molina's goal is to provide member-directed, cost effective behavioral health services in the least restrictive environment. Molina is a pioneer in establishing programs to better integrate physical and behavioral health services. A model program established by the Molina Healthcare of Washington plan brought a new Molina Medical Group primary care delivery practice to an existing provider of behavioral health services to create a remarkable direct delivery model. Molina will seek out similar opportunities in Arizona to establish new and creative approaches to improve the quality of service provided while reducing costs. In support of the need to provide a full continuum of behavioral health services to Molina members, Molina has worked and will continue to work to develop a comprehensive network of behavioral health providers. The success of these efforts will be managed by the Network Operations Committee.

Homeless Members

Molina considers service to the homeless population a fundamental requirement of its program. Molina will secure agreements with Providers who care for the needs of homeless members. Molina will make resources available to assist homeless clinics with administrative issues such as obtaining prior authorization and resolving claims issues. Molina will also meet with AHCCCS representatives as needed to resolve any administrative issues and perceived barriers to homeless members accessing care.

Border Community Members

Because of the Molina Healthcare presence in several border states (California, New Mexico and Texas), Molina acquired a strong competency working with members in

border communities. Molina will establish relationships with key border community providers serving the special needs of the ALTCS population.

Arizona Early Intervention Program

Molina will work with the Arizona Department of Economic Security's AzEIP program coordinators to acquire a better understanding of the program's mission to identify members with early developmental disability education needs and who require medical and housing services. Molina is committed to educating its Primary Care Provider network on the AzEIP fundamentals and the importance of early referral to the program. AzEIP program information will be a key component of the Molina PCP training program.

HIV/AIDS Members

Molina has established a relationship with the Maricopa Integrated Health System; this system includes the McDowell Family Health Clinic. Established in 1989, this health care center is the largest provider of comprehensive and coordinated HIV related medical care. Their services include primary medical care, HIV testing and counseling, and behavioral health care. Molina will seek to establish agreements with other providers who specialize in the treatment of members in this population

Tertiary Hospital Adequacy

Molina proposes a comprehensive network of providers, including a full system of tertiary hospital centers. Molina's strategic alliance with the Banner, Maricopa, and Phoenix Children's Hospital systems offer a core tertiary care presence in central Arizona. Within each GSA, Molina offers key hospitals to provide geographic accessibility to its membership. Because Molina is a large multi-state organization, Molina can offer out of state services at participating large medical centers. To fulfill all tertiary hospital needs, a full description of the hospitals offered in the Molina network is included in each GSA network analysis. An example of Molina's use of its multi-state presence is the current agreement with Phoenix Children's Hospital to provide tertiary and telemedicine services to our members in the State of New Mexico.

Member Access to the Network

Molina provides members with written materials and a Web site describing how to access care within the Molina provider network. In many instances, access to care is facilitated by a Case Manager. Molina or the participating facility arranges and provides transportation for medical appointments. The Molina network is designed to promote improved access to care and to eliminate unnecessary barriers. In most cases, the member's assigned Primary Care Provider (PCP) is the source of a referral within the network. With very few exceptions, Molina does not require prior authorization for PCP referrals to contracted specialists. Molina members may access the following services without referral: well woman, and maternity services, and transportation services

associated with medical services. In collaboration with Molina, inpatient admissions are initiated by the attending physician.

PCP Referrals to Specialists

With very few exceptions, Molina does not require prior authorization of referrals to contracted specialists. The Molina operating model emphasizes efficient and timely access to care. Molina focuses on removing barriers to access of care. Molina strives to be a "provider-centric" organization and the provider preferred health-plan. Members and providers are Molina's largest assets. PCPs are provided a hard copy current listing of contracted specialists. An updated listing is also always available on the Molina Web site. If a PCP has questions about referrals or seeks to refer to a non-contracted specialist, a Molina call center is available to provide assistance. Molina's Medical Management/Utilization Management department accepts referral requests on-line, via facsimile, or via telephone. Molina provides education to its Providers about how to request a service approval. These include the Provider Manual, Provider Newsletters, Provider Bulletins, Molina Healthcare Web site, mailings, and Provider Services Representative meetings. Web site updates include operational and policy updates.

Molina Approach to Establishing Medical Homes

Molina is a pioneer in the establishment of patient centered medical homes, in fact Molina Healthcare was founded on one physician's desire to provide an appropriate medical home to members in need. Molina is a leader in establishing protocols for the accreditation of medical homes through the National Committee on Quality Assurance (NCQA). Quality Incentive Programs are designed to promote compliance with Molina quality and service initiatives.

Collection and Analysis of Member, Provider and Staff Feedback

Molina will be proactive in seeking opportunities to improve upon the type and quality of services provided to members. Feedback from the Molina provider network is obtained in a number of venues, including the following: meetings, internet based surveys and frequent contact.

Routine Provider Services Representative (PSR) Visits

The Molina Provider Services Representatives (PSRs) are the health plans main link to the Provider community. Provider Services Representatives will receive training in ALTCS Provider standards and requirements to ensure that all contracted Providers are adhering to these specifications.
Molina requires and encourages frequent and regular on-site visits with network providers located in assigned geographic territories. Provider Services Representatives will monitor network provider compliance with AHCCCS policies, including those related to the grievance/appeal process. The outcomes of these visits will be recorded in

Provider Services Representatives logs, which will be reviewed on a monthly by Molina's Provider Service Manager. General trends and acute problems will be reported to the appropriate department and the Network Operations Committee for evaluation and resolution on a network wide basis.

Routine Provider Office Manager Meetings (POMMs)

In each GSA, Molina, on a routine basis will conduct large scale office manager meetings which are usually breakfasts or luncheons. In addition to providing education regarding contractual and/or ALTCS program changes and requirements, these meetings are designed to provide office managers with a networking opportunity and a forum to voice concerns and issues. The meetings build and maintain relationships. Provider Service staff use a log to record concerns. The Provider Service Manager routinely reviews the logs. If the Provider Service Manager cannot resolve the issue it is brought to the attention of the Network Operations Committee for resolution.

Annual Molina Provider and Member Satisfaction Surveys

Results of annual member satisfaction surveys are presented to the Network Operations Committee, Medical Management/Utilization Management Committee (MM/UMC) and the Executive Quality Improvement Committee (EQIC). General trends from these surveys will also be discussed in this document in upcoming versions. It is often difficult to obtain a Long-term care member's survey response. In that case the survey is mailed to a family member or legal guardian.

Physician Advisory Committees (PACs)

Molina will establish, in each contracted GSA, routine meetings with key physicians to discuss general operation of the network and opportunities for improvement of the Molina operation specific to Arizona. These sessions are designed to facilitate direct and relevant data gathering and communication with key providers. Outcomes of these meetings are reported to the Network Operations Committee.

Provider Contact with Member, Provider and Medical Management/Utilization Management Departments

Molina encourages and actively facilitates network provider participation in health plan quality, credentialing and pharmaceutical and therapeutics committees. These meetings are held at Molina's office and are also arranged as conference calls or web-based meeting places. In an effort to resolve the special needs of rural providers, we strongly encourage participation in the committees. These meetings foster a sense of ownership in health plan processes. Physicians receive compensation for their time.

Protocols for Resolution of Provider Issues

Molina Network Providers are encouraged to resolve issues through contact with their assigned Provider Services Representative or through contact with the Molina Healthcare Customer Services Unit. General trends and acute issues identified in these areas are elevated to Provider Services management staff members and to the Network Operations Committee for prompt resolution. Additionally, providers are well educated on their formal appeal rights, should the informal resolution process, not meet their needs.

Molina Communication with Network Providers

Molina will establish processes and procedures for communicating and explaining to its network providers the standards for the ALTCS program, changes in laws and regulations, and changes in subcontract requirements. Through the power of frequent and effective communications with the provider network, Molina will actively keep providers up-to-date on program standards and regulatory changes to reduce their administrative burden, improve operational efficiencies, reduce unnecessary calls to Provider Services and minimize claims rework. Molina will keep providers informed of all changes following the timing specified in Molina provider agreements and ALTCS contract requirements. Updates to AHCCCS Subcontract Provisions, as amendments to the contract, will be distributed via direct mail. General updates on plan operations will be delivered using multiple methods, as listed below to ensure providers are receiving information as available.

- **Provider Manual** – The Molina Provider Manual will contain all of the ALTCS program information and regulatory requirements necessary for participation in the Molina provider network. Molina will distribute the Provider Manual to all new practitioners when they enter into a network provider contract with Molina. The Provider Manual is available in hard copy, on CD and on the provider ePortal Web site. Updates to the Molina Provider Manual are distributed throughout the year via direct mailing, facsimile distribution, and electronic mail and on the ePortal Web site.
- **Provider Web Site** – The Molina ePortal is another venue for communicating with providers when program changes or laws and regulations take effect. Molina will post changes on the Web site to alert providers of changes that impact services or requirements.
- **Direct Mail Communications** – Molina will mail notifications to providers to inform them of regulatory, subcontract, or program changes at least 30 days in advance of changes taking effect, unless regulatory or Arizona Department of Health Services' timing requires shorter timeframes.
- **Facsimile Communications** – Molina will establish a database of secure provider facsimile telephone numbers to facilitate transmission of general updates and will use "Just the Fax" software to facilitate automated facsimile distribution. This is a very cost effective means of communication within the network.
- **Electronic Mail** – Molina will establish a database of provider electronic mail

addresses to facilitate electronic submission of real-time information to its provider network.

- **Provider Newsletters** – Molina will publish and mail a Provider Newsletter on a routine basis. The newsletter will note recent changes impacting providers, general information regarding the plan, updates on quality and compliance initiatives, and upcoming training events.
- **Provider Meetings** – Molina will update providers on the latest changes that affect the provider network during Molina provider meetings. During these routine training sessions Molina will include reminders to providers to access the Molina ePortal Web site on a regular basis for access to current information.
- **Physician Advisory Committee Meetings** – Molina will establish Physician Advisory Committee meetings in each assigned Geographic Service Area that will meet no less than biannually. The intent of these meetings is to facilitate a two-way communications venue with key physicians in each community. These meetings keep Molina aware of emerging issues within the network specific to a given Geographic Service Area. These meetings also give network providers a voice in the operation of the plan and a mechanism for continuous operational improvement.
- **Provider Service Representative Interaction** – Molina Provider Service Representatives conduct routine face-to-face visits with providers. Molina emphasizes the importance of routine meetings with providers when hiring and training Provider Service Representatives. Provider Service Representatives annual evaluation criteria is heavily weighted by frequency of provider meetings and timeliness of new provider in-person orientations.

SECTION 2 - GENERAL STATUS OF THE NETWORK – MARCH 2011

Molina Healthcare of Arizona, Inc. (Molina) seeks to provide a comprehensive Long-term Care Provider Network in GSA 42, GSA 44, and GSA 52, designed to meet the specific needs of the AHCCCS Long-term Care membership. Molina will develop and maintain a comprehensive network of Long-term Care Service Providers to deliver the least restrictive and most cost effective services to elderly and physically disabled members. Allowing members, when appropriate, to reside or return to their own home versus residing in an institutional or alternative residential setting will be a priority.

As a new offeror, Molina does not have existing Arizona membership on which to base network adequacy assumptions. For purposes of assessing network adequacy, Molina utilized the entire Maricopa County member set as provided by AHCCCS. As an initial filing of the Network Development and Management Plan, Molina, in this document, will specify the network as it stands in early March 2011 and the final provider network composition expected to be in place at the time of AHCCCS preoperational review. In order to satisfy all contract requirements and meet the needs of potential Molina membership, Molina has partnered with the following groups to provide a significant portion of the overall network needs:

- Arizona State Physician Association (ASPA) is expected to provide as many as 1,200 individual physicians throughout the state.
- Banner Health provides a significant portion of the hospital, professional and ancillary services in Maricopa County.
- CVS Caremark has in place, an extensive retail pharmacy network featuring more than 1,000 retail locations in Arizona and over 800 locations in the service area we propose to cover. CVS Caremark will partner with Molina to develop formularies to control pharmacy trends given Arizona requirements and membership mix.
- The Foundation for Senior Living (a Catholic Charities organization) will provide extended community support services as well as direct contracting for Adult Foster Care Homes.
- Creative Networks, LLC d/b/a ResCare HomeCare will provide a full network of home support services throughout our proposed service area, including: Attendant Care; Habilitation; Home Modifications; Homemaker; Personal Care; and Respite.
- Safe Ride Services Inc. will provide a statewide network of Medical Transportation services. Safe Ride has a centralized call center which handles over 500,000 calls annually and coordinates transportation with over 300 non-emergent transportation vehicles throughout Arizona.
- Various Federally Qualified Health Centers (FQHCs) have been engaged to provide comprehensive services to members, often in remote and medically underserved areas of the state. Yuma Unified IPA in Yuma for provision of physician services in Yuma County.
- Kingman Regional Medical Center and physician group will provide a wide array of services in Mohave County.

- DentaQuest will provide a comprehensive dental services network. DentaQuest's mission is to bring high quality dental care to the nation's neediest residents.
- March Vision Services will provide a statewide network of retail vision service providers. March Vision Care will partner with Molina to provide high quality vision care that focuses on early detection, education and management through innovative member-oriented solutions given Arizona benefits, requirements and membership mix.

Examples of Provider Support in the Network Development Process

ResCare HomeCare
Respect and Care at Home

March 3, 2011

Molina Healthcare of New Mexico
Att: Lynn Allen, President
8801 Horizon Blvd NE, Ste 400
Albuquerque, NM 87113

Re: LETTER OF COMMITMENT

Mr Allen:

Please accept this letter of commitment for ResCare HomeCare to provide the following services under contract with Molina Healthcare in the state of Arizona: Attendant Care, Home Modification, Habilitation, Homemaker, Personal Care, and Respite.

We are willing to provide these services in the following counties: Maricopa, Yuma, LaPaz, Coconino, Mohave, Apache and Navajo.

ResCare HomeCare
Megan Neal,
REGIONAL DIRECTOR

Date: 3/3/11

MOLINA HEALTH CARE
Lynn Allen,
PRESIDENT

Date: 3/3/11

mn/imc

950 W Behrend Drive, Suite 1
Phoenix, AZ 85027-4403

www.ResCareHomeCare.com
623 780 0053 fax: 623 434 8560

Foundation for Senior Living
Thirty Years of Care by Design

1201 E. Thomas Road, Phoenix, AZ 85014
(602) 285-1800 (602) 285-1838 fax
www.fsl.org

February 24, 2011

Molina Healthcare
8801 Horizon Blvd. NE, Ste 400
Albuquerque, NM 87113

Re: State of Arizona AHCCCS/ALTCS Program

To Molina Healthcare,

FSL has been pleased to confer with you since early 2010 to dialog about our collective experiences in offering effective long term care services. In our many exchanges, it is become clear to us that your values, commitment to quality responsive care align not only with the intent of AHCCCS but are also in concert with FSL's own mission, values, and service methodologies. For 37 years, FSL has continually provided a variety of long term care services to the people of Arizona. We have been a contractor of services of every ALTC's contractor in Maricopa County since the inception of the program.

We have found through our meetings with you a delightful, creative, and positive attitude about new designs in "care management" not just case management, service delivery, a commitment to truly working with each client on *their* care plan. A review of your health plans experience certainly suggests that you have an understanding of the realities in providing long term care services, the value of partnerships and communications with your contracted providers of service.

FSL would welcome an ongoing relationship with you in serving the needs of those we have always served, we are here, we will be here, and we are pleased to see new ideas spring forth from a health plan in serving this most vulnerable and worthy group of seniors.

Kindest regards,

Guy Mikkelsen
President & CEO

Molina Healthcare c/o Barbara Johansson.

Ladies and Gentlemen,

As CEO of Mountain Health and Wellness (MHW) in Arizona, I write this letter to confirm our support for Molina Health Care (Molina) in their bid to provide long term care services in Arizona. MHW provides Medicaid and Medicare services in 5 counties in Arizona and specializes in a full array of behavioral health services that are being integrated with primary care in MHW clinics.

We have enjoyed numerous conversations with Molina executive and senior staff members over the last several months. These conversations were directed at understanding mission, vision and values of both organizations but were also highly focused on the model of care each organization will provide patient/clients going forward.

In my experience, Molina has taken a leadership role in the integrated care model. Molina is committed to building a service infrastructure that will provide health care that is fully integrate and include medical and behavioral health care as well as wellness and prevention services. The *Health Care Home* model delivered by integrated health care providers is where the leading edge is in our field.

MHW is building that kind of infrastructure and consulting with Molina so that both organizations enjoy a free exchange of ideas aimed at improving health and reducing health care costs for the populations that we serve.

I am confident in my appraisal of the Molina group and support their proposal.

Sincerely,

Robert R. Evans

Chief Executive Officer

Mountain Health and Wellness

Mountain Health & Wellness P.O. Box 3160 Apache Junction, Arizona 85117-3160
Administration (480)983-0065 * Fax (480) 288-5339

In addition to these larger strategic provider partnerships, Molina has established direct relationships with providers through the Letter of Intent (LOI) process. The combination of these approaches allows Molina to offer a comprehensive, diverse and flexible Long-term Care Network which features more than **4,800** unique provider sites, and over **6,800** unique providers.

As a new offeror, the greatest barriers to establishing a comprehensive provider network can be attributed to three specific reasons:

- In hopes of improving the competitive strength of their offering, delivery systems affiliated with a competing offeror may not participate in the LOI process. It is likely this will be resolved after bid award.

- Some non-system affiliated providers will wait until after bid award before working with the successful offeror. This includes some specific nursing facility and assisted living facility provider groups. Award of the contract will bring these "hold out" providers into the network.

- Some network providers, wishing not to alienate incumbent MCOs have chosen not to engage in the network contracting process until after contract award. This will be resolved after award of the contract.

This Network Development and Management Plan is a working document, as managed by the Network Operations Committee. Molina will provide an updated Network Development and Management Plan in conjunction with the AHCCCS preoperational review. This update will provide AHCCCS with evidence of Molina's continued work and commitment to building the best provider network among the AHCCCS contractors. Specific analysis by provider type is featured in the GSA specific sections below.

Current Status of the Network by General Service Type

Below you will find a description of the Molina provider network, by general provider service types, a more in-depth discussion is offered in the individual GSA network analysis sections.

Hospitals – Molina offers a robust network of participating hospitals sufficient to provide for the needs of all assigned members, including (not all inclusive):

- Banner Health
- Abrazo Hospitals
- IASIS Hospitals
- Scottsdale Healthcare Hospitals
- Phoenix Children's Hospital
- John C. Lincoln Hospitals
- Maricopa Medical Center

- Yuma Regional Medical Center
- Kingman Regional Medical Center
- Western Arizona Regional Medical Center
- Northern Arizona Healthcare
- Havasu Regional Medical Center
- Valley View Medical Center
- La Paz Regional Hospital

Nursing Facilities – Molina offers a robust network of 53 nursing homes throughout GSAs 42, 44, and 52.

HCBS Community Providers – Molina offers a robust network of 350 HCBS Community Providers throughout GSAs 42, 44, and 52.

HCBS Home Providers – Molina offers a solid network of provider to support the needs of Molina Members who reside in their own homes. Molina's key alliance with Creative Networks d/b/a ResCare will strongly support the delivery of home based services. Molina has also established a strong working relationship with the Foundation for Senior Living (FSL) as well as the Area Agency on Aging.

Primary Care Providers – Molina offers a very strong network of over 1,200 individual PCPs practicing in over 800 individual locations.

Specialty Care Providers, including OB/GYN providers – through Molina's affiliation with key large provider groups and a large contingent of direct affiliations, Molina offers a very strong network of specialty care providers. Some of the key large provider groups include, but are not limited to:

- Banner Health
- Banner PHO
- Arizona State Physicians Association (ASPA)
- District Medical Group (formerly MedPro)
- Yuma Unified Medical Group
- Kingman Regional Medical Center Physician Group

Molina has executed agreements with the following ancillary and/or statewide vendors to provide services to its members:

- Apria Healthcare (DME and Home Infusion statewide)
- Edgepark Medical Supply (disposable medical supplies – mail order, statewide)
- Sonora Quest Laboratories (Laboratory services statewide)
- Preferred Homecare (DME most areas of the state)

- Creative Networks d/b/a ResCare – will provide Attendant Care; Home Modification; Habilitation; Homemaker; Personal Care; and Respite Care services in all GSAs.
- Safe Ride Services Inc. (statewide transportation broker)
- CVS/Caremark – retail pharmacy services statewide
- Critical Signal Technologies – emergency alert systems

General network gaps and how they are identified

Specific network gaps are discussed in detail in the applicable GSA analysis section. In general, network gaps are identified in the standing Network Operations Committee. Gaps are identified in a number of ways, including but not limited to:

- Direct input from internal departments to the Network Operations Committee is encouraged, including staff members from Case Management; Provider Services; Members Services; and Appeals and Grievances.
- Trending of member and provider complaints
- Trending of requests for access to non-participating providers
- Geo-Access mapping studies
- Call tracking reports
- Input from Member and Provider committees

Immediate Short Term Interventions

If/when necessary, to provide a short-term intervention, Molina will allow the use of non-contracted providers to meet the immediate needs of Molina members.

Molina is fully aware that services under this program are provided to potentially vulnerable enrollees with complex health and social needs. As such, Molina is committed to maintaining an up-to-date and effective plan for caring for its members in the event that it experience the loss of a major provider, this would include nursing facilities and assisted living facilities.

At a higher level, Molina will maintain a health plan culture which reinforces each staff member's responsibility to manage to the needs of Molina's enrollees and to the contract between Molina and AHCCCS. Molina will establish cross departmental teams to support this culture of responsibility throughout the organization. This cross departmental approach will eliminate departmental silos and improve early identification of issues with providers and promote more effective recovery in the event of a network loss. Molina's Director of Compliance will hold ultimate responsibility for Molina's Network Recovery Plan. The Network Recovery Plan will feature three key functional areas: early intervention and monitoring; recovery action; and post recovery evaluation.

EXAMPLE: Loss of a nursing home or assisted living facility; following are key features of each of these functional areas as they relate to nursing facilities and assisted living facilities:

- Early intervention and monitoring – Molina considers Case Management, Member Services, and Provider Services staff members to be the eyes and ears of the organization. These staff members are trained to indentify early indications of future issues with Molina's facilities. Early indications of potential network loss will be monitored in Molina's Professional Review Committee on a continual basis to identify network issues and resolve them efficiently. In the case of nursing and assisted living facilities areas of review will include:

    - Complaints or concerns when raised by enrollees; enrollee family members; facility staff members; outside providers; or Molina staff members including issues involving: quality of care, availability of care, facility payment of staff and other debts;
    - Issues with credentialing, including state licensure issues; insurance issues; and governmental sanctions; and
    - Requests from the facility for advance payments to cover operating expenses.

    The Professional Review Committee is empowered to take immediate actions to address identified early indicators. These actions include:

    - Increased communication with the provider, including on-site;
    - Suspension of further placements in the facilities;
    - Ordering a corrective action plan from the provider; and
    - Termination of the provider contract.

- Recovery Action – In the event of the loss of a nursing or assisted living facility, any member of the established Molina Business Recovery Team may initiate an immediate meeting of this multidisciplinary team. The team will include the leaders of the Case Management, Medical Services, and Provider Services departments, as well as the Plan President and Medical Director. The team will always approach recovery in such a way as to promote the best quality of care for the member; minimize disruption to the member and to providers; and affect the outcome that will minimize future disruption to the provider and the member. The team will implement the following actions in the case of the loss of one of these facilities:

    - Notify AHCCCS of the initiation of the action;
    - Establish a list of members who will require relocation, as well as any special needs of these members;

- Prioritize members based upon their medical, social and behavioral health needs. Establish a specific plan of action to place the member's alternative sites;
- Document all actions of the recovery team, including when and where the enrollees were transferred. Notify AHCCCS of specific actions taken;
- Ensure that all medications, medical equipment, and medical charts are transferred to the receiving facility; and
- Establish on-site monitoring of the receiving facility to ensure the appropriate quality of care is provided in the new facility.

- Post Recovery Evaluation – Convene a follow-up meeting with the recovery team to assess the effectiveness of their recent actions and to identify areas for improvement. Assess if any early indicators of facility loss were present and if they were properly identified. Incorporate lessons learned into the recovery plan.

General Considerations: Molina will incorporate the following general considerations into the operation of the health plan:

- Network will be adequate to ensure the availability of alternative contracted providers.
- Where Molina offers no alternative contracted provider, non-contracted providers will be utilized.
- Molina Healthcare is a multistate operation, and as such Molina Healthcare features contracted providers in adjoining states. This may prove especially helpful in rural areas of Arizona.

Certain losses are caused by specific events; following are some considerations regarding those loss events.

Contract Termination: In the event of a contract termination with a nursing or assisted living facility, after any immediate concerns regarding member care are first addressed, Molina will follow the terms of the contract with the provider. Contracts with these facilities feature specific provisions concerning the transition of member care following termination of the contract. Molina will first consider the needs of the member in developing the plan for transition. These type of transitions generally a less emergent approach. The transition would still be initiated by the Business Recovery Team, following the same process. The following additional considerations shall be included in the plan established by the recovery team:

- A more formal approach to notification of stakeholders, both internal and external will be followed;
- Case Managers will facilitate meetings with members, their families, and their care givers;

- If a member is placed in a facility that is not their first choice, track availability of other facilities that better reflect the members wishes;
- Review all member trust fund accounts for proper transfer of funds; and
- Ensure Case Manager on-site visits within the first week of transfer.

In addition to the actions identified above, in the case of a natural disaster, Molina would comply with state and federal emergency response regulations. If applicable, Molina would activate its Continuity of Operations Plan that will be tailored to the potential disasters facing Arizona. This plan, developed in accordance with a Molina Continuity of Operations Plan template, delineates activation procedures, identifies a recovery team, and defines procedures to recover critical functions and vital records. Some key considerations of facility closures due to natural disasters:

- Alternate accommodations may not be available in the immediate geographic area; Molina will evaluate the situation and determine the most appropriate, safe accommodations for its members. When indicated, Molina will make arrangements for accommodations in other communities or even in bordering States if necessary, to ensure the safety of its members. Molina's sub-contracted transportation vendor will work closely with the recovery team to provide applicable transportation.

Interventions to Fill Network Gaps and Barriers

Within the analysis of each GSA, Molina will discuss the identified network gaps, planned interventions, and identified barriers to development of the network.

Outcome measures and evaluation of interventions

Outcome measures are set based upon individual gaps identified. The measurement for outcomes may be based on improved Geo-Access results, lowered trending on use of non-contracted providers, increased member or provider satisfaction, etc.

Ongoing Activities for Network Development

The projected activities for continuing to develop a comprehensive Long-term care provider network comprised of physicians, home and community-based providers, institutional providers, and alternative residential setting providers are discussed in detail in the narrative applicable to each GSA. In general, Molina will focus on the following for improvement of the network, prior to the effective date of coverage:

- Refine HCBS Home agreements to ensure appropriate support services are available and offer a cost effective alternative to HCBS Community care.
- Execute additional HCBS Community agreements to offer a cost effective alternative to Nursing Facility Care.

- Execute additional nursing facility agreements to offer services to a larger ALTCS membership and create a cost effective alternative to lower acuity hospital care.
- Meet with advocacy groups to better understand the network barriers faced by Molina members and to specifically address the needs of Molina members.
- Gauge the efficacy of establishing regional Provider Service Representatives in remote GSA locations, with contracting skills and responsibilities, to better keep pace with the specific needs and demands of these rural locations.
- Explore opportunities to establish partnerships between established community behavioral health providers and Molina Medical Group providers to establish coordinated delivery system models which would better service the needs of ALTCS members with specific behavioral health needs.

Coordination between internal departments

Although the Molina Provider Services Department is responsible for the day-to-day communication activities with network providers, Molina fully understands the importance of the interdependencies between the various departments within the health plan and that all members of the Molina team are responsible for facilitating communication with the provider network. A core belief at Molina is that every communication with members, providers, or the state should be viewed as an opportunity to differentiate Molina and show the company's commitment to these customers. Because of this core operating philosophy, Molina's business model is established to promote an integrated, cross-functional approach to working with its customers. The Molina call tracking system is utilized to facilitate efficient cross team communication and inquiry. Other important aspects of the coordination of issues within Molina include:

Network Operations Committee (NOC) – This committee is dedicated to the efficient operation of the Molina provider network. This is a multidisciplinary team comprised of key team members from the Provider Services department, Medical Management/Utilization Management department, Member Services department, Member Outreach department, as well as key executive team members, including the C.O.O., C.M.O., and as available, the C.E.O. This team is tasked with setting general network strategy, evaluating general network data, and establishing corrective actions as indicated. This committee is also the approval committee for inclusion of new providers into the network.

Physician Advisory Committee (PAC) Meetings – Molina will conduct routine, quarterly meetings with representative contracted network physicians, in each contracted GSA. The intent of these meetings is three fold. First, Molina seeks incorporate the best ideas generated by our network physicians into local health plan operations. Second, Molina intends to use this forum as vehicle to communicate general operational issues to key individuals within the communities it serve. Third, the Physician Advisory Committee will be used in a peer capacity to address any quality issues that

may arise in the operation of the Continuous Quality Improvement Committee. Molina believes that network physician compliance with health plan and AHCCCS requirements is greatly enhanced if the physician feels a sense of ownership in the process.

Network Physician Participation in Health Plan Committees – Molina expects the composition of various committees to include Physicians from all contracted GSAs. Physician participation in the Quality Improvement Committee, Pharmaceutical and Therapeutic Committee, and other subcommittees will improve the sense of participation by network providers and aide the health plan in obtaining "provider buy-in" to projects and corrective actions.

Coordination with outside organizations, including member/provider councils

In additional to standing Member and Provider Satisfaction Council meetings, the Molina operating model emphasizes strong communication and involvement with community organizations, provider trade organizations, and advocacy groups. Molina anticipates participation and/or regular meetings with the following groups:

- Arizona Public Health Association, an association of FQHCs and RHCs
- Arizona Health Care Association (AHCA), an association of nursing facilities and assisted living centers
- ARC of Arizona
- ABIL

Other agencies/groups will be added to this list as they are identified.

Physician Advisory Committee (PAC) Meetings – Molina will conduct routine, quarterly meetings with representative contracted network physicians, in each contracted GSA. The intent of these meetings is three fold. First, Molina seeks incorporate the best ideas generated by our network physicians into local health plan operations. Second, Molina intends to use this forum as vehicle to communicate general operational issues to key individuals within the communities it serve. Third, the Physician Advisory Committee will be used in a peer capacity to address any quality issues that may arise in the operation of the Continuous Quality Improvement Committee. Molina believes that network physician compliance with health plan and AHCCCS requirements is greatly enhanced if the physician feels a sense of ownership in the process.

SECTION 3 - PRIOR YEAR PLAN

Not yet applicable.

General Discussion of the Success of Prior Year Interventions

Not yet applicable

Outcome Measures and Evaluation of Interventions

Not yet applicable

SECTION 4 - CURRENT YEAR PLAN

Molina has and will continue to provide all resources needed to complete the initial network development and the on-going network refinement necessary to ensure that services are rendered timely, and in adequate scope and duration. In recognition of the tremendous work involved with establishing a network of providers who will not only adequately meet the needs of Molina and its ALTCS enrollees, but also distinguish Molina from its competitors, Molina representatives began working with providers in Arizona in May of 2010 and Molina representatives have continued to meet with providers in Arizona on a regular basis. Lynn Allen, the president of Molina Healthcare's New Mexico plan was appointed to lead the network development efforts in Arizona. Mr. Allen offers several years of specific experience building and maintaining networks for ALTCS plans. Mr. Allen will serve as president of Molina's Arizona operation.

Molina has also engaged the services of three individual network development consultants who reside in the Phoenix metropolitan area. All three individuals have extensive experience working with AHCCCS plan providers. On January 10, 2011 Molina hired Penny Garrity to lead Molina's network operations department. Penny brings over 29 years of experience specific to the Arizona market. Beginning with the May 2010 initiation of the Molina network development efforts, Molina Healthcare lent the talents of both the established Molina Healthcare of New Mexico contracting department and those of the Molina Healthcare corporate contracting department. This commitment to apply early and flexible staffing to the development of our provider network is a key to the success that Molina Healthcare has enjoyed.

Molina understands that network composition, adequacy and maintenance are key drivers in the success of its health plans. From the corporate CEO level down, Molina staff members are cognizant of the importance of the health plan's working relationship with network providers. Molina grew from a provider practice, and as such it has never lost touch with the impact each contracted provider site has on Molina's enrollees. Molina strives to be the health plan of choice for network providers and enrollees. Because Molina, as an organization, understands the extreme importance of an accessible provider network, Molina will offer a network fully capable of supporting over 8,000 GSA 52 members in Maricopa County, over 1,700 GSA 44 members in Apache, Coconino, Mohave, and Navajo Counties, and over 1,000 GSA 42 members in La Paz and Yuma Counties. Molina will continue to dedicate both in-state and out-of-state resources to building the strongest network among the contracted health plans. Molina understands fully that enrollee satisfaction is driven by the strength of the network and Molina intends to grow substantial membership within Arizona.

In-State Resources

Penny Garrity will lead the Network Operations Department and, brings over 29 years experience in the Arizona market. Additionally, several in-market individuals have expressed an interest in joining the Molina team immediately following award of a contract. Molina anticipates hiring network development and provider services professionals shortly after contract award, and in quantity sufficient to produce the

necessary network prior to the October 1, 2010 effective date. Additionally, Molina has retained the services of three individual network development consultants, who have extensive experience working in the Arizona market and were a key resource in the network development work to date. These consultants would remain available on an as needed basis, after contract award.

Out-of-State Resources

Because Molina's corporate headquarters is located in an adjoining state (California), and because Molina has strong market presence in the following states that border Arizona: California, Utah, and New Mexico, Molina will direct resources from these plans to aid in the further development of the network in Arizona. Molina's corporate Provider Services Staff are available to assist in the Arizona network development project, and have specific experience in assisting in such network builds. Additionally, Molina Healthcare of Utah and Molina Healthcare of New Mexico will offer existing contracted providers to the network in their respective border communities, including: Gallup (NM); Silver City (NM); St. George (UT), and Kanab (UT).

Medicare – Because the large majority of the ALTCS membership is dually eligible, Molina has applied to establish a Medicare Special Needs Plan (SNP) in Maricopa and Yuma Counties, with an effective date of January 1, 2012. Molina will apply to expand that network into Apache, Coconino, Mohave and Navajo Counties if Molina is successful in obtaining the ALTCS contract for GSA 44. Molina looks forward to working with AHCCCS to establish a well integrated dual eligible network model.

In order to allow greater emphasis on core network development needs, Molina has engaged the services of the following key strategic network partners to aid in the development of the network. Molina's established relationships with the following key strategic partners, will greatly expedite the remaining network development process:

- Banner Health Systems;
- Banner PHO;
- Maricopa Integrated Health Systems;
- District Medical Group;
- Foundation for Senior Living;
- IASIS Hospitals;
- John C. Lincoln Health Network;
- Arizona State Physicians Association (ASPA);
- Yuma Unified Medical Association (Yuma IPA);
- Yuma Regional Medical Center;
- Covenant Health Network;
- Kingman Regional Medical Center and physician group;
- Northern Arizona Healthcare;
- ResCare Homecare;
- Doral Dental;

- March Vision Services; and
- Safe Ride Services.

This year's plan is discussed on a general statewide basis, and followed by specific analysis by Geographic Service Area (GSA).

In a relatively short period of time, Molina assembled a comprehensive Long-term Care Provider Network in GSA 42, GSA 44, and GSA 52 featuring over **6,800** unique providers, at over **4,800** unique sites. Molina is committed to providing a comprehensive spectrum of care to its future membership. Within each GSA, Molina will evaluate the relative strength of the following provider types and any perceived network gaps at the time of submission:

- Primary Care Services
- Specialty Care Services
- Hospital Services
- Acute Care Services
- HCBS Home Services
- HCBS Community Services
- Behavioral Health Services
- Pharmacy Services
- Dental Services
- Vision Services

The time period leading up to the October 1, 2011 effective date of the contract will be one of intense contracting and credentialing activity for Molina. Because much of the work today was accomplished via letters of intent and because AHCCCS will not be in a position to approve final provider contract templates until after contract award, there is a great deal of contracting work that will be accomplished in a very short four month period. Molina Healthcare will provide all resources necessary to accomplish this task.

SECTION 5 – GSA NETWORK ANALYSIS

Following you will find an analysis by GSA, of Molina's current proposed network. The analysis will describe the relative strength and opportunities for improvement, within each GSA. Molina is proposing to provide services in GSAs 42, 44, and 52, and will therefore propose a network solution in each of these GSAs.

GSA 42 – La Paz and Yuma Counties

Because of active partnerships with the Yuma Unified Medical Association, La Paz Regional Health Centers, and Sunset Community Health Centers (a Federally Qualified Health Center, Molina has established an extremely strong network within this GSA.

Primary Care Services

Molina offers over 50 unique primary care providers (PCPs) practicing at over 30 unique practice sites in the communities of Bouse, Lake Havasu City, Parker, Quartzsite, Salome, San Luis, Somerton, Wellton, and Yuma. Molina expects PCP access in this GSA to be very strong.

PCP opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Specialty Care Services

Molina offers an extremely strong panel of specialty care providers, as they are available in this GSA. Molina offers a total of over 95 unique specialty care providers, practicing in over 40 unique sites applicable to this GSA. Including the following physician specialties:

010 Allergist/Immunologist
020 Anesthesiologist
040 Dermatologist
050 Family Practice
060 Internal Medicine
062 Cardiovascular Medicine
063 Endocrinologist
064 Gastroenterologist
065 Hematologist
067 Nephrologist
068 Pulmonary Diseases
069 Rheumatologist
075 Neurologist
089 Obstetrician and Gynecologist
100 Ophthalmologist

170 Surgery-Plastic
192 Psychiatrist
200 Radiology
205 Radiology-Therapuetic
210 Surgery
218 Surgery-Vascular
220 Surgery-Thoracic
230 Urologist
241 Oncologist
927 Cardiologist
935 Otorhinolaryngologist (ENT)
950 Orthopedist

Specialty Care opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Hospital Services

Molina has executed Letters of Intent with Yuma Regional Medical Center and La Paz Regional Hospital. These are the only acute care hospitals available within GSA 42.

Hospital Services opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Pharmacy Services

Molina, through an agreement with CVS Caremark, offers an extensive network of retail pharmacies throughout GSA 42. Molina offers 25 pharmacy sites in the following communities:

- Parker
- Quartzsite
- San Luis
- Somerton
- Yuma

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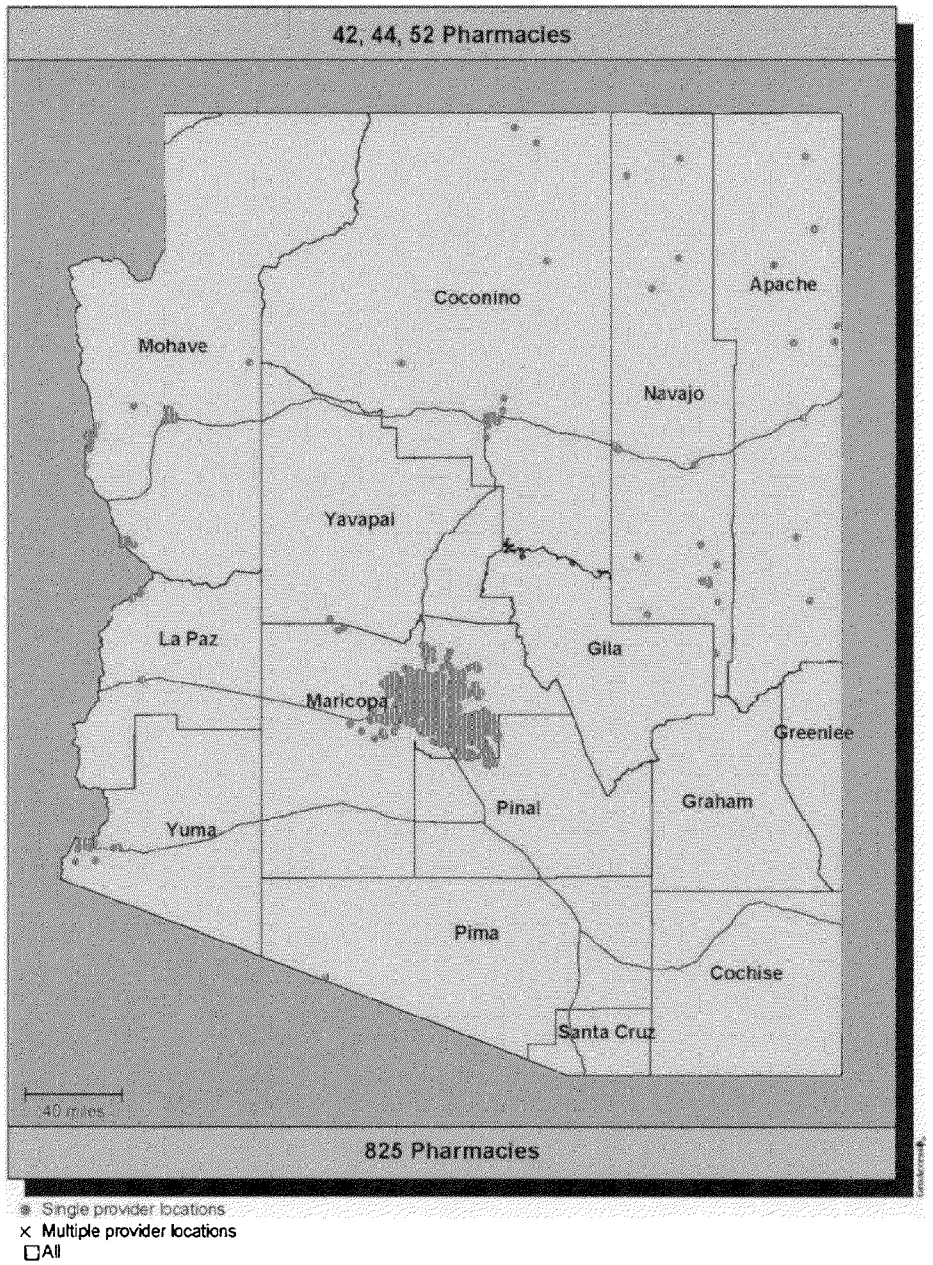
Pharmacies



Pharmacy Services Opportunities for Improvement:

No identified gaps in coverage in this GSA, for this service type.

Nursing Facility Network

Molina has established LOIs with 3 of the 4 required nursing facilities in Yuma:

- Palm View Rehab
- Yuma Nursing Center
- La Mesa Healthcare Center.

The remaining nursing facility in Yuma is affiliated with LifeCare Centers of America and is unwilling to establish an agreement prior to contract award.

Nursing Facility Opportunities for Improvement:

Establish contracts with the following Nursing Facility:

- LifeCare Center of Yuma

HCBS Community Facility Network

Molina has secured LOI's from 9 of the 10 required HCBS Community providers in Yuma County.

HCBS Community Opportunities for Improvement:

Molina will establish an agreement with at least 1 additional assisted living provider in Yuma County.

HCBS Home Support Services Network

Molina offers a comprehensive network of HCBS Home service providers, satisfactory to meet all the needs of GSA 42 members who reside in their own homes. Molina has secured LOI's from HCBS Home providers in Yuma and La Paz Counties, The networks in these counties meet or exceed the minimum ALTCS network standards for GSA 42. LOI's have been received from the following provider types: Adult Day Health, Attendant Care, Emergency Alert, Home Modification, Habilitation, Home Health Care, Home-Delivered Meals, Homemaker, Hospice, Personal Care and Respite Care.

HCBS Home Support Services Opportunities for Improvement:

No identified gaps in coverage in this GSA, for this service type.

Behavioral Health Network

Molina offers a comprehensive network of behavioral health providers in GSA 42.

Behavioral Health opportunities for improvement

No identified gaps in coverage in this GSA, for this service type.

Considerations of Special Populations

Molina will assess actual special populations included in Molina's assigned membership set in GSA 42. In general, Molina will follow the general network considerations special populations previously discussed. The majority of provider offices in GSA 42 offer Spanish speaking staff members, which is expected to fulfill the primary non-English language need in this GSA.

Conclusions for GSA 42

Molina offers an extremely strong network of providers in GSA 42; but Molina will continue to pursue the following:

- One additional nursing facility contract in Yuma to complete that network requirement.
- At least one additional agreement with an assisted living facility provider in Yuma County.

Molina expects that these few identified areas for improvement will be complete prior to the effective date of the contract and perceives no issues in bringing this GSA network to operational status on October 1, 2011.

Short and Long Term Interventions for GSA 42

Short-term Interventions:

- None indicated at this time.

Long-term Interventions: add the following to the network:

- One additional nursing facility contract in Yuma to complete that network requirement. (short term intervention)
- At least one additional agreement with an assisted living facility provider in Yuma County.

Outcome measures for interventions for GSA 42

- Agreement with LifeCare Centers of Yuma
- Agreement with one additional assisted living facility

GSA 44 – Apache, Coconino, Mohave and Navajo Counties

In Molina's experience in building networks within Arizona, this GSA has proven to be the most challenging, given its wide geographic span and extremely rural locations. Although this area will be a challenge, it is a challenge that Molina will fully satisfy. Molina's established relationships with North Country FQHC, Arizona State Physicians Association, and Kingman Regional Medical Center, have served as a foundation for development of the network in this area. Direct letters of intent have enabled Molina to offer a competitive network in this GSA. Molina's existing, established provider networks in the states of Utah, and New Mexico have served to provide additional practice sites in these border areas, thus strengthening the coverage in this GSA.

Primary Care Services

Molina offers over 110 unique Primary Care Providers (PCPS) in over 50 unique PCP practice sites in the following communities applicable to GSA 44: Ash Fork, Bullhead City, Colorado City (UT), Cottonwood, Dewey, Flagstaff, Fort Mohave, Fredonia, Gallup (NM), Golden Valley, Grand Canyon, Hilldale, Holbrook, Kingman, Lake Havasu City, Littleville, Mohave Valley, Page, Sedona, Show Low, Springerville, St. George (UT), St. Johns, Williams, and Winslow. With very few exceptions, PCP coverage in this GSA is strong, additional contracting work prior to the effective date will serve to make this GSA very strong.

PCP opportunities for improvement:

Molina has not established agreements with PCPs in Snowflake/Taylor. Molina is confident that completion of contracts with providers in this area will occur prior to the AHCCCS preoperational review. Molina will exceed all minimum network standards for PCP care in GSA 44 prior to the effective date of coverage.

Specialty Care Services

Molina offers a network of over 200 unique specialty care providers providing services in over 80 unique practice sites applicable to GSA 44, including the following specialties:

020 Anesthesiologist
060 Internal Medicine
062 Cardiovascular Medicine
063 Endocrinologist
064 Gastroenterologist
065 Hematologist
067 Nephrologist

068 Pulmonary Diseases
069 Rheumatologist
075 Neurologist
080 Nuclear Medicine
083 Psychologist
089 Obstetrician and Gynecologist
100 Ophthalmologist
110 Surgery-Orthopedic
120 Otolaryngologist
151 Pediatric Cardiologist
160 Physical Medicine/Rehabilitatior
167 Therapist-Physical
195 Psychiatrist and Neurologist
200 Radiology
201 Radiology-Diagnostic
205 Radiology-Therapuetic
210 Surgery
212 Surgery-Cardiovascular
220 Surgery-Thoracic
230 Urologist
241 Oncologist
250 Emergency Medicine
901 Emergency Room Physicians
927 Cardiologist
950 Orthopedist

Specialty Care opportunities for improvement:

Molina will seek additional specialty coverage in Apache County.

Hospital Services

Molina satisfies all network requirements for hospital services in GSA 44. Molina offers a very expansive hospital network to GSA 44, through agreements with hospitals in bordering state communities.

Hospital Services opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Pharmacy Services

Molina, through an agreement with CVS Caremark, offers an extremely strong pharmacy network in GSA 44. Molina satisfies all retail pharmacy site requirements as specified in the minimum network standards. Molina offers over 80 retail pharmacy sites applicable to GSA 44. Pharmacy sites are available in the following communities:

BULLHEAD CITY
CHINLE
CIBECUE
FLAGSTAFF
FORT DEFIANCE
FORT MOHAVE
FREDONIA
FT MOHAVE
GANADO
GOLDEN VALLEY
HOLBROOK
KAYENTA
KINGMAN
LAKE HAVASU CITY
LAKESIDE
MOHAVE VALLEY
OVERGAARD
PAGE
SANDERS
SHONTO
SEDONA
SHOW LOW
SPRINGERVILLE
ST JOHNS
ST MICHAELS
TAYLOR
TEC NO PAS
TSALIE
TUBA CITY
WHITERIVER
WILLIAMS
WINSLOW

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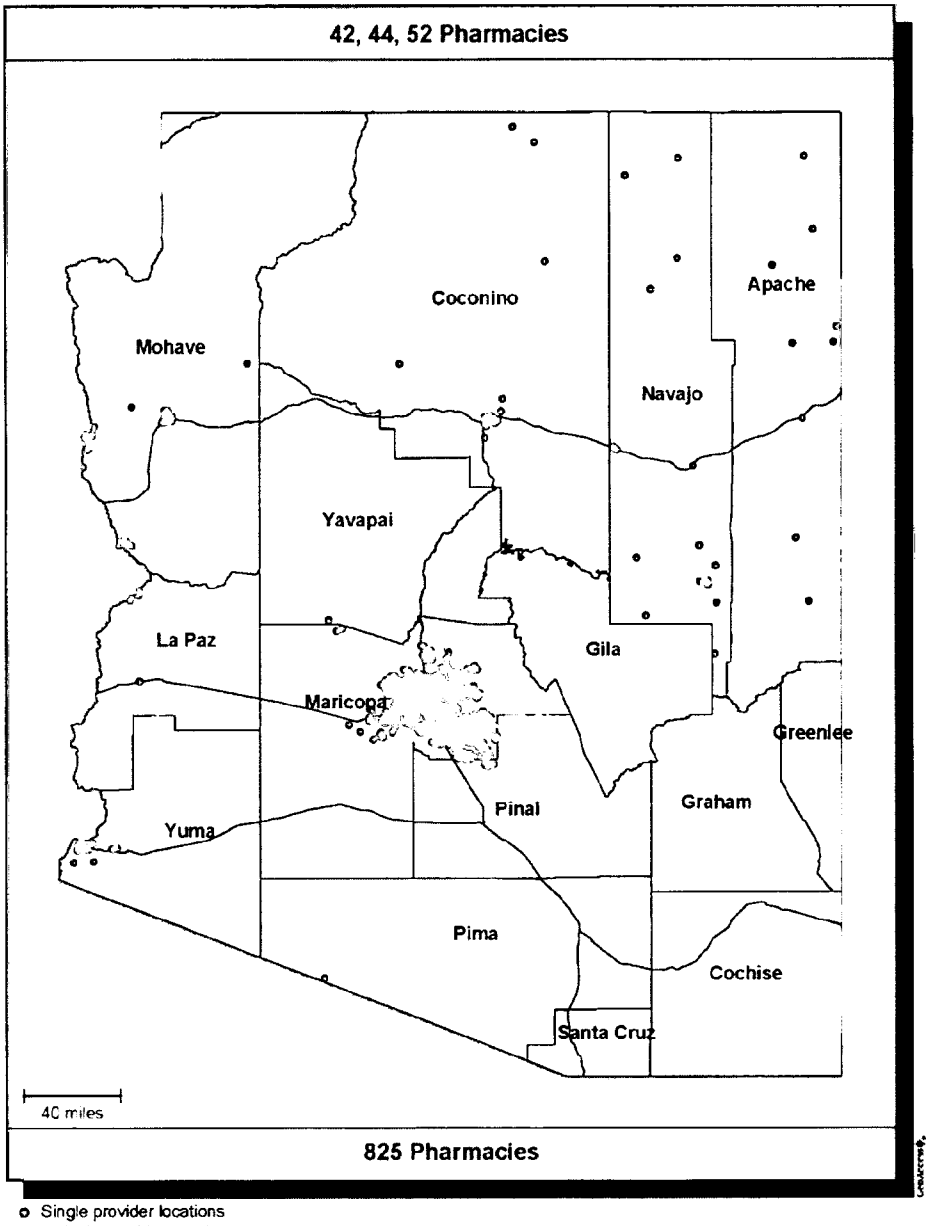
Pharmacies



Pharmacy Services opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Nursing Facility Network

Molina offers 5 of the required 11 nursing facilities in GSA 44. Molina offers the following nursing facilities/locations:

Havasu Nursing Center – Lake Havasu City
Tall Pines Care and Rehab – Show Low
The Legacy Rehab and Care Center – Bullhead City
The Gardens Care and Rehab Center – Kingman
The Lingenfelter Center – Kingman

Nursing Facility opportunities for improvement:

Molina will add 2 nursing facilities in Flagstaff, I additional nursing facility in Lake Havasu City, 1 additional nursing facility in Kingman, 1 nursing center in Sedona, and a nursing facility in Winslow.

HCBS Community Facility Network

Molina offers 24 of 39 assisted living facility locations specified in the network requirements.

HCBS Community Opportunities for Improvement:

Molina will add additional assisted living facilities in Coconino, Mohave, and Navajo Counties.

NOTE: there are not 28 (specified in the network requirements) assisted living facilities in operation in Mohave County, who accept ALTCS members. The incumbent plan in this County lists several providers who are no longer available.

HCBS Home Support Services Network

Molina has secured LOI's from HCBS Community providers in Apache, Coconino, Mohave, and Navaho Counties. The networks in these counties meet the minimum ALTCS network standards for GSA 44.

HCBS Home Support opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Behavioral Health Network

Molina offers a comprehensive network of behavioral health providers in GSA 44.

Behavioral Health opportunities for improvement

Molina will seek to add the following:

- Psychosocial Rehabilitation in Apache and Navajo Counties
- Behavioral Health Day Program providers in Apache, Coconino, and Navajo Counties.

Considerations of Special Populations

Molina will assess actual special populations included in Molina's assigned membership set in GSA 44. In general, Molina will follow the general network considerations special populations previously discussed.

Conclusions for GSA 44

Molina offers a solid network of providers in GSA 44; but Molina will continue to pursue PCPs in Snowflake/Taylor to complete that network requirement. Additionally, Molina will seek to expand the nursing facility and assisted living facility network in GSA 44. Molina will seek certain Behavioral Health providers in GSA 44. Molina expects that these few identified areas for improvement will be complete prior to the effective date of the contract and perceives no issues in bringing this GSA network to operational status on October 1, 2011.

Short and Long Term Interventions for GSA 44

Short-term Interventions:

- Allow use of non-contracted PCP(s) in Snowflake and/or Taylor.

Long-term Interventions: add the following to the network:

- One additional nursing facility contract s in: Flagstaff; Sedona; Lake Havasu City; Winslow and Kingman.
- Seek additional assisted living facility agreements in Mohave, Coconino, and Navajo Counties.

Outcome measures for interventions for GSA 44

- Satisfaction of nursing facility standards in GSA 44.
- Satisfaction of assisted living facility standards in GSA 44.
- Addition of PCP in Snowflake/Taylor

GSA 52 – Maricopa County

Molina offers a robust network of providers in Maricopa County. Key affiliations with Abrazo Hospitals, Arizona State Physicians Association (ASPA), Banner Health Systems, Covenant Nursing Facilities, District Medical Group, IASIS Hospitals, John C. Lincoln Hospitals, Maricopa Integrated Health Systems, Phoenix Children's Hospital, Scottsdale Healthcare, and The Foundation for Senior Living have contributed greatly to the robust network in GSA 52.

Primary Care Services

Molina offers 1,000 unique Primary Care Providers (PCPs) in over 700 unique PCP practice sites. Molina offers very strong PCP coverage in Maricopa County. Geo-Mapping for Phoenix Metropolitan Area members, is provided on the next page. This mapping, maps all members with Metropolitan Phoenix (as defined in the Minimum Network Standards) specific zip codes to our PCP network in GSA 52. The Geo-Mapping software maps to the street address level for accuracy. The findings of this study are as follows:

PCP opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Specialty Care Services

Molina offers a network of over 1,800 unique specialty care providers providing services in over 820 unique practice sites throughout GSA 52. The following specialties are represented in Molina's GSA 52 Specialty Provider Network:

010 Allergist/Immunologist
020 Anesthesiologist
030 Surgery-Colon/Rectal
040 Dermatologist
050 Family Practice
055 General Practice
060 Internal Medicine
062 Cardiovascular Medicine
063 Endocrinologist
064 Gastroenterologist
065 Hematologist
066 Infectious Diseases

067 Nephrologist
068 Pulmonary Diseases
069 Rheumatologist
070 Surgery-Neurology
075 Neurologist
076 Pediatric Neurologist
080 Nuclear Medicine
082 Gerontologist
083 Psychologist
089 Obstetrician and Gynecologist
090 Gynecologist
092 Maternal and Fetal Medicine
093 Reproductive Endocrinologist
100 Ophthalmologist
100 Opthalmologist
110 Surgery-Orthopedic
120 Otolaryngologist
124 Otologist
150 Pediatrician
151 Pediatric Cardiologist
153 Surgery-Pediatric
154 Pediatric Nephrologist
155 Pediatric Neonatal/Perinatal
156 Pediatric Endocrinologist
157 Pediatric Allergist
158 Radiology Pediatric
159 Pediatric Pulmonary
160 Physical Medicine/Rehabilitation
167 Therapist-Physical
170 Surgery-Plastic
182 Preventative Medicine
191 Pediatric-Psychiatrist
192 Psychiatrist
195 Psychiatrist and Neurologist
200 Radiology
201 Radiology-Diagnostic
203 Radiology-Therapuetic
205 Radiation-Therapuetic
205 Radiology-Therapeutic
205 Radiology-Therapeutic
210 Surgery
212 Surgery-Cardiovascular

213 Surgery-Hand
214 Surgery-Head and Neck
215 Surgery-Maxillofacial
216 Surgery-Trauma
217 Surgery-Urological
218 Surgery-Vascular
220 Surgery-Thoracic
230 Urologist
241 Oncologist
250 Emergency Medicine
251 Critical Care Medicine
441 Surgery-Ophthalmological
530 Pathology
798 Physician Assistant
927 Cardiologist
935 Otorhinolargyngologist (ENT)
935 Otorhinolaryngologist (ENT)
943 Pediatric Orthopedist
958 Gynecological Oncology
963 Pediatric Hematology-Oncology

Specialty Care opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Hospital Services

Molina has executed Letters of Intent with the following hospitals in Maricopa County:

ARROWHEAD HOSPITAL
BANNER BAYWOOD MEDICAL CENTER
BANNER BOSWELL MEDICAL CENTER
BANNER DEL E WEBB MEDICAL CENTER
BANNER DESERT MEDICAL CENTER
BANNER ESTRELLA MEDICAL CENTER
BANNER GATEWAY MEDICAL CENTER
BANNER GOOD SAMARITAN MEDICAL CENTER
BANNER HEART HOSPITAL
BANNER THUNDERBIRD MEDICAL CENTER
HEART HOSPITAL OF ARIZONA
HEARTHSTONE HOSPITAL MESA
JOHN C. LINCOLN HOSPITAL DEER VALLEY
JOHN C. LINCOLN HOSPITAL NORTH MOUNTAIN

KINDRED HOSPITAL OF ARIZONA – NORTHWEST
KINDRED HOSPITAL OF ARIZONA – PHOENIX
KINDRED HOSPITAL OF ARIZONA - SCOTTSDALE
MARYVALE HOSPITAL
MOUNTAIN VISTA MEDICAL CENTER
PARADISE VALLEY HOSPITAL
PHOENIX BAPTIST HOSPITAL
PHOENIX CHILDRENS HOSPITAL
PROMISE HOSPITAL OF PHOENIX
SCOTTSDALE HEALTHCARE – GREENBAUM SURGICAL HOSPITAL
SCOTTSDALE HEALTHCARE – OSBORN
SCOTTSDALE HEALTHCARE – SHEA
SCOTTSDALE HEALTHCARE – THOMPSON PEAK
ST LUKES MEDICAL CENTER
TEMPE ST LUKES MEDICAL CENTER
WEST VALLEY HOSPITAL

The Molina GSA 52 hospital network is extremely strong and well placed. Molina more than satisfies all network requirements for this service type.

Hospital Services opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Pharmacy Services

Molina, through an agreement with CVS Caremark, offers an extremely strong pharmacy network in GSA 52. Molina satisfies all retail pharmacy site requirements as specified in the minimum network standards, with Pharmacy locations in Avondale/Goodyear/Laveen; Litchfield Park/Tolleson; Buckeye; Metropolitan Phoenix; and Wickenburg. Molina offers over 800 retail pharmacy sites applicable to GSA 52. Pharmacy sites are available in the following communities:

AHWATUKEE
ANTHEM
APACHE JUNCTION
AVONDALE
BUCKEYE
CAREFREE
CAVE CREEK
CHANDLER
EL MIRAGE
FOUNTAIN HILLS
GILA BEND

GILBERT
GLENDALE
GOODYEAR
LAVEEN
LITCHFIELD PARK
MESA
PEORIA
PHOENIX
QUEEN CREEK
SCOTTSDALE
SUN CITY
SUN CITY WEST
SUN LAKES
SURPRISE
TEMPE
TOLLESON
WICKENBURG
WILLIAMS
YOUNGTOWN

Geo-Mapping for GSA 52 pharmacies, is provided on the next page. This mapping, maps all members with Metropolitan Phoenix specific zip codes to Molina's pharmacy network in GSA 52. The Geo-Mapping software maps to the street address level for accuracy. The findings of this study are as follows:

Of the member population, those members who reside within zip codes defined as "metropolitan Phoenix" in the RFP, 100% of members have access to a retail pharmacy location within 5 miles of their residence.

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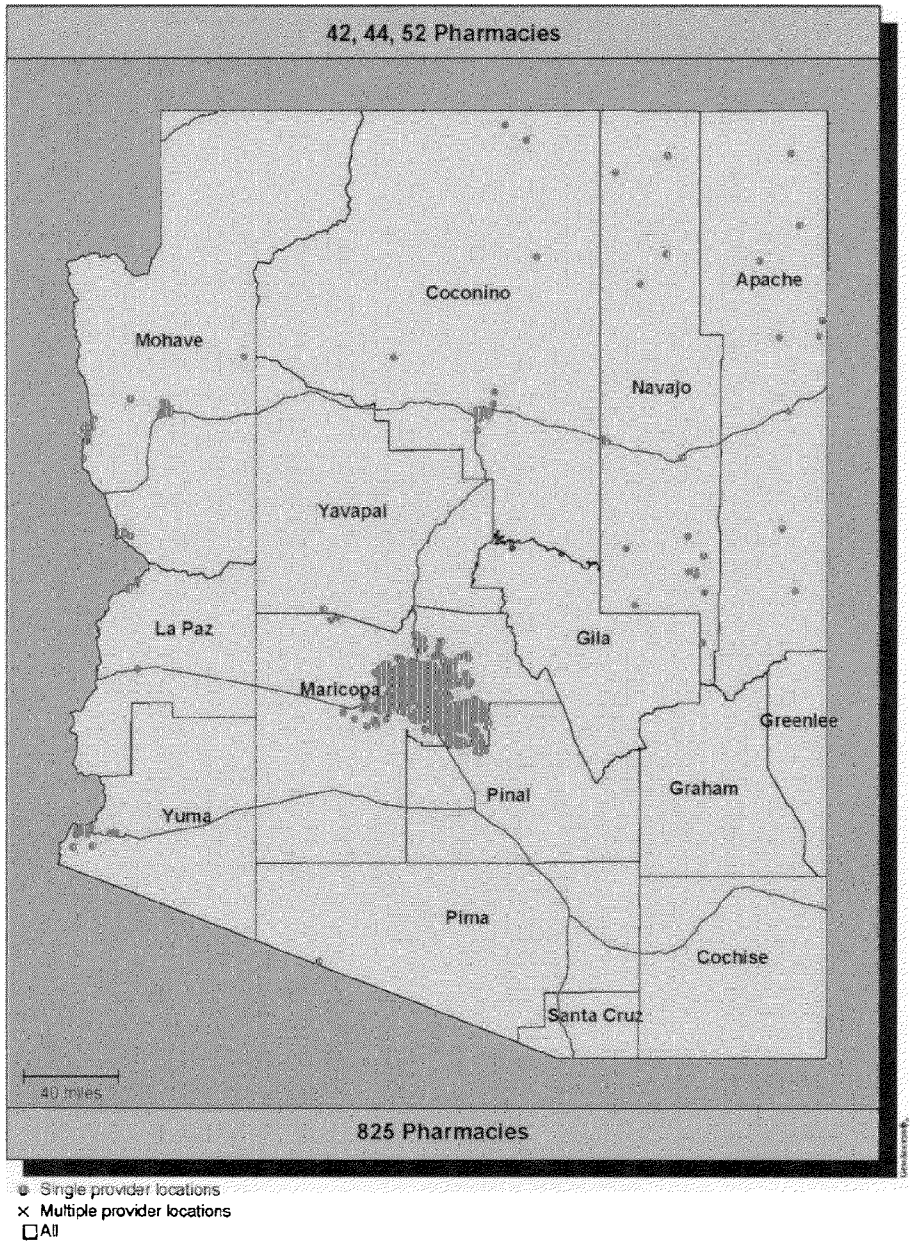
Pharmacies



Pharmacy Services opportunities for improvement:

None identified.

ACUTE CARE SERVICES OTHER

All other acute care services are fully covered on a county wide basis.

Nursing Facility Network

Molina meets or exceeds all nursing facility network standards in zones: 2, 3, 4, 6, 7, 8, and 9 as well as the overall GSA total count.

NURSING HOME NETWORK REQUIREMENTS
GSA 52

	Required	Completed	%
Zone 1	4	3	75.00%
Zone 2	8	9	112.50%
Zone 3	2	2	100.00%
Zone 4	5	5	100.00%
Zone 5	3	2	66.67%
Zone 6	8	8	100.00%
Zone 7	4	5	125.00%
Zone 8	8	8	100.00%
Zone 9	4	4	100.00%
TOTAL	**46**	**46**	**100.00%**

Nursing Facility opportunities for improvement:

Some nursing facilities, including the 11 Life Care Centers have refused to sign an agreement prior to contract award. Molina is confident that such an agreement will be reached after award of the contract. At a minimum, Molina will add one additional nursing facility in zone 1 and 1 additional facilities in zone 5.

HCBS Community Facility Network

Molina offers a very strong network of HCBS Community providers in GSA 52.

ADULT FOSTER CARE
GSA 52

	Required	Completed	%
Zone 1	20	20	100.00%
Zone 2	10	11	110.00%
Zone 3	2	2	100.00%
Zone 4	0	2	N/A
Zone 5	24	26	108.33%
Zone 6	4	4	100.00%
Zone 7	1	2	200.00%
Zone 8	5	6	120.00%
Zone 9	2	2	100.00%
TOTAL	**68**	**75**	**110.29%**

ASSISTED LIVING CENTER
GSA 52

	Required	Completed	%
Zone 1	4	6	150.00%
Zone 2	6	11	183.33%
Zone 3	0	0	
Zone 4	2	2	100.00%
Zone 5	4	4	100.00%
Zone 6	10	7	70.00%
Zone 7	4	3	75.00%
Zone 8	8	9	112.50%
Zone 9	4	2	50.00%
TOTAL	**42**	**44**	**104.76%**

ASSISTED LIVING HOME
GSA 52

	Required	Completed	%
Zone 1	20	48	240.00%
Zone 2	14	14	100.00%
Zone 3	10	11	110.00%
Zone 4	7	15	214.29%
Zone 5	20	22	110.00%
Zone 6	16	22	137.50%
Zone 7	10	9	90.00%
Zone 8	20	27	135.00%
Zone 9	20	29	145.00%
TOTAL	**137**	**197**	**143.80%**

HCBS Community Opportunities for Improvement:

Molina will seek to add the following:

- Additional ALC providers in zones 6, 7, and 9
- An additional ALH provider in zone 7

HCBS Home Support Services Network

Molina has secured LOI's from HCBS Community providers throughout Maricopa County. The Molina HCBS Community provider network satisfies all network requirements.

HCBS Home Support Services opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Behavioral Health Network

Molina has secured LOI's from Behavioral Health providers in Zones 1-9 in Maricopa County. The Behavioral Health Networks in these zones meet or exceed the minimum ALTCS network standards. LOI's have been received for providers of: Behavioral Health Facilities (Level II and Level III); Emergency Care; Evaluation; Individual, Group, and Family Counseling; Partial Care; Medication Monitoring; Behavioral Health Day Program/Partial Care and Psychosocial Rehabilitation as well as DD Group Home.

Behavioral Health opportunities for improvement:

No identified gaps in coverage in this GSA, for this service type.

Considerations of Special Populations

To support the delivery of home-delivered services to the frail elderly, Molina will secure contracts with mobile laboratory and radiology providers. Molina has also secured LOI's from Home Health Agencies to enable members to receive skilled nursing care at home when appropriate as well as to receive influenza and pneumonia immunizations.

Additionally, Molina will assess actual special populations included in Molina's assigned membership set in GSA 52. In general, Molina will follow the general network considerations special populations previously discussed.

Conclusions for GSA 52

Molina is extremely strong in GSA 52 and will continue to build on that strength prior to the effective date of coverage.

Short and Long Term Interventions for GSA 2

Short-term Interventions:

- None at this time.

Long-term Interventions: add the following to the network:

- 1 additional nursing facility in zones 1 and 5.
- Additional assisted living facilities in zones 6, 7, and 9.
- 1 additional assisted living home in zone 7.

Outcome measures for interventions for GSA 52

- 1 additional nursing facility in zones 1 and 5.
- Additional assisted living facilities in zones 6, 7, and 9.
- 1 additional assisted living home in zone 7.

SECTION 6 - ACCESSIBILITY CONSIDERATIONS

In order to ensure adequate and effective access to the network, Molina will perform certain studies to gauge the effectiveness of the network. These studies are performed on routine intervals and the outcomes are presented to the Medical Management/Utilization Management Committee (MM/UMC), the Network Operations Committee (NOC) and the Continuous Quality Improvement Committee (CQIC). Additionally, the outcomes are discussed at the routine Physician Advisory Committee meetings, which are held throughout the state. Combined, these studies are designed to measure the accessibility of services in terms of timeliness, amount, duration and scope. At all times, covered services are expected to be available consistent with those services provided to non-AHCCCS members in a given community.

Appointment Availability Studies

Although network providers are contractually required to provide services within AHCCCS approved appointment availability standards, Molina will conduct an annual survey of provider's offices to confirm provider compliance with these requirements. The results of this survey will be reported to the Medical Management/Utilization Management Committee, the Network Operations Committee, and Physician Advisory Committee meetings. Interventions, if indicated will be determined in the Network Operations Committee and outcomes will be reported. Future versions of this document will include these findings.

After Hours Coverage Studies

Molina will conduct annual provider after hour provider coverage studies, to determine provider office compliance with established standards for after hour coverage by Primary Care Providers. The results of this survey will be reported to the Medical Management/Utilization Management Committee, the Network Operations Committee, and Physician Advisory Committee meetings. This study designed to measure if there is sufficient network coverage for provision of all covered services, including emergency medical care, on a 24 hour a day, 7 day a week basis. Interventions, if indicated will be determined in the Network Operations Committee and outcomes will be reported. Future versions of this document will include these findings.

Network Adequacy and Accessibility Studies

Molina's Provider Services department will conduct an annual study of Network Adequacy and Accessibility. This study will incorporate elements of the data gathered in this report, enhanced with data concerning following:

- Member access to open panel PCPs
- Female member access to OB/GYN providers
- Adult member access to adult care PCPs

- Pediatric member access to pediatric care PCPs

Information from these studies is driven from actual Molina member demographics and the outcome of the studies will be incorporated into future versions of this document.

SECTION 7 - SPECIFIC QUESTIONS

What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?

Because of the variety of causes that lead to avoidable ER visits, Molina takes multiple approaches to addressing the problem. Molina's key intervention strategies are described below.

Urgent Care Centers – Molina strives to contract with multiple urgent care centers within the network, to provide members with a viable alternative to accessing the ER.

PCP Access – Molina closely monitors PCP accessibility and encourages PCPs to offer extended hours. In other states Molina has offered PCPs supplemental payment for after hours care and may do the same in Arizona, with AHCCCS approval.

PCP Call Coverage – Molina closely monitors PCPs for adherence to state mandated appointment standards and after hours call coverage.

Molina Nurse Advice Line – Molina instructs members on the use of the Molina nurse advice line and encourages providers to discuss the nurse advice line with members. Many times, members show up in the ER because they simply don't know what to do. The Molina Nurse Advice Line provides answers to their questions.

Case Management – Molina will assign frequent ER visitors to case management to ensure that they learn the appropriate use of the ER and other valuable health service resources.

Patient Access Coordinator – This intervention was originally introduced as a pilot project in selected physician's offices to test coordinators' effectiveness in decreasing ER visits due to asthma. This approach has proven extremely successful; it resulted in a statistically significant decrease in asthma related ER visits, as well as a significant increase in childhood immunizations in offices that offered a patient coordinator to their members. This program is now being expanded into other Molina service areas for other high-risk members as well as any members who have not been seen within 120 days of enrollment with Molina. The program is designed to rely on non-clinician, community oriented employee who work within a physician's practice to identify and overcome barriers to access and improve patient compliance. Each Coordinator assists patients in navigating the healthcare delivery system, including patients with limited English proficiency or cultural diversity-related access issues. In the pilot phase, each

Coordinator was provided a list of members who had been to the ER 3 times over 2 months. After directly contacting the member and family, the Coordinator facilitated doctor appointments and assisted with potential access-to-care barriers such as transportation, pharmacy access, and language barriers. The Coordinator also reviewed charts of immediate family members, and arranged for preventive care services (such as immunization of siblings) while the member was in the physician's office.

ER Utilization Reduction Task Force and Tool Kit – Molina takes proactive measures to monitor ER utilization and design programs that address inappropriate care utilization. A multi-disciplinary team, including an ER physician and nurse, designed the ER Tool Kit to establish policies and procedures, and provide tools for the Case Management team to identify members with frequent ER visits for non-emergent care and to educate, inform and assist members in meeting their healthcare needs in a more efficient and effective manner. The Tool Kit provides letters, reports, and materials to support Molina staff and members. The program and process will promote member relationships with PCPs, use of Molina's Nurse Advice Line, and improved member healthcare knowledge and self care skills.

Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?

Members are allowed to use a contracted specialist for primary care services if 1) the specialist is willing to provide or arrange for all primary care requirements of the member, and 2) if the member's health care needs warrant such consideration based on a review of the members needs by the Molina Chief Medical Officer.

What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?

Some barriers identified are specific to Molina as a new offeror within Arizona, others are more general. Following are significant barriers identified to date:

- Certain nursing facilities, including the large Life Care Centers group, have refused to establish an agreement prior to contract award. Molina believes that these issues will be resolved post award.
- There are not 28 HCBS Community providers, who take ALTCS members available in Mohave County. The incumbent MCO's provider listing has not been maintained and thus promotes a false perspective of availability. AHCCCS could assist here by verifying the true availability of providers in this County.
- Some providers, particularly nursing facilities, assisted living facilities, and assisted living homes are reluctant to establish agreement with a new bidder because they are concerned with alienating an incumbent bidder. This would be resolved following contract award.

What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?

Molina recognizes the value of members keeping their appointments and arriving as scheduled. Given the financial and other related societal difficulties faced by many of Molina's members, Molina strives to provide assistance to both the member and provider to reduce the member no-show rate and the administrative burdens associated with missed services.

Early Identification of members with special needs – Early case management assessment of a member's special needs will often uncover issues which may preclude a member from consistently keeping appointments timely. Case Managers are encouraged to work with internal departments and outside vendors/agencies to address these needs.

Tracking of missed appointments – Molina will utilize a standard form that the provider may fax or email to the health plan for follow up with the member. Reported incidents of missed appointments and late arrivals are tracked and trended and specific incidents are provided to member services for follow-up. Members who consistently miss appointments are also referred to case management for intervention. Molina will use technology to establish proactive methods to collect data that allows it to assist members prior to their appointments. When members or their children are identified as at risk for no-show, an evaluation of needs will be performed to allow the Case Manager to develop a case management plan that addresses the specific needs of the member. Interventions and case management can include providing transportation arrangements, calling the member or providing a text message to remind them of the appointment, assisting them with language needs, or assisting them with developing a self-management plan.

Missed Services Reports – Molina is also working to implement a system to track HEDIS missing services reports. When fully operational, any Molina staff will have instant access to missed service information during any member interaction. Molina will also make this information available in reports to providers over Molina's e-Portal so providers are aware of the services that are needed by their members. The function will include the ability for the provider to download and manipulate the information so that they can send reminder letters to patients regarding needed services. This implementation exemplifies how Molina partners with providers to construct efficient solutions to administrative burdens.

Reducing barriers to accessing services – In coordination with AHCCCS, Molina will utilize telehealth services when appropriate, particularly for members in rural areas or who face hardship in reaching health care facilities with specialty care. Molina publishes telehealth guidelines and protocols on its Web site and through its online ePortal messaging systems, and through its Provider Manual and Provider Newsletter articles,

all in an effort to encourage Molina's contracted practitioners and providers to access this telehealth service, especially in the rural or frontier areas of the state.

Lack of transportation is frequently the reason cited for members failing to appear for scheduled appointments. This lack of access often is greatest for members residing in rural areas where public transportation is minimal or absent. Molina considers transportation covered services to be a vital part of a member's overall healthcare package. A member's ability to access healthcare by the most appropriate mode of transportation according to their benefit will encourage them to maintain compliance with procedures, medications, and appointments, thus improving or maintaining their health status. Molina provides members and providers clear instructions on how to access services, including those that require prior approval or referral. Members seeking approval for non-emergent transportation will be advised to call the transportation broker toll-free number and speak with a Customer Service Representative. The Customer Service Representative will determine the member's eligibility and the date, time, and level of service required and ensures that the service to be obtained is appropriate and covered by Molina. ITM will contact the member to remind them of the date and time of transportation. At the appointed time scheduled to ensure prompt or earlier arrival at the designated destination, the vehicle will be dispatched to pick up the member. If a contracted provider is not available, the vendor will make appropriate arrangements with non-contracted vendors in the area to ensure the member's covered transportation needs are met. The vendor also has capacity to serve members who speak other languages, as well as TDD/TTY for speech and hearing impaired members.

Provider Input – Molina routinely seeks input from network providers through its Physician Advisory Committee forum. These meetings with key network physicians are designed to solicit ideas and information from network providers to enable Molina to continuously improve operational efficiency and provider satisfaction. Molina expects to receive helpful suggestions from Physician Advisory Committee physicians to further reduce member appointment no show rates.