Molina Medicaid Solutions

Response to State of West Virginia Request for Proposal MED13006

Medicaid Management Information System Re-procurement

9037MMS0412

Response to:

The State of West Virginia
Bureau for Medical Services
Medicaid Management Information
Systems (MMIS)
Re-procurement
Request for Proposal MED13006

200 Oceangate, Suite 100
Long Beach, CA 90802

Norm Nichols

Norm Nichols
President
Molina Medicaid Solutions

225.216.6010
8591 United Plaza Boulevard
Baton Rouge, LA 70809

06-13-12

Date

Some of the information furnished in this proposal in response to RFP MED13006 is submitted in confidence and contain trade secrets and/or privileged or confidential information and such information shall only be disclosed for evaluation purposes. Provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of West Virginia shall have the right to use or disclose the information therein to the extent provided in the Contract. This restriction does not limit the State of West Virginia's right to use or disclose information obtained from any source, including the Proposer, without restrictions. This information is proprietary or confidential and contains trade secret information that is privileged and is therefore exempt from disclosure under the provisions of West Virginia Code 29B-1-4. Pages containing such proprietary or confidential trade secret information are appropriately marked.

SECRETARY'S CERTIFICATE

Molina Information Systems, LLC, a California limited liability company doing business as Molina Medicaid Solutions ("Molina Medicaid Solutions"), is the wholly owned subsidiary of Molina Healthcare, Inc., a Delaware corporation. I serve as the Senior Vice President- General Counsel of Molina Healthcare, Inc. and all of its subsidiaries, and am the Secretary of Molina Medicaid Solutions.

I hereby certify and affirm that Norman Nichols is the duly appointed President of Molina Medicaid Solutions, and has full power and authority to enter into binding contracts on behalf of Molina Medicaid Solutions.

Executed this 5th day of January, 2012.

Jeff Barlow, Senior Vice President, Secretary and General Counsel

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Molina Medicaid Solutions
200 Oceangate, Suite 100
Long Beach, CA 90802

June 12, 2012

West Virginia Department of Health and Human Resources
Office of Purchasing
Attention: Donna Smith
One Davis Square, Suite 100
Charleston, WV 25301

Subject: Transmittal of Molina's Proposal in Response to the State of West Virginia Bureau for Medical Services Request for Proposal (RFP) Number MED13006 entitled, "Medicaid Management Information System (MMIS) Re-procurement"

Dear Ms. Smith:

On behalf of Molina Medicaid Solutions (Molina), I am pleased to submit this proposal to the State of West Virginia, Bureau for Medical Services. Molina meets or exceeds the requirements presented in the Request for Proposal. Our Web enabled and configurable Healthcare Payer Administration Solution (Health PAS) and proven Medicaid fiscal agent services meet the State of West Virginia's MMIS Re-Procurement objectives.

Our long-lasting business relationship with the State of West Virginia is built on mutual respect and a shared commitment for success. Molina offers a proven, talented team of experienced professionals with extensive knowledge of West Virginia's Medicaid requirements and our current operations in meeting those requirements. We are positioned to leverage our West Virginia Medicaid knowledge to ensure a successful and low risk transition to an enhanced Health PAS as a replacement MMIS and to successfully carryout the RFP project requirements. In our Executive Summary, Molina identifies five reasons why Molina is the best choice for West Virginia:

- A healthcare company aligned with BMS' mission and objectives
- Low-risk implementation with knowledge gained from an eight year relationship with BMS
- Best practices and lessons learned from three decades of MMIS and fiscal agent experience
- Sophisticated, proven solution that provides a cost-effective, streamlined MMIS replacement strategy
- On-time delivery from our experienced, dedicated team.

Molina has created a tradition of excellence and commitment in delivering critical, enterprise-wide healthcare solutions and has established a routine of providing innovative solutions and unparalleled services. Molina's methodology and approach interacts effectively with the overarching BMS Project Plan, and we agree to work cooperatively with the MMIS Re-Procurement Project Team.

Health PAS is an integrated CMS certified solution that aligns with Medicaid Information Technology Architecture (MITA). Molina is confident that the proposed combination of people, methodologies, and system features provides the best possible solution for satisfying the requirements set out in the RFP.

Molina agrees to all mandatory deliverables and requirements, as described in the RFP. Molina has the ability to perform the services described in the RFP, and we are committed and willing to enter into a contract with the State of West Virginia to perform these services.

I hereby acknowledge receipt of the following addenda and assure that the necessary revisions have been made to this proposal, plans, and/or specifications:

ADDENDUM	DATE RELEASED
1	June 7, 2012
2	June 12, 2012

As the person signing this proposal, I am authorized to submit this proposal and bind Molina Medicaid Solutions to the services and requirements as stated in the RFP and this proposal. Molina accepts the RFP terms, and I certify that the price was arrived at without any conflict of interest.

I affirm that neither Molina nor our representatives have contracted nor intend to contract with the vendors identified below in accordance with West Virginia Code §9-2-9b (e):

Fenwick Technologies Inc.

- Phil Weikle

Berry Dunn

- Tim Masse
- Judy Higgins
- Laurel Arnold
- Joe Herlihy
- Laurie Sturgis
- Nicole Becnel
- Chad Snow
- Marcey McHatten
- Seth Hedstrom
- Brandon Milton
- Charlie Leadbetter
- Laura Killebrew
- Kristan Drzewiecki

I also certify that Molina is not debarred or suspended; and to the best of our knowledge no entity, agency, or person associated with Molina is debarred or suspended.

Please contact me on 225.216.6010 or at Norman.Nichols@MolinaHealthCare.com or Ruth Ann Panepinto, our local Molina Executive Account Manager for West Virginia, on 304.348.3324 or at Ruth.Panepinto@MolinaHealthCare.com if we can be of assistance.

Sincerely,

Norm Nichols
President
Molina Medicaid Solutions

Enclosure
NN/jw

2.0 TRANSMITTAL LETTER

RFP Requirement 4.1.2 Transmittal Letter

The transmittal letter is located immediately behind Proposal Section 1.0, Title Page, as required in RFP Section 4.1.2.

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4.0 EXECUTIVE SUMMARY

This section contains confidential and proprietary information and has been redacted.

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5.0 VENDOR'S ORGANIZATION

RFP Requirement 4.1.5 Vendor's Organization

This section's content is not applicable to Request for Proposal (RFP) MED13006's 300-page limitation. As specified in RFP Requirement 4.1, all items excluded from the three-hundred (300) page limit should be placed as separate sections at the back of the technical proposal; therefore, please refer to Proposal Section 14.3, Business Organization.

5.1 Business Name and Address

Please refer to Proposal Section 14.3, Business Organization.

5.2 Licenses

Please refer to Proposal Section 14.3, Business Organization.

5.3 Subcontractor Business Information

Please refer to Proposal Section 14.3, Business Organization.

5.4 Financial Information

Please refer to Proposal Section 14.3, Business Organization.

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6.0 LOCATION

RFP Requirement 3.1.1, 3.1.2, 3.1.4, 3.1.6, 3.1.9, 3.1.10, 3.2.4, 3.2.4.1, 4.1.6

BMS' relationship with Molina's staff is strengthened by the close proximity of our current and proposed Charleston facility.

Molina cares about its clients and staff and understands that its facilities, environment, and infrastructure form the foundation for effective operations. Molina uses that objective to establish a work environment within which the co-located Bureau partners and Molina team successfully and comfortably complete their appointed tasks.

The location and facilities meet the requirements established by BMS.

Molina intends to conduct all phases of the project out of its existing site at 1600 Pennsylvania Avenue, Charleston, West Virginia, which is two miles from the BMS office at 350 Capitol Street. All key staff members designated in RFP Section 3.2.3 will be located at this facility. The facility will have one individually lockable private office for a BMS staff member. This office will be fully equipped with furniture, telephone service, a personal computer (with access to the Health PAS MMIS, Microsoft Office™ Suite, and the Internet) as well as access to a printer and copier. Six BMS reserved parking space and six general visitor parking spaces are provided. The office areas are secured by restricted badge access to the building. Molina computers in office areas have automatic log off functionality, and USB ports are disabled for use by portable data storage devices.

Molina assumes all costs associated with securing and maintaining this facility for the contract duration including hardware and software necessary to maintain approved performance requirements, maintenance, lease hold improvements, utilities, equipment, supplies, janitorial, security, storage, transportation, and insurance.

Engaging BMS staff and other key stakeholders in various DDI sessions is an important part of Molina's DDI process. Our project schedule includes identifying essential participants and scheduling their participation in appropriate sessions. The facility will have multiple meeting rooms outfitted with high quality telephone conferencing, Cisco TelePresence video conferencing, and computer projection equipment for use in project team meetings and work sessions, and Web-based application sharing for ten or more attendees. The Bureau will have access to conference space for the DDI review, planning, testing, and training sessions as well as during the Operations Phase.

Molina and our partners perform all work associated with this contract within the continental United States or U.S. Territories. Specific functions that will be performed in our Charleston facility include:

- Business operations
- Claims receipt (hard copy) and pre-screening
- Mail room (including print fulfillment functions)
- Data entry (paper claims)
- Imaging operations
- Exception claims processing
- All call center operations, *including* the POS pharmacy (provider) help desk operations
- Provider enrollment and re-enrollment
- Provider relations
- Member relations
- Account management
- Quality assurance
- Designated system modification and enhancement activities described in RFP Section 3.2.7.3
- Financial management.

To provide optimum protection against a local disaster, Molina uses a geographically-dispersed approach to establishing and running its Medicaid operations. Molina has identified all system critical and operational processes and detailed the procedures necessary to restore those processes to service at the backup location. Examples of these systems and processes include performing daily backups of system files, defining processes for handling emergency provider applications and out-of-network provider

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PHASE 1 MMIS REPLACEMENT DDI & CMS CERTIFICATION PLANNING			
Location	**Functions**	**Contractor/ Subcontractor**	**Quality Assurance and Timeliness**
			• Schedule adherence by PMO and project plan
Charleston, WV	Implementation work for: • Document imaging • Claims data entry • Non-claim indexing	GTESS	Subcontractor management
Ann Arbor, MI	Validating requirements and integration to support data analytics	Thomson Reuters	Subcontractor management
Albuquerque, NM	Data center	Molina	Onsite quality assurance as well as RFP SLA monitoring and reporting
Scottsdale, AZ	Back up data center	Molina	Onsite quality assurance as well as RFP SLA monitoring and reporting
Long Beach, CA	Network monitoring	Molina	Onsite quality assurance as well as RFP SLA monitoring and reporting

PHASE 2 FISCAL AGENT OPERATIONS			
Location	**Functions**	**Contractor/ Subcontractor**	**Quality Assurance and Timeliness**
Charleston, WV	Per RFP Requirement 3.2.4 (except imaging and data entry)	Molina	Onsite quality assurance department
Charleston, WV	Imaging and data entry	GTESS	Subcontractor management
Ann Arbor, MI	DataProbe analytics	Thomson Reuters	Subcontractor management
Herndon, VA	• Maintenance and monitoring • Change requests and system customization	Molina	Change, issue, and problem management
Glen Allen, VA	• MMIS maintenance and monitoring • MMIS change requests and system customization	Molina	Change management
Virginia Beach, VA	• Pharmacy POS maintenance and monitoring • Pharmacy POS change requests and system customization • Pharmacy clinical recommendations	Molina	Change management
Albuquerque, NM	Data center	Molina	Onsite quality assurance as well as SLA monitoring and reporting
Scottsdale, AZ	Back up data center	Molina	Onsite quality assurance as well as SLA monitoring and reporting
Long Beach, CA	Network monitoring	Molina	Onsite quality assurance as

PHASE 2 FISCAL AGENT OPERATIONS			
			well as SLA monitoring and reporting

PHASE 3 TURNOVER & CLOSE-OUT			
Location	**Functions**	**Contractor/ Subcontractor**	**Quality Assurance and Timeliness**
Charleston, WV	Support turnover and close-out for functions in RFP Requirement 3.2.4 with the exception of imaging and data entry	Molina	Project management plan for turnover and close-out
Charleston, WV	Support turnover and close-out for imaging and data entry	GTESS	Project management plan for turnover and close-out
Ann Arbor, MI	Support turnover and close-out for data analytics	Thomson Reuters	Project management plan for turnover and close-out
Herndon, VA	Support turnover and close-out requirements for MMIS design and functionality	Molina	Project management plan for turnover and close-out
Glen Allen, VA	Support turnover and close-out requirements for MMIS design and functionality	Molina	Project management plan for turnover and close-out
Virginia Beach, VA	Support turnover and close-out requirements for Pharmacy POS design and functionality	Molina	Project management plan for turnover and close-out
Albuquerque, NM	Support turnover and close-out requirements for data center	Molina	Project management plan for turnover and close-out
Scottsdale, AZ	Support turnover and close-out requirements for back up data center	Molina	Project management plan for turnover and close-out

7.0 VENDOR CAPACITY, QUALIFICATIONS, REFERENCES, AND EXPERIENCE

RFP Requirement 4.1.7 Vendor Capacity, Qualifications, References, and Experience

All West Virginia customers (BMS, members, and providers) will receive the benefit of our named staff with 190 cumulative years of West Virginia Medicaid experience. Molina has more than 30 years of experience delivering quality DDI, fiscal agent, MCO, and clinical services.

Through its acquisition of Unisys Health Information Management (HIM), Molina has more than three decades of experience in providing MMIS implementation and fiscal agent services to state programs and to underserved populations within the public sector. Molina has extensive experience in supporting both fee-for-service populations and managed care programs.

We bring a fresh approach to the fiscal agent services market – driven by family values and a determination to be the best. The name "Molina" means something special to the leaders and employees of our fast growing healthcare company. There is nothing old and stale about the way we think or act. We are driven to be successful in all of our client engagements.

While the staff members BMS interacts with everyday most likely were part of the Unisys team, the culture, the support systems, significantly enhanced resource allocations and capital commitments as well as expectations for delivery are all changing to reflect the way Molina does business.

The first visible change is the creation of the Implementation and Support Organization (ISO) which includes professional project management, Medicaid SME, testing, data management, application development, and infrastructure personnel who will be soley dedicated to the West Virginia Health PAS implementation. Just like BMS, this team understands the significance of an onsite presence in Charleston and the necessity of a close working relationship with BMS staff. It is essential and critical to an on-time delivery of the new MMIS.

The Molina Difference

- **More than eight years of experience with West Virginia Medicaid**
- **A healthcare company that serves patients in clinics, managed care organizations, and as a Medicaid fiscal agent**
- **Three decades of fiscal agent experience in states of similar size and complexity**
- **Nationally recognized commitment to quality**
- **An experienced and proven Implementation and Support Organization (ISO) to drive an on-time delivery**

A second visible change is leadership. Molina is led by a physician with certification in three areas of medicine (internal, metabolic, and endocrine) as well as a former Molina medical director, Dr. Mario Molina; and Mr. Norm Nichols, a Medicaid veteran with more than 30 years of experience. This executive leadership with hands on, front line, real world experience enforces with our staff what it takes to meet the needs of a state Medicaid agency in an ever changing and challenging environment. Molina is a capable, honorable, and willing corporation whose leadership stands behind its word and supports its account managers to ensure that they have the resources necessary to assure operational excellence and positive outcomes every day.

The third and most distinctive change is our company's culture and DNA. **We are a healthcare company**. Prior to Molina's acquisition, we were associated with a technology company whose primary business was the support of mainframe computers and technology. Today, we are a strategic arm of a family-led healthcare company where the understanding of the health care market, and particularly the Medicaid culture, is highly valued. Service excellence is expected. Understanding and valuing the

Medicaid culture and the underserved public-sector populations provides the basis for Molina to be a truly effective partner to BMS.

7.1 Organizational Profile

Molina Healthcare, Inc. (Molina Healthcare), the parent organization of Molina Medicaid Solutions (Molina), is a multi-state healthcare organization with flexible care delivery systems focused exclusively on Medicaid, Medicare, and other government-sponsored healthcare programs for low income families and individuals. Molina Healthcare was founded under the name Molina Medical Centers in 1980 by C. David Molina, M.D., an emergency room physician, as a safety net provider for Medicaid. The initial clinic sites started by Dr. Molina served people who had previously turned to emergency rooms for care because they lacked adequate access to primary care services. Today, Molina continues to focus on serving the needs of diverse, underserved, and underprivileged populations and responds to their unique health care delivery challenges. Molina Medicaid Solutions leverages Molina Healthcare's wealth of experience tailoring programs and services for diverse and special needs populations to support the West Virginia MMIS Re-Procurement Project's vision and objectives.

Molina Healthcare is a publicly traded (NYSE: MOH) Fortune 500 company. Its MCO Division, Molina Healthcare (MHI), conducts business primarily through ten licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans receive strategic direction and cultural influence from the Molina family and are locally operated by its respective wholly-owned subsidiaries, each of which is licensed as a health maintenance organization in that state. Molina Healthcare is committed to:

- Caring about the people served
- Delivering quality services, promoting healthier populations, and removing barriers to health services
- Being healthcare innovators and embracing change quickly
- Serving as a trustworthy partner and being prudent stewards of the public's funds
- Respecting the dignity of every member and valuing ethical business practices

Molina Medicaid Solutions embraces the commitments and objectives of Molina Healthcare's core values by being an innovative healthcare leader that delivers quality services efficiently and effectively.

Quality and integrity are top priorities for Molina Healthcare, and we hold and maintain accreditation and certification for each of our service areas. Molina health plans are accredited by the National Committee on Quality Assurance (NCQA). The Molina Nurse Advice Line is accredited by the Utilization Review Accreditation Committee (URAC). Most recently, Molina Pathways, a care management delivery process, obtained QIO-Like Certification from CMS, enabling enhanced federal financial participation (75%) for Medicaid services. Desiring to grow and expand, Molina became a publicly traded company in 2003. With more than 30 years of experience, Molina is a Fortune 500 company serving Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries.

We believe that our employees are our greatest assets, and we treat them with respect and dignity. We strive to foster a creative, productive, and energized work environment. Our innovative practices were recognized in 2011 with the Alfred P. Sloan Award for Business Excellence in Workplace Flexibility, which ranks Molina in the top 20 percent of companies nationally. An innovative Molina practice that reflects our collective and individual dedication to help those in need is compensated volunteer time off to foster employee volunteer work. Molina also funds local "Community Champions" programs that spotlight and reward the good deeds of everyday community heroes.

7.1.1 Molina Management Structure

Molina Healthcare's service success depends on its ability to leverage certain administrative functions across its subsidiaries including case and care management, disease management, nurse advice call

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MOLINA MEDICAID SOLUTIONS

Molina Medicaid Solutions (Molina), a wholly-owned subsidiary of Molina Healthcare, provides fiscal agent services to state Medicaid programs in West Virginia, Idaho, Louisiana, Maine, and New Jersey, as well as drug rebate services to the State of Florida. Molina Healthcare acquired the HIM division of Unisys Corporation as a wholly owned subsidiary on May 1, 2010 and was renamed Molina Information Systems, LLC (doing business as Molina Medicaid Solutions). The acquisition allows Molina Healthcare and Molina Medicaid Solutions to collaboratively address a state's needs through the administration of its multiplicity of service delivery options, resources, and capabilities.

Molina Medicaid Solutions (and its predecessor Unisys HIM) has performed 10 successful Medicaid fiscal agent implementations. Current MMS contracts all represent large-scale data processing system takeover, enhancement, implementation, operations, and maintenance projects.

MOLINA MEDICAL OFFICES

Molina Healthcare owns and operates over 20 primary care health clinics in Northern and Southern California, Florida, New Mexico, Washington, and Virginia. Our medical offices provide individuals who qualify for government sponsored programs with medical care including prenatal care, immunizations, and flu vaccines, acute and chronic care. With the growth of our clinics, we continue to serve the most vulnerable of our citizens by providing access to quality health care in a convenient setting.

MOLINA HEALTHCARE'S MEDICAID AND MEDICARE PROGRAMS (HEALTH PLANS)

Molina Healthcare provides services to both Medicaid and Medicare patients with a focus on the Medicare patients who are also Medicaid members. Molina Healthcare operates Medicaid plans in the states of California, Florida, Michigan, Missouri, Ohio, New Mexico, Texas, Utah, Washington, and Wisconsin.

In addition, Molina Healthcare operates Medicare Advantage plans designed to meet the needs of individuals with Medicare or both Medicaid and Medicare coverage. Molina Medicare plans provide comprehensive quality benefits and programs including access to a large selection of doctors, hospitals, and other healthcare providers at little or no out-of-pocket cost.

MOLINA PATHWAYS

BMS has care management requirements as defined in RFP Appendix E and Section 3.2.10 Other Optional Services. Our proposal responds to these requirements in Proposal Sections 10.1.1.1.1.5 Care Management and 14.13 Other Optional Services. Our Pathways solution is delivered through Molina Pathways, LLC, a subsidiary of Molina Healthcare. Pathways obtained QIO-Like Certification from CMS, enabling enhanced federal financial participation for Medicaid care management services.

Formed in September 2011, Pathways offers access to our expert care management and clinical programs that had been only available to our MCO health plan members. Using nationally recognized guidelines and proven clinical management techniques, Pathways provides care access and monitoring, care management, care transitions, and a nurse advice line.

7.1.2 West Virginia Replacement MMIS Organizational Ownership and Authority

Molina Medicaid Solutions, led byPresident Norm Nichols, has corporate ownership and oversight responsibility for the West Virginia Medicaid account. To remain nimble and responsive to our clients' needs, the reporting structure for Molina Medicaid Solutions is simple and direct, ensuring our fiscal agent accounts receive the necessary resources and leadership required to be successful. Mr. Nichols has over 30 years of Medicaid and health care experience; and for 16 years, served as the Louisiana fiscal agent contract executive account manager. As the leader of Molina, Mr. Nichols has executive

responsibility for all contracts, making certain that resources are made available to meet performance and service-level requirements. Mr. Nichols reports to Terry Bayer, Chief Operating Officer, Molina Healthcare, who reports directly to J. Mario Molina, MD, Chief Executive Officer.

The Molina internal structure is designed to allow state Medicaid accounts immediate access to key management personnel. **Figure 7.1.1-1** illustrates the placement of Molina's West Virginia Medicaid account within our corporate structure. This organizational structure allows BMS and the account manager ready access to key staff that can effectively and efficiently resolve issues, provide the necessary resources and expertise, and answer questions. Mr. Tim Brewer, who oversaw the successful Health PAS implementations in Maine and Idaho, is leading the ISO team who will be implementing the new West Virginia MMIS. The ISO lets BMS leverage lessons learned from other Molina accounts and increases management responsiveness.

Ruth Ann Panepinto, Ph.D., West Virginia's Account Manager, has overall responsibility for the contract and collaborates with BMS on all contract issues. She is responsible for and has the authority to make certain that all contractual, fiscal, and fiduciary obligations are met. Dr. Panepinto manages the administrative operations; serves as chief liaison with BMS; directs the planning, scheduling, and coordination of contractual commitments; and oversees the submission of all required deliverables.

Molina Healthcare includes personnel who possess specialized healthcare and administrative skills (e.g., clinical programs and services, regulatory analysis and expertise, data center administration, and disaster recovery). These corporate resources are available to support the successful implementation of the West Virginia Replacement MMIS.

Figure 7.1.2-1 depicts the Molina organization, including the West Virginia fiscal agent account, and the relationship between Molina Medicaid Solutions and Molina Healthcare.

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8.0 STAFF CAPACITY, QUALIFICATIONS, AND EXPERIENCE

RFP Requirement 4.1.8, 3.1.3, 3.1.38, 3.1.45, 3.1.46, 3.2.3

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MOLINA Medicaid Solutions

9.0 PROJECT APPROACH AND SOLUTION

RFP Requirement 4.1.9

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coordination and approval of all medically necessary services, claims processing, member services, provider relations, and network development.

Molina's proposed approach and methodologies for completing the work of the MMIS Re-Procurement Project are described in the following sections.

9.1 Statement of Understanding

RFP Requirement 4.1.9, bullet 1

Molina brings proven technology and experienced staff to help the Bureau move forward to accomplish their goals outlined in the RFP, without disruptions to provider payments or member access to care. The MMIS Replacement DDI Phase will replace the existing Health PAS solution in West Virginia with an advanced version using the latest release of the COTS software. This solution will replace current MMIS functionality with a system that meets or exceeds RFP requirements. Molina will improve the existing systems, operations, and infrastructure as needed to comply with new contract requirements. The combination of software configured for West Virginia and an improved infrastructure will provide BMS with a modern, certified, MITA-aligned MMIS solution that will enable the State to achieve its goals and objectives. Health PAS provides proven CMS certification, fully meets CMS' Seven Conditions and Standards for enhanced CMS funding, and is built for the future. This configurable and highly flexible solution offers BMS an effective method to meet evolving program demands.

Background: Each year, the Bureau processes more than 17.7 million medical, dental, and pharmacy claims for 24,000 providers delivering health care services. More than 420,000 low-income individuals and families who need access to quality healthcare rely on Medicaid managed care or fee-for-service, waiver, and other benefit programs. Some of these programs are large and involve all 55 counties in West Virginia, like Mountain Health Trust, which serves more than 165,000 people. Others, like the Intellectually/Developmental Disabled Waiver program, serve smaller segments of the community. These programs share the common goal of providing access to care, tailored services, and opportunities and incentives enabling members to make choices that improve their health.

BMS relies on many diverse organizations to connect needy citizens to health care providers and pay for medically necessary services. The fiscal agent contractor is one of 12 business entities contracting with BMS to provide services, such as a preferred drug list vendor and a psychological consulting services company. The MMIS is one of five information systems that the Bureau uses to administer health benefits through a total of 13 different defined State programs. In 2010, Molina processed 298,000 claims and denied 30,397 claims per week, paying out an average of more than $36 million per week. On a weekly basis, Molina responded to more than 3,000 phones calls from providers and members, conducted 191 provider field representative visits, handled 13,744 paper claims, and received 447 change requests.

Project Objectives: Activities of the MMIS Re-Procurement Project will occur concurrently with operations and enhancement activities for the existing fiscal agent contract, such as the ICD-10 implementation. In addition, BMS is overseeing four other technology projects: a data warehouse/decision support system, master data management solution, HIT/HIE, and transformation grants. Transformation grants enabled BMS to undertake an automated pharmacy prior authorization project and a patient care Web portal project, both of which must be included in the replacement MMIS. The State's goals, activities, and personnel are subject to State and federal regulations, and the successful vendor must work with the Bureau to ensure regulatory compliance.

One of the Bureau's key goals is to streamline administration. Accessing CMS funding opportunities will help the Bureau achieve this goal. Through this RFP, the Bureau is seeking a vendor with an operational system that has the functional capability identified in the MITA State Self-Assessment (SS-A). Our proposed operational and certified system has the business capabilities that the Bureau identified in the MITA SS-A and better serves members and providers through current HIT and HIE. CMS requirements, regulatory changes, and standards, such as ICD-10 or PPACA, will be incorporated.

The Bureau requires a qualified vendor to design, develop, and implement a replacement MMIS, gain CMS certification, and provide fiscal agent operations, modifications, and enhancements for the replacement system. BMS is looking for a flexible MMIS that can quickly respond to changes in the State program, effectively address new regulatory requirements, and efficiently remediate deficiencies. Our

MMIS solution provides all components and functions that are detailed in RFP Section 1.2, aligns with MITA, and uses an open and service-oriented architecture. The new MMIS meets all Seven Conditions and Standards for enhanced funding requirements as described in Medicaid IT Supplement (MITS-11-01-v1.0). The system achieves the goals and objectives of Medicaid and the 14 business to-be processes selected by BMS in the SS-A to advance maturity.

Scope of Work: BMS desires the proposed solution to be aligned based with MITA business areas and the goals listed in RFP Table 2-1 MITA Business Area Goals and Objectives, including:

- Member Management: Serves West Virginia's Medicaid members through enrollment, outreach, communications, information management, and support services. The Bureau's goals include an enhanced ability for members to participate in and exercise responsibility for their personal health choices. BMS has identified one business process to be raised from MITA maturity level 1 to level 2. The new MMIS is able to provide the functionality to administer the incentive program as developed by BMS and approved by CMS.
- Provider Management: Manages and maintains the files for West Virginia's 24,000 providers, effectively communicating with them, informing concerned stakeholders, and handling complaints or grievances. The Bureau's goal is to simplify the process for submission of provider information. The Bureau has identified five processes for improvement from MITA maturity level 1 to level 2.
- Operations Management: Manages the information used to pay providers, sustains the relationship with managed care organizations, shares administrative duties with other agencies, and interacts with other insurers and responsible parties. BMS' goals include improving operational efficiency and reducing costs in the healthcare system, access to information necessary for operations management, as well as provider access to real-time data. BMS has identified seven business processes to advance from MITA maturity level 1 to level 2.
- Program Management: Provides the structure needed for the Medicaid Program to conduct strategic planning, ensure program oversight and monitoring, conduct analysis of the State's program, and make needed business decisions. The Bureau has targeted one business process for improvement from MITA maturity level 1 to level 2. The Bureau's goals include enhancing the ability to analyze the effectiveness of potential and existing benefits and policies and improve consistency of program management processes and enhance the effectiveness of the communication of policy. Molina will work with BMS to be certain that the policy management and MMIS change management processes align and synchronize law/regulation, policy, MMIS processing, and provider communication.
- Care Management: Supports individual care management, population management, and promotion of health education and awareness. As part of the MITA SS-A, the Strategic Leadership Committee identified two goals. The first is to improve healthcare outcomes for members, and the second is to increase use of evidence-based clinical and appropriate services.
- Program Integrity (PI) Management: Improve effectiveness and efficiency of PI. As the incumbent fiscal agent, Molina is already working with the data warehouse vendor and Office of Quality and Program Integrity (OQPI) to support PI and will continue in the new contract.
- Other Requirements: Pharmacy Point-of-Sale (POS); General/Technical Requirements; Mandatory Requirements (RFP Section 3.1); CMS Certification Requirements (RFP Appendix D); Operational Requirements (RFP Appendix F); Service Level Agreements (RFP Appendix G); Performance Metrics (RFP Appendix H).

These services must be developed, tested, transitioned, operated, certified, enhanced, and monitored during the three phases, all of which require a Formal Notice to Proceed from BMS before the start of each phase:

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9.2 Detailed Proposal for Providing the Services

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Table 9.2.1.3-1 illustrates our proposed interaction between the Bureau's and Molina's leadership teams. Various members of both teams participate in the project's governance entities. The chart is not an organization chart; rather it is the suggested governance alignment structure. The leadership positions identified are organized in a participatory stature and horizontally aligned to clarify the suggested relationships.

Table 9.2.1.3-1: Proposed Governance Team Integration

GOVERNANCE ENTITY	State of West Virginia	Molina
ESC	• State Medicaid Director • BMS MMIS Re-Procurement Project Sponsor • BMS Project Officer • Office of Technology Enterprise Project Management Office (EPMO) Oversight Project Manager	• MMIS Account Manager • Senior Vice President, Molina Medicaid Solutions, Project Delivery • Implementation Director • Medical/Dental Systems Manager
PROJECT LEADERSHIP	• BMS MMIS Re-Procurement Project Sponsor • BMS Project Officer • Office of Technology EPMO Oversight Project Manager	• MMIS Account Manager • Implementation Director • DDI Coordinator • Medical/Dental Systems Manager
PMO	• BMS Project Officer • Office of Technology EPMO Oversight Project Manager	• Implementation Director • PMO Manager • POS Project Manager • Medical/Dental Project Manager • EDI Manager/Web Portal Manager • DDI Coordinator
CCB	• BMS MMIS Re-Procurement Project Sponsor • BMS Project Officer • MMIS RE-Procurement Project Team (as needed)	• Implementation Director • MMIS Account Manager • PMO Manager • DDI Coordinator • Medical/Dental Systems Manager

Executive Steering Committee: A strong BMS and Molina partnership is critical to meeting project objectives and achieving CMS certification. The proposed Molina governance model incorporates the formation of a strong, binding relationship at the highest management levels through the use of an ESC. The ESC is chaired by the BMS MMIS Re-Procurement Project Sponsor, composed of senior leadership individuals from both the Bureau and Molina organizations, initiated at the kickoff meeting, and fostered throughout the project during the monthly ESC project review meetings. This partnership approach promotes overall executive sponsorship, enables clear lines of open communication, cultivates close cooperation, and maintains a positive working relationship necessary for project success.

The ESC and the CCB exist for all project phases to provide a collaborative approach to project governance. During the fiscal agent operations phases, the PMO role will transition to the POS project manager and the medical/dental project manager, and Molina will use our same project controls, such as risk and issue management, defect tracking, and change management, along with status reporting, used during the DDI and Certification Planning Phase. We will also include quality and performance management to ensure operational metrics are meeting contractual obligations.

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9.2.2 Project Facilities

RFP Reference: 4.1.9, bullet 2, sub-bullet 2; 3.2.4

9.2.2.1 Vendor Response Requirements

RFP Reference: 3.2.4.1

Molina has considerable experience providing Medicaid operational services for both MMIS and managed care programs. Molina develops strong partnerships with clients to enhance the success of these programs. One of the key parameters for a successful partnership is close proximity. Molina has and will continue to maintain an operations site easily accessible to the BMS team to encourage the sharing of information, not only for the day-to-day DDI and operations activities, but for continuous business process improvement.

9.2.2.1.1 Description of the Work Sites

RFP Reference: 3.2.4.1, bullet 1

Molina continues to conduct business out of its existing site at 1600 Pennsylvania Avenue, Charleston, West Virginia, which is 1.3 miles from the Bureau's office at 350 Capitol Street. Molina has recently completed an expansion of our office footprint that will accommodate the space required to successfully execute all project phases. All key staff members designated in RFP Section 3.2.3 will be located at our existing site. The facility will have one individually lockable private office for a BMS staff member. This office is fully equipped with furniture, telephone service, a personal computer (with access to the MMIS, Microsoft Office™ Suite, and the Internet), as well as access to a printer and copier. Seven reserved parking spaces are provided to accommodate BMS staff members. Molina will perform all work associated with this contract within the continental United States or U.S. Territories. Specific functions that will be performed in Molina's local Charleston facility include those listed in Proposal Section 6.

9.2.2.1.2 Description of Work to be Performed Offsite

RFP Reference: 3.2.4.1, bullet 2

Proposal Section 6.0 provides information about function location by phase. All offsite work performed is subject to reporting and service level agreements for quality and timeliness that meet or exceed RFP requirements. Molina's contracts with these vendors require regular and frequent reporting, and Molina assigns staff to monitor vendor performance. Functions performed by offsite Molina and partner employees have either direct or indirect reporting relationships established with the local site management. Quality assurance and timeliness for these functions are handled through the onsite quality assurance department or by Molina's performance management system.

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9.2.3 Phase 2: Fiscal Agent Operations

RFP Requirement 4.1.9 (bullet 2, sub-bullet 3), 3.1.25, 3.2.7

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9.2.4 Phase 3: Turnover and Close-Out

RFP Requirement 4.1.9, 3.2.8 Phase 3: Turnover and Close-Out

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9.2.5 Drug Rebate Solution

RFP Requirement 4.1.9 bullet 2, sub-bullet 4, 3.2.9

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9.3 Project Timeline (or Gantt)

RFP Requirement 4.1.9, bullet 3

Molina provides a project timeline in Proposal Section 14.6, Timeline or Gantt Chart. This section's content is not part of Request for Proposal (RFP) MED13006's 300-page limitation. As specified in RFP Requirement 4.1, all items excluded from the three-hundred (300) page limit should be placed as separate sections at the back of the technical proposal.

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9.4 Attachment II – Requirements Checklist

RFP Requirement 4.1.9, bullet 4, Attachment II

Molina has completed Attachment II, to crosswalk each RFP requirement to where we address it in our proposal. This section's content is not applicable to Request for Proposal (RFP) MED13006's 300-page limitation. As specified in RFP Requirement 4.1, all items excluded from the three-hundred (300) page limit should be placed as separate sections at the back of the technical proposal; therefore, please refer to Proposal Section 14.8, Requirements Checklist (Attachment II) for this required document.

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10.0 SOLUTION ALIGNMENT WITH BMS' BUSINESS AND TECHNICAL NEEDS

RFP Requirement 4.1.10

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MOLINA Medicaid Solutions

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10.1.2 Phase 1: MMIS Replacement DDI and CMS Certification Planning

RFP Requirement 4.1.10, bullet 1, sub-bullet 2, 3.2.6

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11.0 SUBCONTRACTING

RFP Requirement 4.1.11 Subcontracting

Molina has conducted a detailed review of the RFP requirements and assembled a talented and multi-disciplinary team of experts to provide the best possible solution for BMS. **Table 11-1** is a summary of Molina's proposed subcontractors' project roles and qualifications.

Table 11-1: The Proposed Molina Team

COMPANY	ROLE	QUALIFICATIONS
GTESS BETTER THAN HUMANLY POSSIBLE	Conversion of paper claims into an electronic format as well as indexing documents for loading to the document management system	• Healthcare company with more than 15 years of experience serving the healthcare market with data capture of claims and related documents • Serving Medicaid clients for 10 years • Applying technologies that ensure quality and improve claims adjudication processing
THOMSON REUTERS **As of June 2012, Thomson Reuters' new name is Truven Health Analytics**	Data analytics	• Healthcare information company with 18 years of Medicaid experience • Specialized expertise in healthcare performance measurement and quality improvement • A long track record of success helping Medicaid programs contain cost and improve care

11.1 GTESS

GTESS has been providing imaging and data capture services since its inception in 1990 and focuses exclusively on the healthcare and dental market. Their unique software includes the company's workflow system and proprietary and adaptable optical character recognition technology, along with a number of advanced technology processes including patent pending technology for selecting the correct provider and member on submitted claims. Essentially, GTESS' system applies logic in an automated fashion that would normally fall to a human to apply, achieving enhanced data quality. As part of the Molina team, GTESS will co-locate with Molina in our Charleston facility to convert claims data into electronic media and index paper documents received for subsequent retrieval through the electronic document management system.

11.2 Thomson Reuters

To supplement Health PAS-Analytic's capabilities, Thomson Reuters provides the DataProbe® System for up to 16 BMS users. DataProbe is a sophisticated Web-based healthcare data investigative tool designed for data exploration, analysis, and reporting. The DataProbe database contains historical claims data, encounter data, eligibility data, provider information data, and waiver program data. Thomson Reuters enhances the DataProbe database capabilities by applying certain analytic methods, such as Medical Episodes Grouper (MEG), to assist in the evaluation of total cost of care. Enabled with extensive standard reporting capabilities, DataProbe was designed to support ad hoc analysis of large volumes of healthcare data through straightforward, query-building techniques that do not require programming skills. To ensure that BMS takes full advantage of the extensive DateProbe reporting capabilities, a full-time experienced analyst is assigned to produce report output and analysis as directed by BMS and to support BMS users.

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12.0 SPECIAL TERMS AND CONDITIONS

RFP Requirement 4.1.12 Special Terms and Conditions.

Molina does not offer any specific special terms and conditions in our proposal.

12.1 Disclosure by Fiscal Agents: Information on Ownership and Control

RFP Requirement 4.1.12 The Vendor is to complete the form provided in Appendix L and include it with Section 4.1.13 Signed Forms.

This section's content is not applicable to Request for Proposal (RFP) MED13006's 300-page limitation. As specified in RFP Requirement 4.1, all items excluded from the three-hundred (300) page limit should be placed as separate sections at the back of the technical proposal; therefore, please refer to Proposal Section 14.12, Signed Forms.

12.2 Bid and Performance Bond

RFP Requirement 3.3.1 Bid and Performance Bonds: Non-applicable.

Molina acknowledges that neither a bid nor a performance bond is required for this RFP.

12.3 Insurance Requirements

RFP Requirement 3.3.2 Insurance Requirements.

Molina will comply with the insurance requirements as outlined in RFP Section 3.3.2, providing the proof of insurance at the time the contract is awarded. Molina will maintain and furnish proof of coverage of liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the Vendor, our agents and employees.

12.3.1 Bodily Injury

Molina will comply with the insurance requirements for bodily injury (including death): $500,000.00 per person, up to $1,000,000.00 per occurrence.

12.3.2 Property Damage and Personal Liability

Molina will comply with the insurance requirements for property damage and professional liability, up to $1,000,000.00 per occurrence.

12.4 License Requirements

RFP Requirement 3.3.3 License Requirements.

Proposal Section 14.3, Business Organization, includes Molina's Secretary of State's Office registration, our certificate of good standing with the State Agency of Employment Programs for both Unemployment Compensation and Worker's Compensation.

12.5 Litigation Bond

RFP Requirement 3.3.4 Litigation Bond: Non-applicable.

Molina acknowledges that a litigation bond is not required for this RFP.

12.6 Debarment and Suspension

RFP Requirement 3.3.5 Debarment and Suspension.

Molina certifies that we are not debarred or suspended, and to the best of our knowledge no entity, agency, or person associated with Molina is debarred or suspended.

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13.0 SIGNED FORMS

RFP Requirement 4.1.13 Signed Forms

Molina has completed and signed all necessary forms. This section's content is not applicable to Request for Proposal (RFP) MED13006's 300-page limitation. As specified in RFP requirement 4.1, all items excluded from the three-hundred (300) page limit should be placed as separate sections at the back of the technical proposal. Please refer to Proposal Section 14.12, Signed Forms, Addenda, and Transmittal Letters. Proposal Section 14.12 includes:

- MED Purchasing Affidavit
- MED 96 Agreement Addendum
- HIPAA Business Associate Addendum (BAA)
- Resident Vendor Preference
- Vendor Registration and Disclosure Statement
- Disclosure by Fiscal Agents: Information on Ownership and Control.

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14.0 ITEMS EXCLUDED FROM THE 300 PAGE LIMIT

RFP Requirement 4.1 Technical Proposal Format. Vendors should place all items excluded from the three-hundred (300) page limit as separate sections at the back of their Technical Proposal. Proposals in excess of the 300 page limit specified above will result in a reduction in technical score. Each item should be labeled in accordance with the information provided.

Proposal Section 14 contains all proposal items excluded from the three-hundred (300) RFP page limitation as itemized in **Table 14-1**.

Table 14-1: Proposal Items Excluded from 300 Page Limit

PROPOSAL SECTION NUMBER	CONTENTS
14.1	Annual Audited Financial Reports
14.2	Appendix E: Business and Technical Requirements
14.3	Business Organization
14.4	Description of Roles, Responsibilities, and Skill Sets
14.5	Key Staff Resumes
14.6	Timeline or Gantt Chart
14.7	Project Management Plan Subsidiary Documents
14.7.1	Work Breakdown Structure and Deliverable Dictionary
14.7.2	Project Schedule
14.8	Requirements Checklist
14.9	Staff Matrix
14.10	Initial Draft Project Management Plans
14.10.1	Staffing Plan
14.10.2	Facility Plan
14.10.3	Documentation Management Plan
14.10.4	Training Plan
14.10.5	Testing Plan
14.10.6	Scope Management Plan
14.10.7	Schedule Management Plan
14.10.8	Cost Management Plan
14.10.9	Quality Management Plan
14.10.10	Human Resources Management Plan
14.10.11	Communications Management Plan
14.10.12	Risk Management Plan
14.10.13	Issue Management Plan
14.10.14	Change Management Plan
14.10.15	Integration Management Plan
14.10.16	Workflow Management Plan
14.10.17	Problem Management Plan
14.10.18	Transition Plan
14.10.19	Weekly Status Report Template
14.10.20	Monthly Status Report Template

PROPOSAL SECTION NUMBER	CONTENTS
14.10.21	Integrated Test Environment Plan
14.11	Other Initial Draft Plans
14.11.1	Security, Privacy, and Confidentiality Plan
14.11.2	Configuration Management Plan
14.11.3	Data Conversion Plan
14.11.4	Disaster Recovery and Business Continuity Plan
14.11.5	Data and Records Retention Plan
14.12	Signed Forms, Addenda, and Transmittal Letters
14.12.1	Signed Forms
14.12.1.1	Med Purchasing Affidavit
14.12.1.2	MED 96 Agreement Addendum
14.12.1.3	HIPAA Business Associate Addendum (BAA)
14.12.1.4	Resident Vendor Preference
14.12.1.5	Vendor Registration and Disclosure Statement
14.12.1.6	Disclosure by Fiscal Agents: Information on Ownership and Control
14.12.2	Addendum Acknowledgement(s)
14.12.3	Transmittal Letter
14.13	Other Optional Services
14.14	Additional Materials
14.14.1	Additional Company Offerings
14.14.2	Glossary and Acronym List
14.14.3	Organizational Charts
14.14.4	Letters of Recommendation

14.1 Annual Audited Financial Reports

RFP Requirement 4.1, 1st bullet under not-included-in-300-page-limit section: The Technical Proposal should be limited to three-hundred (300) pages, including all charts and attachments, excluding the following:

• Annual audited financial reports (may be submitted via hyperlink in the Technical Proposal, but must be submitted in full in the CD).

Please refer to Proposal Section 14.3, Vendor (Business) Organization, for annual audited financial reports requirements. Molina's financial reports are listed as hyperlinks in the technical proposal and submitted in full on the CD.

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14.2 Appendix E: Business and Technical Requirements

RFP Requirement 4.1.10 Solution Alignment with BMS' Business and Technical Needs, second bullet

Molina offers BMS technology and services that align with "to be" vision goals and objectives. Health PAS aligns with the MITA standards and can facilitate West Virginia's move into the future while meeting the goals and objectives of the MMIS re-procurement project.

Table 14.2-1 contains Molina's completed RFP Appendix E, Business and Technical Requirements. In summary:

- 2,268 out of a total of 2,297 requirements (99%) are available without customization
- 29 out of a total of 2,297 requirements (1%) are available with customization
- 0 requirements (0%) are unavailable

Table 14.2-1: Molina's Response to RFP Appendix E, Business and Technical Requirements

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.1	**1. Determine Eligibility**			
ME.2	Ability to provide role-based (inquiry vs. update) access to the Member eligibility information using a variety of secure methods, including:	X		
ME.3	Web portal	X		
ME.4	By telephone to the Provider Help Desk	X		
ME.5	Automated Voice Response System (AVRS)	X		
ME.6	Electronic inquiry through a 270 transaction	X		
ME.7	Other as identified by BMS during DDI and accepted via formal change control	X		
ME.8	The Vendor is expected to accept eligibility information from a state-maintained sponsor system. Currently, this system receives eligibility information from Recipient Automated Payment and Information Data System (RAPIDS), and Families and Children Tracking System (FACTS).	X		
ME.9	The Vendor is required to on a daily basis, process Member eligibility, including Pharmacy, update information received from eligibility sponsor systems (in the sequence in which they were created) for use in claims processing, and generate all applicable update reports according to an agreed-upon processing schedule.	X		
ME.10	The Vendor is expected to verify that Medical/Dental and Pharmacy POS Member eligibility data match on, at a minimum, a monthly basis. If the two eligibility sources are not in the same database they should be synchronized and reconciled on a schedule that ensures that eligibility data used for all claims adjudication matches between both systems.	X		
ME.11	The Vendor is expected to transmit an interface file to RAPIDS and FACTS so that required Mountain Health Trust (HMO and PAAS), LTC rates, MHC (Mountain Health Choices), other insurance or Third Party Liability (TPL) and lock in information so that some of this information can be printed on the Medicaid ID cards.	X		
ME.12	Ability to support flexible rules-based logic (as specified by BMS and Federal guidelines) to determine Member benefit plans.	X		
ME.13	Ability to identify potential or actual overlaps in program eligibility periods (such as when a client switches from/to Medicaid, State-funded, or any other programs).	X		
ME.14	The system is expected to accept conflicting or overlapping eligibility segments, and should apply a hierarchy of business rules to determine which one takes precedence.	X		
ME.15	The MMIS is expected to accept the Medicaid ID assigned by the eligibility source or through the Master Data Management (MDM) solution.	X		
ME.16	Ability to accept and maintain eligibility to pay for services provided for Members who are not Title XIX or Title XXI Members.	X		
ME.17	The system should allow authorized users to manually enter Member eligibility information.	X		
ME.18	Ability to automatically apply data validation edits during manual entry of Member eligibility information.	X		

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.19	**2. Enroll/Disenroll Member**			
ME.20	Capture, retain and report in a roster enrollee choice of provider. It can be either the MCO or the PAAS PCP.	X		
ME.21	Enrollment broker is to have direct (role-based) user-access to the MMIS. (The enrollment broker enters PCP information for the Health Maintenance Organization (HMO) and the Primary Care Case Management (PCCM) program).	X		
ME.22	The Vendor is to maintain appropriate benefits package for services for enrolled Member.	X		
ME.23	Ability to support flexible administration of benefits from multiple programs so that a Member may receive a customized set of services.	X		
ME.24	Ability to report on duplicate Member records using multiple criteria (e.g., name, SSN) in order to reconcile duplicate enrollment records.	X		
ME.25	Ability to capture and display from eligibility source head-of-household name. (These pieces of information are currently stored in the member record and do not vary by benefit plan or payor).	X		
ME.26	Capture and display case number in each individual Member record.	X		
ME.27	Ability to track and display on one screen: all Members in the case, including individual Members name under that case number; Medicaid ID number; date of birth; PCP/HMO name; and benefit program.		X	
ME.28	Ability to store, track and display eligibility source data including but not limited to eligibility codes, termination reason codes, termination dates, etc.	X		
ME.29	Generate monthly PAAS rosters to be submitted to the PAAS providers monthly.	X		
ME.30	**3. Manage Member Information**			
ME.31	Capture the Health Improvement Plan (HIP) from the enrollment broker. Generate monthly file to all parties as necessary (e.g., MCO Admin Vendor and MCOs). (The Health Improvement Plan (HIP) is a plan the member must complete with their physician and agree to complete specific health related activities in order to earn healthy rewards. This information is currently sent on a file to the MMIS vendor and loaded into the system).	X		
ME.32	Ability to accept electronic updates of the Member eligibility data (including updates to existing Member data and creation of new Member records) on a daily basis via batch file from the following or equivalent external systems:	X		
ME.33	RAPIDS (Recipient Automated Payment and Information Data System)	X		
ME.34	FACTS (Families and Children Tracking System)	X		
ME.35	TPL vendor/s as specified by BMS (the Bureau currently only receives TPL information from one vendor).	X		
ME.36	Enrollment broker/s as specified by BMS	X		
ME.37	Other systems as specified by the BMS during DDI	X		
ME.38	Ability to support the following functionality in regards to processing updates to the Member data set:	X		

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.39	Automatically edit fields for reasonableness, validity, format and consistency with other data present in update transaction.	X		
ME.40	Transaction reconciliation reporting for file/data reconciliation with external data sources (e.g., totals and detail information, difference reports, change reports). (This requirement applies to reporting only).	X		
ME.41	Maintains record/audit trail of updates (including time/date, source, type, status of request). Reject files with fatal errors should be returned to source.	X		
ME.42	Online display of audit trail should include Member add and termination dates, PCP add and termination dates, and user who made the change.	X		
ME.43	Error correction/synchronization error reporting - report all failed synchronization.	X		
ME.44	Ability to perform the following functions:	X		
ME.45	Maintain identification of all applicants eligible for Medicaid benefits.	X		
ME.46	Allow for timely updating of the data base to include new Members and all changes to existing Member records.	X		
ME.47	Maintain positive (active, as opposed to passive) control over all data pertaining to Medicaid Member eligibility. (Maintain the data in a safe and secure environment including, but not limited to, appropriate access controls, change management, auditing functionality, and security).	X		
ME.48	Build and maintain a computer file of Member data to be used for claims processing, administrative reporting, and surveillance and utilization review.	X		
ME.49	Able to distribute eligibility data to other processing agencies. (This currently includes the three Medicaid Eligibility Verification Systems (MEVS) vendors and the State's eligibility vendors, which are RAPIDS and FACTS. For State eligibility vendors, we provide a monthly reconciliation file).	X		
ME.50	Provide file space for, and record whenever available, the Social Security Number of each eligible Member.	X		
ME.51	Contain and use the data necessary to support Third Party Liability recovery activities.	X		
ME.52	Role-based security providing confidential access for individuals or groups.	X		
ME.53	Ability to provide external eligibility sources daily access to approved Member eligibility data. (The vendor should propose their preferred method of accommodating this access. This could be through the MEVS vendor, online/portal access by other agency personnel, etc.).	X		
ME.54	Ability to support on-line data presence, validity, format, and relationship edits for manually entered updates.	X		
ME.55	Ability to maintain an audit trail of changes to Member data at the field or line level rather than at a higher tracking level of last change to screen or file.	X		

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.56	Ability to identify recipients with multiple ID numbers for cross referencing, and for unduplicated counts of recipients for reporting purposes.	X		
ME.57	Ability to automatically or manually populate, maintain and display multiple (at a minimum 15) indicators at the Member level (e.g., disease state management, TBI, MRDD).	X		
ME.58	Enrollment broker can automate or be able to directly enter information that would be maintained in the Member record.	X		
ME.59	Ability to allow enrollment brokers to enter Member choice (PCP or HMO) directly into the MMIS.	X		
ME.60	Ability to allow enrollment brokers to enter notes, comments, etc., into MMIS.	X		
ME.61	The Vendor is expected to provide RAPIDS an interface containing HMO/PAAS assignments, TPL, and lock-in information 2-3 days prior to the cut-off date to print on the Medicaid ID cards.	X		
ME.62	Ability to automatically update and edit eligibility information based on information received in Vital Statistics file.	X		
ME.63	Ability to interface with the Department of Corrections to receive incarceration file.	X		
ME.64	Send data to RAPIDS for review of Member termination.	X		
ME.65	Provide an automated link to claims for the Member under current and historical names and ID numbers and display the data.	X		
ME.66	Ability to track and display all Member current and historical names and ID numbers.	X		
ME.67	Provide update capability for all Member data for designated BMS staff and make update separate from inquiry	X		
ME.68	Allow the user to inquire on Member benefit availability, service limitations, monetary limits, service utilization, and out-of-pocket contributions such as co-pay, deductible, and coinsurance.	X		
ME.69	Allow direct navigation access to a Member's historical claims, PAs, referrals, and case histories.	X		
ME.70	Ability to maintain current and historical eligibility data to support the following:	X		
ME.71	Basic program eligibility verification	X		
ME.72	Special program eligibility verification	X		
ME.73	ID card production (currently the Fiscal Agent provides an interface file that goes to RAPIDS and FACTS which contains Mountain Health Trust, Mountain Health Choices, TPL, and LTC information).	X		
ME.74	Claims processing	X		
ME.75	Premium processing	X		
ME.76	Prior authorization processing	X		
ME.77	Reporting	X		
ME.78	Other activities as specified by the BMS during the DDI phase	X		

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.79	Ability to maintain a Member data set that contains all data elements, including (but not limited to): (FACTS currently sends different ID numbers for Foster Children vs. State Covered Entities. These numbers are different from the Medicaid ID numbers. Some member IDs are manually entered and are different from RAPIDS and FACTS ID numbers. In the future, the Master Data Management Solution may use different numbering schemes that the MMIS would need to be able to accommodate).	X		
ME.80	Name	X		
ME.81	Residence and mailing address(es)	X		
ME.82	Phone numbers (home, cell, etc.)	X		
ME.83	E-mail address	X		
ME.84	Gender	X		
ME.85	Date of Birth (DOB)	X		
ME.86	DHHR County Office ID	X		
ME.87	Member ID number	X		
ME.88	Unique and/or universal Member identifiers from the eligibility systems	X		
ME.89	Social Security Number (SSN)	X		
ME.90	Medical Health Insurance Claim (HIC) Number (Medicare Number)	X		
ME.91	Race	X		
ME.92	Ethnicity	X		
ME.93	Head of household detail (including but not limited to name, Member ID, SSN)	X		
ME.94	Rate code or MAS/BOE ("aid category")	X		
ME.95	Long Term Care	X		
ME.96	Nursing Home name and Provider ID the Member resides in	X		
ME.97	Effective/Term dates for stay	X		
ME.98	Resource amounts (patient responsibility amount)	X		
ME.99	Resource amounts effective and term dates (patient responsibility amount)	X		
ME.100	Other as identified by BMS during DDI and accepted via formal change control	X		
ME.101	Ability to establish unique, date-specific benefit packages for each program applicable to a Member to ensure correct benefit application.	X		
ME.102	Ability to maintain periods of Medicare eligibility with flexible segments. (Maintaining separate segments for Part A, Part B, and Part D).	X		
ME.103	Ability to maintain client (member) identification numbers to twelve (12) or more digits.	X		
ME.104	Ability to cross-reference current and historical Member identification numbers for all eligibility sources.	X		
ME.105	Maintain and cross-reference Member name changes, including name change date and effective date (the date at which the name change becomes effective).	X		

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.106	Ability to maintain accurate, date-sensitive SSN information for foster and adopted children whose SSNs are changed by SSA while protecting confidential client information. (This is date-sensitive SSN information regarding Foster and Adopted Children. Fiscal Agent should be able to maintain all claim history for a member even if his SSN is changed).	X		
ME.107	Ability to capture and restrict user access to the actual residential address information, including Zip Codes, for protected populations, in addition to publicly disclosed residential addresses.		X	
ME.108	Ability to maintain and report Member and other data in order to respond to a request from a Member for an accounting of disclosures of his/her Protected Health Information (PHI), in accordance with HIPAA guidelines.	X		
ME.109	**4. Inquire Member Eligibility**			
ME.110	The Vendor is expected to maintain a Medicaid Eligibility Verification System (MEVS).	X		
ME.111	The Vendor is expected to provide each Medicaid Eligibility Verification System (MEVS) vendor daily access to approved Member eligibility data.	X		
ME.112	The Vendor is expected to provide an Automated Voice Response System (AVRS) which accesses the MEVS information.	X		
ME.113	The system is expected to provide web portal eligibility verification with at least the same functionality as that which is available via AVRS.	X		
ME.114	Ability to electronically generate eligibility verification reports based on supplied list (there may be an associated cost to the provider).	X		
ME.115	The system should maintain a log of all telephone and electronic inquiries to eligibility inquiry systems.	X		
ME.116	**5. Perform Population & Member Outreach**			
ME.117	Ability to track Member outreach communications detail, including:	X		
ME.118	Target population	X		
ME.119	Quality measure/s addressed	X		
ME.120	Purpose (e.g., implement programs like enrollment campaigns for waiver programs or other plan/benefits change, privacy notice)	X		
ME.121	Date/s of distribution	X		
ME.122	Method/s of distribution	X		
ME.123	Other as identified by BMS during DDI and accepted via formal change control	X		
ME.124	**6. Manage Applicant & Member Communication**			
ME.125	Ability to generate and distribute Member-related correspondence, reports and associated documents.	X		
ME.126	Ability to attach Member-related correspondence documents to the Member record.	X		
ME.127	Periodically generates Member satisfaction surveys.	X		
ME.128	The system is expected to receive and track summary level mailing data from the enrollment broker for reporting purposes.	X		

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.129	**7. Manage Member Grievance & Appeal**			
ME.130	Ability to track PA denials in MMIS.	X		
ME.131	Provide the ability for BMS to manually flag denied prior authorizations under appeal.	X		
ME.132	Provide the ability for BMS to run a report of all denied prior authorizations flagged as under appeal.	X		
ME.133	Provide the ability for BMS to display a report of all denied prior authorizations flagged as under appeal.	X		
ME.134	The system should support workflow for the appeals and grievances processes.	X		
ME.135	The system should employ the use of a control mechanism which automatically assigns unique control numbers to monitor, track, and maintain control over all consumer review cases.	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.1	**1. Enroll Provider**			
PM.2	Ability to enroll Providers eligible to provide Medicaid services.	X		
PM.3	Ability to enroll non-traditional Medicaid Providers to support payment of services in the MMIS. For example, taxi/transportation and respite.	X		
PM.4	Ability to enroll non-Medicaid Providers on behalf of different program or different agency or others as defined by BMS and accepted via formal change control. (No other entities identified at this time, but the Vendor's system is expected to be flexible, scalable, and capable of supporting others).	X		
PM.5	The Vendor is expected to maintain control over all data pertaining to Provider enrollment (including paper batches and electronic data).	X		
PM.6	Ability to generate unique tracking numbers for Provider enrollment applications and updates.	X		
PM.7	Ability to give Providers secure temporary access to the enrollment process and once approved for enrollment, permanent access to the online system.	X		
PM.8	The system should allow Providers the ability to complete and submit enrollment applications and updates in a secure online environment.	X		
PM.9	Ability to automatically assign Providers a temporary username/password for the online enrollment process.	X		
PM.10	Ability to automatically generate to the submitter a receipt notification with a tracking number when an online application and/or update are submitted for review.	X		
PM.11	Ability to notify Provider that an online update has been received, but requires validation before it becomes effective. (Any update provider would submit. Addition of Medicare number, new address, new certification, etc.).	X		
PM.12	Ability to allow Providers to access their own information and group owners to access information for all Providers in the group.	X		
PM.13	Ability to allow Providers access (with appropriate level of security) to retrieve the status of online applications and updates using their application tracking number.	X		
PM.14	Online screens should provide alternative contact information (e.g. telephone access number, help desk number) for use in case of questions or technical issues.	X		
PM.15	Ability to allow Providers to view and send online alerts and notifications generated by BMS or Vendor staff.	X		
PM.16	The Vendor is to notify Providers of acceptance/rejection as a West Virginia Medicaid Provider (per BMS specifications regarding notification medium and content).	X		
PM.17	Ability to route online applications and updates to the appropriate staff to work. Configuration of workflow to be defined by BMS during DDI.	X		
PM.18	Ability to alert appropriate staff that a Provider enrollment application has pended for a certain amount of days as defined by BMS.	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.19	Ability to provide forms online and in downloadable format. Specific forms to be defined by BMS during DDI (e.g., applications, addendums, Provider agreements, W-9 form, EFT, change of address, CLIA forms).	X		
PM.20	Ability to maintain hard and soft (electronic) copies of required Provider enrollment documentation, as defined by the BMS.	X		
PM.21	The Vendor is to maintain a file of all electronic enrollments, including approved and denied Providers. The specifications of the file (including contents and medium) are to be defined by the BMS.	X		
PM.22	Ability to purge enrollment tracking data based on parameters defined by the BMS.	X		
PM.23	Ability to enroll only those Providers who agree to abide by the rules and regulations of the State Medicaid program.	X		
PM.24	Ability to identify and assign Provider applications and updates by Provider types, as defined by BMS.	X		
PM.25	Ability to identify and assign Provider enrollment application status, as defined by BMS (e.g., Initial/New, Resubmitted with Modifications, Cancellation).	X		
PM.26	Ability to identify and display the applicant type, as defined by BMS (e.g., Rendering Provider, Billing Agent, Pay to Affiliations).	X		
PM.27	Ability to track the date enrollment forms are received for each Provider application.	X		
PM.28	Ability to automatically identify and terminate a duplicate enrollment request or update, and give the Provider a meaningful error message.	X		
PM.29	Ability to save partially completed Provider enrollments for a given number of days (to be defined by BMS).	X		
PM.30	Ability to notify applicants of partially submitted applications.	X		
PM.31	Ability to conduct re-verification of currently enrolled Provider, based on BMS-specified conditions. (Specified conditions will be determined during DDI).	X		
PM.32	Ability to use a single online Provider enrollment application with required fields or forms that are dynamically driven by Provider or application characteristic/s (as defined by BMS), including:	X		
PM.33	Applicant type	X		
PM.34	Provider type	X		
PM.35	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.36	Ability to incorporate edits into the dynamic (online) application process to ensure that required fields (as defined by BMS) are completed properly before the application may be submitted.	X		
PM.37	Ability to verify required licenses and certifications at the time of Provider enrollment, and thereafter, at the time of renewal, and maintain all related information.	X		
PM.38	Ability to hold application in pending status until pre-approving entity gives authorization to proceed.	X		
PM.39	Ability to cross-reference license and sanction information with other State and/or Federal agencies. (BMS currently received a monthly file from OIG. A State equivalent is being developed for national use).	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.40	Ability to verify certification in other states for participating out-of-state Providers.	X		
PM.41	Ability to track, display, and maintain verification of enrollment application/record information, including:	X		
PM.42	Provider Identifiers (e.g., NPI, SSN, EIN)	X		
PM.43	Sanction status (e.g., HIPDB, NPDB, boards, criminal background checks)	X		
PM.44	Credentials (e.g., licensure specialty boards, school, affiliations)	X		
PM.45	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.46	Ability to use an expedited enrollment process to enroll Out of Network Providers for a limited period of time.	X		
PM.47	Ability to allow approved users to manually reactivate inactive Providers.	X		
PM.48	Ability to automatically reactivate inactive Providers, according to criteria defined by BMS.	X		
PM.49	Ability to track and report a Provider's enrollment activity from receipt of application to final disposition.	X		
PM.50	Ability to assign unique Provider number when enrollment is approved.	X		
PM.51	Ability to track and support BMS-established review schedule to ensure Providers continue to meet program eligibility requirements.	X		
PM.52	Ability to maintain and display history and audit trails for online changes and updates.	X		
PM.53	Ability to report and maintain enrollment and update activity statistics (as defined by the BMS). For example: number of enrollment applications/updates received hourly, daily, etc.; number of applications/updates pending.	X		
PM.54	**2. Provider Contracts**			
PM.55	Ability to define procedures and diagnoses a Provider is allowed to render under a Provider's license.	X		
PM.56	Ability to define types of Provider contracts.	X		
PM.57	Ability to support flexible rules-based logic (as specified by BMS and Federal guidelines) to define Provider contracting parameters.	X		
PM.58	Ability to define and easily update (per BMS) the procedures or services a Provider is allowed to provide under a contract.	X		
PM.59	Ability to define and easily update (per BMS) the procedures or services a Provider is allowed to provide based on a Provider grouping.	X		
PM.60	Ability to 'model' or create a new contract from an existing contract.	X		
PM.61	Ability to track and support BMS-established review schedule to ensure Providers continue to meet program eligibility requirements.	X		
PM.62	Ability to maintain and display history and audit trails for online changes and updates.	X		
PM.63	Ability to report and maintain enrollment and update activity statistics (as defined by the BMS). For example: number of enrollment applications/updates received hourly, daily, etc.; number of applications/updates pending.	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.64	**3. Disenroll Provider**			
PM.65	Ability to allow Providers to submit online request for termination of their Provider agreement.	X		
PM.66	Ability to identify Provider disenrollment request status, as defined by BMS (e.g., initial, duplicate, resubmitted with modifications).	X		
PM.67	Ability to validate that disenrollment meets State rules, as defined by the BMS.	X		
PM.68	Ability to allow users with appropriate authorization to terminate providers.	X		
PM.69	Ability to process disenrollment requests for the full range of Provider types, organizations, specialties, types of applicants (e.g., primary Provider, billing agent, pay-to entity).	X		
PM.70	Ability to process disenrollment requests for all application status types (e.g., Initial/New, Modification, Cancellation, Update).	X		
PM.71	Ability to disenroll Providers after a certain period of inactivity (to be defined by BMS).	X		
PM.72	Ability to distribute notifications of disenrollment due to sanctions or disciplinary actions to the WV Office of the Inspector General (OIG) and other states.	X		
PM.73	**4. Inquire Provider Information**			
PM.74	The Vendor is expected to accommodate Provider enrollment verification requests via phone, fax, portal, and other methods (as specified by BMS during DDI and accepted via formal change control).	X		
PM.75	Ability to log and track all Provider information requests, including:	X		
PM.76	Name of requesting party	X		
PM.77	Date of inquiry	X		
PM.78	Parameters used in system query	X		
PM.79	User name (of user querying system)	X		
PM.80	Validation of Authorization detail	X		
PM.81	Date/time information queried in system	X		
PM.82	Date/time information sent to requester	X		
PM.83	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.84	Ability to support entry of free-form text field that allows narratives (of a length defined by the BMS) for each Provider information inquiry. Each entry is expected to include identification of user and date/time entered.	X		
PM.85	Ability to display free-form narrative in chronological or reverse chronological sequence.	X		
PM.86	**5. Manage Provider Communication**			
PM.87	Ability to generate and distribute Provider-related correspondence, information requests, and notifications, including:	X		
PM.88	Enrollment applications	X		
PM.89	Enrollment rejection notifications	X		
PM.90	Billing instructions	X		
PM.91	Relevant State policy information	X		
PM.92	Request for information to support enrollment/contracting process	X		
PM.93	Mailing labels	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.94	Program memorandum	X		
PM.95	Notifications of pending expired Provider eligibility	X		
PM.96	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.97	Ability to maintain a record (including an audit trail) of all communication sent to Providers.	X		
PM.98	Ability to maintain a record (including an audit trail) of all communication received from Providers.	X		
PM.99	Ability to maintain an Inquiry Log which identifies each Provider inquiry (electronic, written or telephone) by name, date, nature of the inquiry, and outcome.	X		
PM.100	Ability to track and maintain working files of historical Provider inquiries. Common inquiries (e.g., eligibility, payment status, and billing questions) are to be logged and documented in these files.	X		
PM.101	The BMS is to have the ability to view and update the Provider Inquiry Log.	X		
PM.102	Ability to track and report Provider inquiries regarding billing and submission practices.	X		
PM.103	Ability to allow Provider correspondence to be generated or suppressed according to BMS defined parameters.	X		
PM.104	Ability to allow users to choose between standard/routine Provider correspondence, or to develop customized correspondence.	X		
PM.105	Ability to track and notify Providers of date-dependent events, as defined by BMS (e.g., review dates).	X		
PM.106	Ability to refer Providers to appropriate licensing board (according to criteria defined by BMS).	X		
PM.107	Ability to allow users to view Provider labels, letters, and listings online or on paper.	X		
PM.108	Ability to suppress Provider's ID number from labels, envelopes and other correspondence, as required.	X		
PM.109	Ability to suppress Member's ID number from labels, envelopes and other correspondence, as required.	X		
PM.110	Provider notifications should be linked to related documentation in the system.	X		
PM.111	**6. Manage Provider Appeal**			
PM.112	Ability to support appeals for prospective and current Providers.	X		
PM.113	Ability to track Provider appeal detail, including:	X		
PM.114	Issue detail	X		
PM.115	Filing party	X		
PM.116	Reviewer/s	X		
PM.117	Process status (initial, second, expedited, withdrawn, disposed)	X		
PM.118	Review/hearing date/time	X		
PM.119	Hearing ruling	X		
PM.120	Disposition	X		
PM.121	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.122	Ability to support entry of free-form text field that allows narratives (length to be defined by BMS) for each Provider grievance/appeal that identifies user and date/time entered.	X		

2. Provider Management (PM)

Req #	Description of Requirement	YES without custom-ization	YES with custom-ization	NO unable to provide
PM.123	Ability to display free-form narrative in chronological or reverse chronological sequence.	X		
PM.124	Vendor should filter Provider correspondence to verify that it meets the criteria (as defined by BMS) to qualify as a grievance prior to submitting to the BMS	X		
PM.125	Ability to support grievance/appeals process work flow, including automatic notification to appropriate parties (as defined by the BMS).	X		
PM.126	**7. Manage Provider Information**			
PM.127	Ability to perform data exchanges to obtain Provider data from licensing boards, CMS, DEA, the NPI enumeration contractor, and other BMS specified sources.	X		
PM.128	Ability to identify and display the source of any data that is obtained from an external source.	X		
PM.129	Ability to generate automatic notification to the Provider when information is received from external sources to update Provider records (as defined by BMS).	X		
PM.130	Ability to provide role-based access to authorized users to perform mass updates to Provider data, based on flexible selection criteria.	X		
PM.131	Ability to provide role-based access to authorized users, allowing online update and inquiry capabilities of the Provider information files.	X		
PM.132	Ability to provide online, real-time, role-based access to the Provider information using a variety of secure methods, including:	X		
PM.133	Web	X		
PM.134	WAN/LAN	X		
PM.135	Point-of-service devices	X		
PM.136	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.137	Ability to integrate with the following systems to allow users to access and/or enter/edit Provider data:	X		
PM.138	Medicaid Provider Web Portal	X		
PM.139	Automated Voice Response System (AVRS)	X		
PM.140	Electronic Document Management System (EDMS)	X		
PM.141	Other systems as specified by the BMS during DDI	X		
PM.142	Ability to maintain and display an audit trail of all changes to Provider attributes, including date/time and username/source of change (for an amount of time to be defined by BMS).	X		
PM.143	Ability to identify the NPIs of prescribers for Pharmacy purposes.	X		
PM.144	Ability to identify crossover-only Providers.	X		
PM.145	The Vendor should update Provider information as follows:	X		
PM.146	Perform authorized updates on a daily (or otherwise specified) basis with online updates.	X		
PM.147	Perform updates using full transaction files received.	X		
PM.148	Perform mass Provider updates as directed by BMS.	X		
PM.149	Ability to provide authorized users access to current Provider information (e.g., P.A.s and referrals, Claims, correspondence).	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.150	Ability to provide online inquiry or look-up of historical Provider information (including enrollment records of terminated Providers), searchable by entering complete or partial identifying information, including:	X		
PM.151	Medicaid Provider ID	X		
PM.152	Provider name	X		
PM.153	National Provider Identifier (NPI)	X		
PM.154	Medicare number	X		
PM.155	Social Security Number (SSN)	X		
PM.156	Phone number	X		
PM.157	Employer Identification Number (EIN)/Taxpayer Identification Number (TIN)	X		
PM.158	Federal Drug Enforcement Agency (DEA) number	X		
PM.159	Previous Identifier(s) (so that all data is historically maintained)	X		
PM.160	Phonetic search		X	
PM.161	Other identifiers used by the BMS	X		
PM.162	Ability to provide authorized users limited role-based access to archived Provider data.	X		
PM.163	Ability to uniquely identify each Provider, allowing for the association of multiple standardized and user-defined identifiers and qualifiers, including:	X		
PM.164	National Provider Identifier (NPI)	X		
PM.165	Former Medicaid ID number	X		
PM.166	Federal Drug Enforcement Agency (DEA) number	X		
PM.167	National Council of Prescription Drug Programs (NCPDP) number	X		
PM.168	Other as identified and/or defined by BMS during DDI and accepted via formal change control	X		
PM.169	Ability to maintain an online cross-reference of BMS-assigned identifier to all other identifiers maintained for a Provider.	X		
PM.170	Ability to maintain an online cross-reference of a Provider's Tax ID number(s) in the event that a new ID is issued to an existing Provider.	X		
PM.171	Ability to identify when multiple BMS-assigned Provider numbers are assigned to a single Provider.	X		
PM.172	Ability to maintain CLIA information.	X		
PM.173	The system should have an automated process that verifies CLIA numbers (e.g., interface with CMS, Health and Human Services (HHS) and Centers for Disease Control (CDC) that monitors CLIA).	X		
PM.174	Ability to use consistent Provider naming conventions to differentiate between first names, last names, and business or corporate names or DBA (Doing Business As) names and to allow flexible searches based on Provider name.	X		
PM.175	Ability to display claims summary information by Provider, including total number of claims submitted, pended, denied, paid and the total dollar amounts (billed and paid amounts) of each category. Reporting periods to be determined by BMS (e.g., calendar month-to-date, Medicaid processing month-to-date, calendar year, Provider fiscal year, Federal/State fiscal year).	X		

2. Provider Management (PM)

Req #	Description of Requirement	YES without custom-ization	YES with custom-ization	NO unable to provide
PM.176	Ability to identify the Provider Program(s) the Provider is participating in, including but not limited to:	X		
PM.177	State Plan Medicaid	X		
PM.178	Ryan White Program	X		
PM.179	Juvenile Services Benefit Plan	X		
PM.180	Tiger Morton Benefit Plan	X		
PM.181	Mental Retardation/Developmentally Disabled (MRDD) waiver	X		
PM.182	Aged Disabled waiver	X		
PM.183	Children's Health Insurance Plan (CHIP)	X		
PM.184	Breast and Cervical Cancer Program	X		
PM.185	Birth to Three Benefit	X		
PM.186	Other as identified by BMS and accepted via formal change control	X		
PM.187	Ability to associate multiple service locations to the same Provider base identifier. (Service locations are not currently used in claims billing or claims processing and are not captured in the service location claim field).	X		
PM.188	Ability to identify multiple practice locations for a single Provider and associate all relevant data items with the location, such as address and CLIA certification.	X		
PM.189	Ability to maintain group affiliations and managed care enrollment.	X		
PM.190	Ability to affiliate individual Providers to their group(s) (i.e., program(s)).	X		
PM.191	Ability to associate a group with all individual Providers.	X		
PM.192	Ability to associate an unlimited number of Providers with a single group.	X		
PM.193	Ability to define Providers and Provider groups that share common ownership.	X		
PM.194	Ability to identify the type of Provider ownership arrangement.	X		
PM.195	Ability to transfer Provider ownership without re-entry of duplicate information.	X		
PM.196	Ability to identify, cross reference, and link one Provider owner to many rendering Providers and one rendering Provider to many owners.	X		
PM.197	Ability to process changes in Provider ownership in which a new owner assumes liability for all activity performed by the Provider prior to the ownership change.	X		
PM.198	Ability to establish Provider pay-to affiliations in a way that accommodates actual practicing locations and Federal and State tax requirements (one 1099 per taxable entity).	X		
PM.199	Ability to identify the affiliation a physician may have with a hospital or multiple hospitals and indicates what types of privileges they have.	X		
PM.200	Ability to maintain corporate names with a naming structure for corporations that do not have first and last names.	X		
PM.201	Ability to track and maintain licensing, credentialing, sanction and certification information that includes:	X		
PM.202	Type, specialty, and sub-specialty	X		
PM.203	Taxonomy	X		
PM.204	Certification begin and end dates	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.205	Certification type code	X		
PM.206	Certifying agency	X		
PM.207	Certifying state	X		
PM.208	Verification type	X		
PM.209	Verification date	X		
PM.210	Verification due date	X		
PM.211	License ID	X		
PM.212	Sanctioning agency	X		
PM.213	Sanctioning state	X		
PM.214	Sanction begin and end dates	X		
PM.215	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.216	The system should support automatic re-verification of credentials on a periodic basis by program and Provider type, by identifying and notifying when Provider credentials are expiring (notification may include e-mail and/or letters).	X		
PM.217	Provider enrollment/screening should be conducted in compliance with PPACA rules and regulations (e.g., ownership and ownership exclusions are to be screened as directed under PPACA).	X		
PM.218	Ability to enter, store, display and access Provider data, including:	X		
PM.219	Provider Number	X		
PM.220	Provider name	X		
PM.221	Facility name	X		
PM.222	Billing name	X		
PM.223	Provider license number	X		
PM.224	IRS name	X		
PM.225	Provider type - with the flexibility to accommodate and maintain non-medical Providers on the Provider master and affiliates.	X		
PM.226	Provider title	X		
PM.227	Multiple mailing addresses	X		
PM.228	Multiple practice addresses	X		
PM.229	Ownership information	X		
PM.230	Change in ownership information	X		
PM.231	Long-term care facility data, including:	X		
PM.232	Number of beds by licensed level of care	X		
PM.233	WV DHHR Office of Health Facility Licensure and Certification (OHFLAC) certification/re-certification	X		
PM.234	Physical address and contact information of the facility	X		
PM.235	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.236	Payment address	X		
PM.237	County number	X		
PM.238	Multiple phone numbers	X		
PM.239	Fax number	X		
PM.240	Multiple e-mail addresses	X		
PM.241	Web site url	X		
PM.242	Drug Enforcement Agency (DEA) number - including historic data with effective and end dates	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.243	National Council for Prescription Drug Programs (NCPDP) number - including historic data with effective and end dates	X		
PM.244	Employer Identification Number (EIN)/Taxpayer Identification Number (TIN) and effective and term dates	X		
PM.245	Social Security Number (SSN)	X		
PM.246	Provider CLIA (Clinical Laboratory Improvement Amendments) number and related address	X		
PM.247	Medicare numbers	X		
PM.248	Managed Care Organization (MCO) affiliations	X		
PM.249	Group number	X		
PM.250	Specialty/sub-specialty data	X		
PM.251	License and certification data	X		
PM.252	Date of birth	X		
PM.253	Date of death	X		
PM.254	Gender	X		
PM.255	Language	X		
PM.256	Additional training or certification indicator	X		
PM.257	Restrictions on dispensing of specific drugs	X		
PM.258	Provider enrollment status codes with associated effective and end dates	X		
PM.259	Provider program eligibility with associated effective and end dates	X		
PM.260	Contractual terms, including:	X		
PM.261	Services contracted to provide	X		
PM.262	Performance measures (service level agreements and KPIs)	X		
PM.263	Reimbursement rates	X		
PM.264	Summary level payment data which is automatically updated after each claims processing payment cycle by the following:		X	
PM.265	Calendar week-to-date		X	
PM.266	Calendar month-to-date		X	
PM.267	Calendar year-to-date		X	
PM.268	State fiscal year-to-date		X	
PM.269	Federal fiscal year-to-date		X	
PM.270	1099 reported amount (current & prior year)		X	
PM.271	Ownership date	X		
PM.272	Physician Assured Access System (PAAS) indicator	X		
PM.273	Fee-for-service (FFS) indicator	X		
PM.274	Crossover indicator	X		
PM.275	Suspended/Suspension indicator	X		
PM.276	Suspended/Suspension effective and terminated dates	X		
PM.277	Primary Care Case Management (PCCM) indicator	X		
PM.278	Out-of-state Provider indicator	X		
PM.279	Rural, urban, or teaching hospital indicator	X		
PM.280	Electronic Funds Transfer (EFT) information	X		
PM.281	Electronic Claims Management (ECM) data	X		
PM.282	Billing restriction data, with applicable begin and end dates	X		
PM.283	Medical degree information.	X		
PM.284	Providers PCP panel information including:	X		

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PM.285	Accepting new patient indicator	X		
PM.286	Age range	X		
PM.287	Gender	X		
PM.288	Authorized enrollment	X		
PM.289	Current enrollment/maximum enrollment and number left	X		
PM.290	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.291	Ability to identify Provider 'on call' information to capture 'covering for' and 'covered by' Providers.	X		
PM.292	Ability to provide an free-form text narrative (length to be determined by BMS) at the base-Provider level that:	X		
PM.293	Identifies the user, date, and time entered.	X		
PM.294	Provides the capability to display free form narrative in chronological or reverse chronological sequence.	X		
PM.295	Includes an associated user-defined special condition code/flag (for classification/reporting purposes).	X		
PM.296	Ability to report on the special condition code/flag.	X		
PM.297	Ability to define the relationship between a Provider and an EDI submitter as well as billing agent.	X		
PM.298	**8. Perform Provider Outreach**			
PM.299	Ability to track Provider outreach communications detail, including:	X		
PM.300	Target population	X		
PM.301	Issues or measure/s addressed (e.g., new immigrant population in need of language compatible Providers)	X		
PM.302	Purpose (e.g., corrections to billing practice, public health alerts, public service announcement)	X		
PM.303	Date/s of distribution	X		
PM.304	Method/s of distribution	X		
PM.305	Other as identified by BMS during DDI and accepted via formal change control	X		
PM.306	Ability to perform Provider outreach to both prospective and current Providers.	X		

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3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.1	**1. Authorize Referral**			
OM1.2	Ability to adjudicate claims for PAAS Member service referrals from the Member's PCP to another Provider, using the standard fee-for-service claims processing rules.	X		
OM1.3	Ability to verify Member eligibility and PAAS participation during referral claim processing.	X		
OM1.4	Ability to verify PAAS referral during claim processing.	X		
OM1.5	Ability to conduct claims edits/audits for referral claims according to BMS business rules.	X		
OM1.6	**2. Authorize Services**			
OM1.7	The Prior Authorization component of the system should integrate with the Claims component.	X		
OM1.8	Claim processing performs Prior Authorization validation.	X		
OM1.9	The Prior Authorization component should be integrated with the web portal, AVRS, EDI and EDMS components.	X		
OM1.10	Ability to access (or extract) data in other BMS system files to obtain reference information, including service limitations, to update PA records. The prior authorization file should interface with, as a minimum, Claim Processing, Provider Management Data Store, Member Management Data Store, and reference systems.	X		
OM1.11	Ability to interface with MMIS to identify procedure codes that require PA (medical utilization requirements).	X		
OM1.12	Ability to accommodate additions and updates of prior authorizations by interface.	X		
OM1.13	The Vendor is expected to support on-line entry and interface entry of prior authorization data with other prior authorization vendors.	X		
OM1.14	The system is expected to provide real-time access via various methods (e.g., Web, AVRS, WAN/LAN workstations) for PA status inquiries.	X		
OM1.15	Ability to support submission of prior authorizations by other State agencies, other vendors, and BMS. (The Vendor is expected to be responsible for providing the prior authorization part of the MMIS system. In some cases the vendor will be expected to key PAs into the system. Prior Authorization review is to be performed by BMS or by the prior authorization vendor).	X		
OM1.16	Ability to allow users to submit a PA request on the Provider's behalf.	X		
OM1.17	Ability to accept and create PAs from MDS data for nursing facilities. (MDS is the Minimum Data Set which is a federally mandated assessment to be completed for all nursing home residents that reside in Medicare and Medicaid certified beds).	X		
OM1.18	Ability to accommodate future versions of the HIPAA electronic PA transactions.	X		
OM1.19	Ability to ensure all known and emerging BMS and Federal policy changes are reflected in the maintenance of the PA data repository.	X		
OM1.20	Ability to maintain and easily retrieve Provider-specific and Member-specific PA history.	X		

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.21	Ability to accept on-line, real-time inquiry, entry and update of PA requests, including initial entry of PA requests pending determination.	X		
OM1.22	Ability to allow Providers to submit PA requests electronically or through the web portal.	X		
OM1.23	Ability to provide an on-line tutorial for PA application to guide users through the screens necessary to complete to request a PA.	X		
OM1.24	Ability to allow for electronic submission of PA request attachments (e.g., EDI 275, HL7).		X	
OM1.25	Ability to allow PA request forms to be available online for download by users.	X		
OM1.26	Ability to automatically generate and distribute the necessary (i.e., specific to the situation / PA requirements) BMS-approved PA request forms and attachments to Providers.	X		
OM1.27	Ability to integrate prior authorization-related correspondence, reports and associated documents with the EDMS component.	X		
OM1.28	Ability to support PA entries for medical services such as (but not limited to) the following:	X		
OM1.29	Vision	X		
OM1.30	Dental	X		
OM1.31	Durable Medical Equipment (DME)	X		
OM1.32	Surgical procedures	X		
OM1.33	Other as identified by BMS during DDI and accepted via formal change control	X		
OM1.34	Ability to process PA requests for covered services excluded from the long-term care all-inclusive rate (e.g., Physician services, Hospital, etc.) or an indicator that serves to deny their services for purposes of reporting.	X		
OM1.35	Ability to automatically provide PA staff (during PA process) with information when Member is a LTC facility resident/inpatient. Information should include:	X		
OM1.36	Level of Care (LOC)	X		
OM1.37	LOC effective dates	X		
OM1.38	Name of facility	X		
OM1.39	Medicaid Provider Number	X		
OM1.40	LTC facility date spans	X		
OM1.41	Spend-down amount	X		
OM1.42	Patient Liability Amount (PLA)	X		
OM1.43	PLA effective dates	X		
OM1.44	Ability to submit and approve retrospective authorizations.	X		
OM1.45	Ability to interface with MMIS and populate PA screens with PA information to be determined during design.	X		
OM1.46	Ability to generate a unique tracking number for PA requests.	X		
OM1.47	Ability to automatically notify submitter of successful submission and display the tracking number.	X		
OM1.48	Ability to assign a unique PA number as soon as the submitted request is approved.	X		

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.49	Ability to accept and retain the PA number submitted by the PA vendor.	X		
OM1.50	Ability to use tracking number to link attachments submitted by mail to electronic PA request.	X		
OM1.51	Ability to use tracking number to link attachments submitted electronically to electronic PA request.	X		
OM1.52	Ability to recognize both the NPI and former Medicaid ID number.	X		
OM1.53	The system should have the ability to capture and display PA data which includes, at minimum, the following:	X		
OM1.54	PA number	X		
OM1.55	Member ID	X		
OM1.56	Service code/s	X		
OM1.57	Procedure/NDC code	X		
OM1.58	Modifier codes	X		
OM1.59	Billing, rendering, and referring Provider information, including name, and Provider ID/NPI	X		
OM1.60	Dates of service	X		
OM1.61	Effective and term date of PA	X		
OM1.62	Requested effective date of PA	X		
OM1.63	Units of service expressed as days, quantity per day, number of services, dollars, tooth number/letter, tooth surface	X		
OM1.64	Quantity used	X		
OM1.65	Miscellaneous codes w/ notes field (for contractors)	X		
OM1.66	Rates	X		
OM1.67	Member Rate code	X		
OM1.68	Dollar cap	X		
OM1.69	Local Provider information	X		
OM1.70	Limits (including calendar month limits)	X		
OM1.71	Room and board	X		
OM1.72	Waiver start date	X		
OM1.73	Manufacturer product number	X		
OM1.74	Status of the PA request (including pending, denied, approved, and modified)	X		
OM1.75	Date approved	X		
OM1.76	History of all actions taken on PA request, including amendments	X		
OM1.77	Date of last change, ID of person changing, and information changed for each PA record	X		
OM1.78	ID of authorizing person	X		
OM1.79	Other as identified by BMS during DDI and accepted via formal change control	X		
OM1.80	Ability to allow the identification of the principal procedure and date, and the inclusion of five additional procedures and dates.	X		
OM1.81	Ability to include descriptions of codes in the PA request.	X		
OM1.82	Ability to allow for expansion and addition of fields to the on-line PA request form.	X		
OM1.83	Ability to provide a free-form text narrative (length to be approved by BMS) at the base PA level and at functional levels that:	X		

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.84	Identifies and displays the user, date, and time entered	X		
OM1.85	Provides the capability to display free form narrative in chronological or reverse chronological sequence	X		
OM1.86	Ability to accommodate flexible time span dates for PA (by calendar month, calendar year, rolling month, and other as defined by BMS).	X		
OM1.87	Ability to apply the method and hierarchy of PA processing criteria as defined by BMS.	X		
OM1.88	Ability to automatically approve certain PA requests based on information entered (as identified by BMS).	X		
OM1.89	Ability to perform comprehensive on-line and batch edits to ensure the integrity of prior authorization data.	X		
OM1.90	Ability to run edits on submitted PA requests, such as the following:	X		
OM1.91	Relationship edits	X		
OM1.92	Field length/type	X		
OM1.93	Character type	X		
OM1.94	Ability to edit PAs on-line for the presence of required data to include:	X		
OM1.95	Valid Provider ID and eligibility	X		
OM1.96	Valid procedure and diagnosis codes	X		
OM1.97	Presence of required claim type-specific data on the PA	X		
OM1.98	Covered service	X		
OM1.99	Allowed dollar amounts/unit	X		
OM1.100	Other as identified by BMS during DDI and accepted via formal change control	X		
OM1.101	Ability to automatically alert Providers of the need for additional information (e.g., HIPAA 278 transaction, pdfs), providing return messages that clearly describe necessary action.	X		
OM1.102	Ability to reject PA request if it does not pass all edits.	X		
OM1.103	Ability to automatically notify the submitter of failed PA submission and identify which field(s) did not pass edits.	X		
OM1.104	Ability to automatically generate Provider alerts and notifications, to include:	X		
OM1.105	The need for additional information on an already submitted PA request	X		
OM1.106	Reminders of missing information	X		
OM1.107	System updates/policy changes	X		
OM1.108	Duplicate or possible duplicate requests		X	
OM1.109	Ability to automatically notify users of duplicate or possible duplicate PA requests for on-line PAs as well as PAs submitted via the interface files.	X		
OM1.110	Ability to identify and reject duplicate PAs across all PA types based on user configurable criteria including:	X		
OM1.111	Client identifier	X		
OM1.112	Rendering Provider identifier	X		
OM1.113	Service from and through dates	X		
OM1.114	Diagnosis code(s)	X		

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.115	Procedure code(s), revenue code(s)	X		
OM1.116	Other as identified by BMS during DDI and accepted via formal change control	X		
OM1.117	Ability to allow Providers access to pended PAs for near real-time corrections, but only have access to certain data fields (those fields that need to be corrected).	X		
OM1.118	Ability to alert/notify specified staff when an on-line PA request pends. Notification should identify and briefly describe the edit that caused the PA request to pend/suspend.		X	
OM1.119	Ability to retain incomplete PA request submissions for a minimum number of days, to be defined by BMS, before deleting the record.	X		
OM1.120	When a Member record is not on file, an electronic PA should be re-cycled (i.e., resubmitted for processing) for 30 days before being included in the PA rejection file.	X		
OM1.121	Ability to notify the Provider following the approval or denial of a PA.	X		
OM1.122	Ability to automatically generate approval or denial notices as soon as the determination has been made.	X		
OM1.123	Ability to support role-based override capabilities for individual edits by authorized user.	X		
OM1.124	Ability to identify those individuals who authorized and performed an override.	X		
OM1.125	Ability to accept PAs for a terminated Member for eligible dates of services.	X		
OM1.126	Ability to maintain PA active status when Member loses eligibility.	X		
OM1.127	Ability to allow staff to suspend PA requests, based on BMS rules, and identify the PA suspense status. Notify Provider electronically or in a written format (e.g., mail) with results of PA clerical and/or clinical reviews and request additional information that is required from the Provider.	X		
OM1.128	Ability to allow staff to select the reason codes explaining the disposition of the request when a PA denies/approves.	X		
OM1.129	Ability to allow staff to query PA history on-line, and filter and sort results based on select criteria defined by BMS (e.g., Member, Provider, procedure code).	X		
OM1.130	Ability to link to eligibility data when reviewing the PA request.	X		
OM1.131	Provide authorized PA staff information about the Member's participation or enrollment in other programs that would affect the disposition of the PA without having to move to another application or environment.	X		
OM1.132	Ability to auto-populate the PA number at the claim line level regardless of Provider submission.	X		
OM1.133	The system should allow Providers to view remaining/unused units authorized.	X		

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.134	Ability to make authorization data available to BMS staff, if other vendors or organizations perform authorizations, to the same extent the information would be available if BMS performed the PA function.	X		
OM1.135	Ability to provide PA search options, including search by PA number.	X		
OM1.136	Ability to return multiple PAs if more than one match is found.	X		
OM1.137	Ability to provide multiple users with simultaneous, on-line, role-based access to a PA request, but build in features that would preclude simultaneous edits by multiple users.	X		
OM1.138	Ability to allow users to amend a PA record multiple times and display the history on-line.	X		
OM1.139	Ability to provide PA audit trail capability to:	X		
OM1.140	Track and report all PA related changes	X		
OM1.141	Identify the individual who modified the system data	X		
OM1.142	Record the date that the modification occurred	X		
OM1.143	Display an audit trail of all PA processing steps	X		
OM1.144	View on-line all PA audit trail information	X		
OM1.145	Other as identified by BMS during DDI and accepted via formal change control	X		
OM1.146	Ability to process the PA and limit the price for a service to the amount authorized on the PA.	X		
OM1.147	Ability to maintain the authorized PA price.	X		
OM1.148	Ability to develop business rules which dictate whether the rate established under the PA approval takes precedence over other payment rules (e.g., lesser of billed charges cannot exceed the maximum fee scheduled) or vice versa. Assure that, if non-PA pricing rules take precedence, pre-determined override procedures and business rules are followed to make special pricing exceptions requiring that special documentation be completed for the override to work.	X		
OM1.149	Ability to provide flexibility to allow waiver PAs to be capped at a dollar amount at the consumer level, at the service level, at the Provider level or any combination that can be controlled and/or measured through available claim/PA file data (as determined by business rules approved by BMS).	X		
OM1.150	Ability to approve service authorization requests for waiver services up to a specific dollar amount.	X		
OM1.151	Ability to prohibit PA approval from occurring (i.e., PA should not force the claim to pay) if BMS business rules prohibit coverage of the service.	X		

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.152	Ability to assure that, when an overall service requiring PA results in the submission of multiple claim types from a variety of Provider types, the disposition of all PA requests are consistent with one another (if the methodology requires a separate PA request for each claim to be submitted). The system should link or bundle all related PAs so that the disposition is the same across all Providers. (For example, if gastric-bypass surgery requires PA, the disposition for the hospital facility payment, the surgeon's payment, and the anesthesiologist's payment should be consistent (e.g., approved, denied, deferred, etc.).	X		
OM1.153	The system should allow users to call up PA requests with a linked or bundled relationship as a complete service package.	X		
OM1.154	Ability to handle HCPCS codes with a minimum of four (4) modifiers. When processing prior authorized claims, the system should match the PA-required procedure codes submitted on the claim against the approved PA request at the modifier, or if applicable, at the multiple modifier level.	X		
OM1.155	Ability to automatically link the paid claim record with the PA record.	X		
OM1.156	Ability to update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars, during each PA request period. This information should be captured and displayed with PA history.	X		
OM1.157	Ability to provide dual limitation (e.g., total units/year with a monthly limit) controlling the dispensing of services over a long period of time.	X		
OM1.158	Ability to identify service categories that are subject to the same limitation and accumulate the same combination of services. Use combined services to compare to service authorization limit.	X		
OM1.159	Ability to allow for modification to the scope of services authorized and extend or limit the effective dates of authorization.	X		
OM1.160	Ability to update PA records based on claims processing to restore reversed units to the PA, during each PA request period.	X		
OM1.161	Ability to amend authorizations past the end date.	X		
OM1.162	Ability to identify and review PA requests for which an appeal has been submitted (including those that are approved and on appeal), indicate the outcome of such reviews, and identify PAs for which an appeal has been filed.	X		
OM1.163	Ability to automatically identify active or pended PA records when a reference file has been updated (e.g., procedure code, Provider ID), generate a report and request an update as necessary.	X		
OM1.164	The system should provide statistical and operational reporting capabilities.	X		
OM1.165	Ability to report and maintain web portal PA activity statistics.	X		
OM1.166	Ability to automatically generate a letter to the Provider for BMS entered authorizations. The letter is to include the PA number.	X		
OM1.167	Ability to provide PA-related correspondence functions to include the following:	X		

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM1.168	Template development and the ability for users to select desired correspondence from a list of available templates	X		
OM1.169	Display, print, and save PA-related correspondence via the EDMS component of the MMIS	X		
OM1.170	Regenerate correspondence	X		
OM1.171	Allow users to suppress or allow auto generation of correspondence based on user configurable event-driven criteria	X		
OM1.172	Allow users to insert and override address information on correspondence	X		
OM1.173	Allow users to add free form text to individual or groups of PA correspondence	X		
OM1.174	Other as identified by BMS during DDI and accepted via formal change control	X		
OM1.175	Ability to automatically alert staff via email that letters/notifications have been generated.	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.1	**1. Claims Processing**			
OM2.2	Ability to provide and maintain a claims processing component with the capability to process electronic and paper transactions.	X		
OM2.3	Ability to perform real-time adjudication of claims.	X		
OM2.4	Ability to process all standard claim types, including:	X		
OM2.5	Institutional (UB-04, 837-I)	X		
OM2.6	Professional (CMS-1500, 837-P)	X		
OM2.7	Dental (ADA, 837-D)	X		
OM2.8	Pharmacy (NCPDP current and future versions (electronic) or Universal claim form (paper))	X		
OM2.9	Ability to provide a Claims Processing component that offers the following functionality:	X		
OM2.10	Claim Entry and Editing	X		
OM2.11	Claim Auditing	X		
OM2.12	Claims Inquiry	X		
OM2.13	Claims Tracking	X		
OM2.14	Batch Control (Batch Control is used for paper claims. Currently these are batches of 50 claims. A report is also produced as these claims are sent to a keying organization. The Batch Control report verifies that all claims in a batch are accounted for).	X		
OM2.15	Quality Control	X		
OM2.16	Pricing	X		
OM2.17	Claim Output (Claim Output would be used in interface files or in reporting. The formats of Claim Output would be discussed in DDI).	X		
OM2.18	Suspense (pend) Correction	X		
OM2.19	Interface with POS system	X		
OM2.20	Third Party Liability	X		
OM2.21	Month-End Processing	X		
OM2.22	1099 Adjustments	X		
OM2.23	Claims History File	X		
OM2.24	Attachments	X		
OM2.25	Claim Forms	X		
OM2.26	Automated procedure code editing which allows acceptance of nationally recognized modifiers	X		
OM2.27	Claim Disposition (for all claim types, according to BMS and Federal processing rules)	X		
OM2.28	Electronic Media Claims	X		
OM2.29	Claim Payment	X		
OM2.30	Accounts Payable Management	X		
OM2.31	Accounts Receivable Management	X		
OM2.32	Provider Credits and Adjustments Processing	X		
OM2.33	Explanation of Medical Benefits (EOMB) Processing	X		
OM2.34	Diagnosis Related Group (DRG) Processing	X		
OM2.35	Resource Based Relative Value Scale (RBRVS) Processing	X		
OM2.36	APC (Ambulatory Patient Classification) Processing (OPPS, out-patient prospective processing system)	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.37	Prior Authorization (PA) Processing	X		
OM2.38	Refund Function at Header and Line Level (for all medical, dental and pharmacy claims)	X		
OM2.39	Gross payment for Med/Dent and Pharmacy POS	X		
OM2.40	Adpay for Med/Dent and Pharmacy POS	X		
OM2.41	Manage Member Incentive Programs	X		
OM2.42	Produce Check Files	X		
OM2.43	Produce Remittance Advice	X		
OM2.44	Other as identified by BMS during DDI and accepted via formal change control	X		
OM2.45	Ability to accept all HIPAA formatted electronic claims submissions.	X		
OM2.46	The system should not accept non-HIPAA compliant codes or characters into the system.	X		
OM2.47	Ability to identify Members with other insurance (including, but not limited to, Medicare Part A, B, and D).	X		
OM2.48	Ability to collaborate with Medicare intermediaries, Part A, B and D, on an ongoing basis to receive and process cross-over claims through the Medicare electronic data submission system.	X		
OM2.49	Ability to identify and process pay-and-chase claims (including subrogation). Capture other insurance allowed and payable amounts.	X		
OM2.50	Ability to identify TPL and assure that the Title XIX program is the payer of last resort in accordance with the State plan.	X		
OM2.51	Ability to process claims for populations that are not Title XIX.	X		
OM2.52	The claims processing component is expected to integrate with all other functional areas of the MMIS, including Member, Provider, Benefit Plans, Prior Authorizations, Contracts, Pharmacy, Referrals, Reference (including Correct Coding Initiative, editing), enhanced claim editing, other insurance, and Financial.	X		
OM2.53	Adjudicated claims cannot be changed outside an approved adjustment process. Once a claim is adjudicated and in a final status, the information is to remain static while it is displayed (e.g., users may not cut claim information from claim lines/data).	X		
OM2.54	Ability to provide a free-form text narrative (length/number of characters to be approved by BMS) on the claim record that:	X		
OM2.55	Identifies the user, date, and time entered	X		
OM2.56	Provides the capability to display free form narrative in chronological or reverse chronological sequence	X		
OM2.57	Includes an associated user-defined special condition code/flag	X		
OM2.58	Ability to report on the special condition code/flag.	X		
OM2.59	Other as identified by BMS during DDI and accepted via formal change control	X		
OM2.60	**2. Claims History File**			
OM2.61	Ability to maintain a full historical record, which includes edit, audit, and resolution information, from initial receipt to paid status.	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.62	Ability to capture and store adjudication details to include payments, contracts, discount adjustments, and patient liability.	X		
OM2.63	Ability to capture and store the data that is derived during claims processing functions.	X		
OM2.64	Ability to use historical records of client eligibility for claims processing functions.	X		
OM2.65	**3. Claims Management / Claims Capture and Controls**			
OM2.66	The system is expected to capture and control claims data from the time of initial receipt through the final disposition, payment and archiving on claims history files.	X		
OM2.67	Ability to employ the use of a claims control mechanism which automatically assigns unique control numbers to monitor, track, and maintain control over claims, adjustments and financial transactions.	X		
OM2.68	Ability to maintain accurate and complete registers and audit trails of all processing.	X		
OM2.69	Ability to provide claims audit trail capability to:	X		
OM2.70	Track and report all claim related changes	X		
OM2.71	Identify the individual who modified the claim data	X		
OM2.72	Record the date that the modification occurred	X		
OM2.73	Display an audit trail of all processing steps	X		
OM2.74	View on-line all claims audit trail information	X		
OM2.75	Other as identified by BMS during DDI and accepted via formal change control	X		
OM2.76	Records and edits that all required attachments, per the reference records or edits, have been received and maintained for audit purposes.	X		
OM2.77	Ability to retain and display as part of the claim record the billing agent submitter/ID number.	X		
OM2.78	**4. Claims Inquiry**			
OM2.79	Ability to respond to queries concerning Member eligibility and benefit status.	X		
OM2.80	Ability to verify that Member is eligible for the type of service at the time the service was rendered, plus a hierarchy algorithm for dual eligibles.	X		
OM2.81	Ability to provide online, real-time claims inquiry by search criteria including:	X		
OM2.82	Member ID and/or name	X		
OM2.83	Rendering Provider ID and/or name, including NPI	X		
OM2.84	Billing Provider ID and/or name	X		
OM2.85	PA or referral	X		
OM2.86	Dates of service, paid, denied, pended	X		
OM2.87	HCPCs, CPT, DRG, revenue, and/or NDC codes	X		
OM2.88	Combination of any of the above	X		
OM2.89	Other inquiry criteria as determined by the BMS during DDI	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.90	**5. Prior Authorization**			
OM2.91	Ability to automatically identify and link the correct PA based on matching data between the claim and the PA, driven by BMS-defined user configurable criteria such as Client ID, Rendering Physician ID, Date of Service, diagnosis code, and procedure code, and payment amount.	X		
OM2.92	Ability to provide a selection screen when multiple PAs match the auto assignment criteria.	X		
OM2.93	Ability to link PAs to claims based on PA identifiers submitted with the claim.	X		
OM2.94	Ability to allow multiple PAs to be linked to a specific claim.	X		
OM2.95	Ability to provide a claims screen that displays all PAs linked to a specific claim.	X		
OM2.96	Ability to update PA data during the adjudication process to reflect utilization of services including:	X		
OM2.97	Authorized unit, visit, and dollar amounts used	X		
OM2.98	Authorized unit, visit, and dollar amounts remaining	X		
OM2.99	Accumulators reset for claims reversals	X		
OM2.100	Other as identified by BMS during DDI and accepted via formal change control	X		
OM2.101	**6. Business Rules**			
OM2.102	Ability to maintain information that allows procedures to be automatically priced according to BMS–defined business rules, rates and effective dates.	X		
OM2.103	Ability to manage audits/edits to avoid hard-coding that is not accessible to the user.	X		
OM2.104	Ability for the user to define and update business rules real-time.	X		
OM2.105	Ability to maintain and view business rule change history on-line.	X		
OM2.106	Ability to maintain status of business rules (development, testing, production).	X		
OM2.107	Ability to retain in and display as part of the claim record all business rules that were applied to the claim for adjudication and pricing.	X		
OM2.108	Ability to execute impact analysis testing of any proposed business rule change.	X		
OM2.109	**7. Edits/Audits**			
OM2.110	Ability to process claims according to a Member's program benefits.	X		
OM2.111	Ability to provide claim editing processes necessary to detect and correct (when possible and appropriate) erroneous data. The system should include:	X		
OM2.112	Real-time integration to MMIS claims adjudication processes	X		
OM2.113	User configurable functions	X		
OM2.114	Report generation features	X		
OM2.115	Up-to-date code sets and edit criteria	X		
OM2.116	Other as identified by BMS during DDI and accepted via formal change control	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.117	The system is expected to incorporate the BMS's existing edits and audits.	X		
OM2.118	Ability to apply any defined audit/edit specific to any procedure code when billed on any claim form type, as defined by the user.	X		
OM2.119	Ability to apply Medicare Correct Coding Initiative (CCI) edits to defined claim line items.	X		
OM2.120	Ability to edit Third Party Liability (TPL) claims to adhere to the cost avoidance adjudication rules specified in the Federal Regulations.	X		
OM2.121	Ability to establish edits specific to a TPL insurance policy.	X		
OM2.122	Ability to allow authorized users (per BMS approval) to set criteria allowing claims to bypass the enhanced claim editing component based on a variety of factors to include:	X		
OM2.123	Dollar thresholds	X		
OM2.124	Member or Provider specific criteria	X		
OM2.125	Medical coding	X		
OM2.126	Other as identified by BMS during DDI and accepted via formal change control	X		
OM2.127	Ability to apply any claims processing function based on characteristics of the Provider (e.g., type, specialty, and individual or group enrollment).	X		
OM2.128	Ability to perform pre-payment claims audits using criteria that includes:	X		
OM2.129	Comparison of diagnosis codes against billed services	X		
OM2.130	Unbundling of procedure codes, when bundling is more appropriate and vice versa	X		
OM2.131	Mutually exclusive procedures	X		
OM2.132	Duplicate or near duplicate payments	X		
OM2.133	Duplicate services	X		
OM2.134	Service limits	X		
OM2.135	Age and gender appropriate services	X		
OM2.136	Duplicate Medicare cross-over claims	X		
OM2.137	Consistent payment across various Provider types for the same services	X		
OM2.138	Breakdowns of savings based on changes to clinical rules	X		
OM2.139	Trends in historical data	X		
OM2.140	Rules review	X		
OM2.141	New visit frequency	X		
OM2.142	Incidental surgical procedures	X		
OM2.143	Pricing of multiple surgeries and multiple modifiers	X		
OM2.144	Add-on codes from multiple surgery editing	X		
OM2.145	Application of AMA guidelines as defined in the CPT for asterisked procedures	X		
OM2.146	Appropriate use of modifiers	X		
OM2.147	An automated clinical review process	X		
OM2.148	Other as identified by BMS during DDI and accepted via formal change control	X		
OM2.149	Ability to use data in any field on a claim to apply an audit.	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.150	Ability to verify that all Providers submitting input are properly enrolled.	X		
OM2.151	Ability to pay for services, Members or Providers who are normally not paid through the MMIS (where applicable), when required for exception claim processing. (Note - Provider is to be enrolled to receive payment.)	X		
OM2.152	Ability to process mathematical calculations on the current claim and associated claims in history to limit payments to global (i.e., bundled, controlling) procedures.	X		
OM2.153	Ability to define date parameters to support adjudication of services.	X		
OM2.154	**8. Suspensions (Pends) and Exceptions**			
OM2.155	The Vendor is expected to perform online pended claims resolution.	X		
OM2.156	Ability to automatically suspend all transactions in error until corrections are made.	X		
OM2.157	Ability to perform exception control (desktop procedures).	X		
OM2.158	Ability to allow authorized users to override any edits/audits to manually adjudicate a claim when required for exception claim processing.	X		
OM2.159	Ability to capture the identity of the user who authorizes the exception payment.	X		
OM2.160	Ability to reprocess claims that have not been finalized for payment.	X		
OM2.161	Ability to reprocess claims automatically when that claim was denied as a result of an unapproved PA and that PA is later approved.	X		
OM2.162	Ability to systematically reprocess claims that have not reached final disposition without requiring the user to intervene on a claim-by-claim basis.	X		
OM2.163	Ability to define criteria for systematic claims reprocessing, with the ability to review and modify that selection of claims prior to reprocessing.	X		
OM2.164	Ability to flag and reprocess previously paid claims within the designated service date span if a rate change happened to be a retroactive rate change, and implement into production only upon authorized staff approval.	X		
OM2.165	Ability to capture and report on reprocessed claims detail, including (but not limited to) retroactive rate changes, identify of the user authorizing, dates of original processing and reprocessing.	X		
OM2.166	Ability to override established pricing calculations if the claim or the Provider billing the claim meets the requirements defined by BMS for pricing exceptions.	X		
OM2.167	Able to capture, display and report on encounter data.	X		
OM2.168	**9. Price Claim/Value Encounter**			
OM2.169	The system is expected to price all claims in accordance with West Virginia Medicaid program policy, benefits and limitations.	X		
OM2.170	The Vendor is expected to allow for manual pricing of claims.	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.171	Ability to price each claim line item according to the applicable pricing rules.	X		
OM2.172	Ability to display all service lines of a single claim.	X		
OM2.173	Ability to determine and display the number of units paid on a claim line.	X		
OM2.174	Ability to define Member co-payments at the claim line level.	X		
OM2.175	Ability to define Member co-payments at the claim header level.		X	
OM2.176	Ability to process claims including Member liability in the final payment amount.	X		
OM2.177	Ability to provide an automated process, approved by BMS, to acquire Medicare Rates, and ensure conformance with Federal requirements regarding Medicare pricing.	X		
OM2.178	Calculate Medicare and TPL coinsurance and deductible charges for specified crossover and TPL claims using BMS "lesser than" calculation described in common chapters of the Provider manuals.	X		
OM2.179	Ability to accommodate Provider custom fees which override other pricing considerations.	X		
OM2.180	Ability to accommodate pricing for payments that may exceed billed charges, including payment of encounter fees to:	X		
OM2.181	Rural Health Clinics (RHCs)	X		
OM2.182	Federally Qualified Health Clinics (FQHCs)	X		
OM2.183	DRGs	X		
OM2.184	Critical Access Hospitals (CAHs)	X		
OM2.185	Ability to calculate spend down and reimbursement amount after capturing and applying information captured in the patient pay field.	X		
OM2.186	Ability to limit claim payments based on Member-specific expenditure histories (i.e., to limit payments to budgeted amounts at the Member level).	X		
OM2.187	Ability to view Benefit utilization information through the user interface (UI) for Benefit Plan accumulations.	X		
OM2.188	Ability to maintain a DRG file as determined by BMS. The DRG file should contain, at a minimum, elements such as:	X		
OM2.189	DRG code	X		
OM2.190	DRG description	X		
OM2.191	Add date	X		
OM2.192	Begin date	X		
OM2.193	End date	X		
OM2.194	DRG weight (relative value)	X		
OM2.195	Audit trail	X		
OM2.196	Average length of stay	X		
OM2.197	Other as identified by BMS during DDI and accepted via formal change control	X		
OM2.198	Ability to provide on-line role-based access to pricing formulas and their associated parameters/variables, including the ability to view and modify (for authorized staff only) pricing formulas. Parameters should include:	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.199	Anesthesia conversion factors (with the ability to accept and process by units and/or minutes based on BMS's choice)	X		
OM2.200	Anesthesia base rates	X		
OM2.201	Vaccine for Children (VFC) rates	X		
OM2.202	Multiple RBRVS Conversion Factors for the same period of time	X		
OM2.203	All other conversion factors as defined by BMS during DDI	X		
OM2.204	Ability to define date parameters to support pricing of services.	X		
OM2.205	Ability to capture and display rate codes defined by BMS. (The term "Rate Code" is a combination of RAPIDS program codes plus the old CMS Aid Category codes, or in the case of a non-Medicaid program, the aid category plus the first two numbers assigned to the MAID#.)	X		
OM2.206	Ability to allow for consistent calculation of payment amounts according to all reimbursement methodologies approved by BMS, including:	X		
OM2.207	Provider specific fee schedule	X		
OM2.208	Usual and Customary Rate (UCR)	X		
OM2.209	Per diems	X		
OM2.210	LTC facility room and board charges	X		
OM2.211	LTC coinsurance amount (uses "lesser than" calculation)	X		
OM2.212	Diagnosis Related Groups (DRGs)	X		
OM2.213	Medicare coinsurance/deductible and pricing methodology	X		
OM2.214	TPL pricing methodology	X		
OM2.215	Formulas	X		
OM2.216	Percentages	X		
OM2.217	Pricing by PA	X		
OM2.218	Other payment methods (as defined by BMS during DDI)	X		
OM2.219	Ability to maintain pricing history per BMS specifications.	X		
OM2.220	Ability to establish edits for production or test region adjudication and notify BMS staff of any services that are not priced under the current fee schedules.	X		
OM2.221	Ability to generate pricing data for all Provider programs using selection parameters specified by the State.	X		
OM2.222	**10. Apply Claim Attachment**			
OM2.223	Ability to accurately accept, store, track, and process claim attachments submitted via both hard-copy and electronic transmission.	X		
OM2.224	Ability to integrate with the EDMS component, for inbound imaging of claims and attachments, claims reporting, and correspondence.	X		
OM2.225	Ability to electronically match attachments to their associated claims.	X		
OM2.226	Ability to allow authorized users to manually modify the link between a claim and its associated attachments, PAs and image files.	X		
OM2.227	Ability to process related claims based on the presence of specific attachments, as defined by the user.	X		

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM2.228	Ability to accept unlimited number and types of attachments per claim.	X		
OM2.229	Ability to allow users to navigate to and view claims attachments from within the claim screens.	X		
OM2.230	Accepts Medicare crossover claims with Medicare Explanation of Benefits (EOB) claims attachments.	X		
OM2.231	Employs an electronic tracking mechanism to locate archived source documents or to purge source documents in accordance with HIPAA security provisions.	X		
OM2.232	**11. Apply Mass Adjustment**			
OM2.233	Ability to provide mass update capability for claims, including paid and denied claims determined eligible for adjustment.	X		
OM2.234	Ability to link together claims reversal and replacement claim (for mass updates only) so claims go through budget relief at the same time.	X		

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3. Operations Management (OM) OM3. Payment Management, Payment & Reporting				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM3.1	**1. Prepare Remittance Advice/Encounter Report**			
OM3.2	Ability to generate paper and electronic Remittance Advice (RA) that captures all data necessary to meet BMS, State, and Federal reporting requirements (HIPAA 835 transaction).	X		
OM3.3	Ability to print and distribute paper Remittance Advice in accordance with BMS approved schedule.	X		
OM3.4	Ability to produce the paper Remittance Advice copies on demand.	X		
OM3.5	Ability to generate additional remittance voucher pages (X number of pages free, fee thereafter -- per Fiscal Agent pricing structure).	X		
OM3.6	Ability to allow Remittance Advice for zero pay and zero balance items.	X		
OM3.7	Ability to suppress Remittance Advice relating to adjustments performed for the purpose of correcting internal account or category codes.	X		
OM3.8	Ability to associate the warrant/ACH number with the claim.	X		
OM3.9	Ability to include warrant/ACH number in 835 Remittance Advice transaction.	X		
OM3.10	Ability to print warrant/ACH number on the Remittance Advice.	X		
OM3.11	Ability to include all claims and financial transactions (such as recoupments) on the paper Remittance Advice.	X		
OM3.12	Ability to distribute the Remittance Advice to multiple locations.	X		
OM3.13	Ability to report any withholdings to a Provider's payment on the Remittance Advice.	X		
OM3.14	Ability to generate reports summarizing payment and status transactions (HIPAA 820, 277).	X		
OM3.15	**2. Prepare Coordination of Benefits (COB)**			
OM3.16	Ability to capture and provide COB information online and in batch format.	X		
OM3.17	Ability to comply with the following Federal Third Party Liability (TPL) processing and HIPAA requirements, including:	X		
OM3.18	Ability to store a unique identifier for individual health plans	X		
OM3.19	Other as identified by BMS during DDI and accepted via formal change control	X		
OM3.20	Ability to maintain a process to identify projected allowed amount for previously denied claims in order to estimate savings due to TPL.	X		
OM3.21	Ability to identify all payment costs avoided due to established TPL.	X		
OM3.22	Ability to use the HIPAA 837 transaction to facilitate TPL billing functions (i.e., using the 837 COB functionality).	X		
OM3.23	**3. Prepare Home and Community-Based Services (HCBS) Payment**			
OM3.24	Ability to support processing for HCBSs as it is conducted for any other claim/transaction type. WV has no unique processing requirements for HCBS.	X		
OM3.25	**4. Prepare EOMB**			
OM3.26	Ability to increase or decrease sample sizes (in regards to CMS checklist item CMS FI1.1, "Provides individual EOMB notices, within 45 days of the payment of claims, to all or a sample group of the Beneficiaries who received services under the plan as described in §11210.").	X		

3. Operations Management (OM) OM3. Payment Management, Payment & Reporting				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM3.27	**5. Prepare Provider EFT/Check**			
OM3.28	The Vendor is to generate a check file in accordance with BMS process and schedule. The process is as follows: Pass check file to MIS, MIS passes to State Auditor and State Treasurer offices (where warrant #, EFT conf #, payment date added), passed back to MIS and then back to Vendor to load into the MMIS.	X		
OM3.29	Ability to generate an electronic check file that segregates types of payment based on check, Electronic Fund Transfer (EFT), and Inter-Governmental Transfer (IGT) payment data (Medicare A, B, D).	X		
OM3.30	Payment processing should be independent of other system activity.	X		
OM3.31	Ability to support a fixed payment schedule (as defined by BMS).	X		
OM3.32	Ability to support unscheduled payment generation (per BMS request).	X		
OM3.33	Ability to calculate payment amounts for claims, including:	X		
OM3.34	FFS Claims	X		
OM3.35	Pharmacy POS	X		
OM3.36	HCBS Provider claims	X		
OM3.37	MCO/Capitation	X		
OM3.38	Performance incentives (per BMS)	X		
OM3.39	Withholdings	X		
OM3.40	Other as identified by BMS during DDI and accepted via formal change control	X		
OM3.41	Ability to base payment calculations on inputs that include:	X		
OM3.42	Patient Resource Amounts	X		
OM3.43	Spend-down amounts	X		
OM3.44	TPL payment adjustments	X		
OM3.45	Crossover payment adjustments	X		
OM3.46	Member payment Adjustments	X		
OM3.47	Ability to determine net payment amount	X		
OM3.48	Other as identified by BMS during DDI and accepted via formal change control	X		
OM3.49	Ability to support payroll processing (e.g., HCBS Providers), including withholding payments for payroll, and State and Federal taxes.	X		
OM3.50	The Vendor is expected to support WV BMS budget relief (Accounts Payable) process. Processes include: reconciliation process for managing A/P inventory, release of payments per BMS criteria, withhold amounts per defined repayment schedules, and suspension of Provider payment, creation of check file, updating of claim with payment data	X		
OM3.51	**6. Prepare Premium EFT/Check**			
OM3.52	Ability to calculate payment amounts for premium payments, including:	X		
OM3.53	MCO premium payments based on MCO contract data (reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package)	X		
OM3.54	PCCM premium payments based on BMS rules	X		

3. Operations Management (OM) OM3. Payment Management, Payment & Reporting				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
OM3.55	Other as identified by BMS during DDI and accepted via formal change control	X		
OM3.56	Ability to associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA.	X		

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3. Operations Management (OM) OM4. Payment Management, Capitation & Premium Preparation				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM4.1	**1. Prepare Health Insurance Premium Payment**			
OM4.2	Ability to support HIPP invoicing and payment processing.	X		
OM4.3	Ability to update Member records to reflect capitation payments made on his/her behalf.	X		
OM4.4	Ability to calculate premium assistance cost effectiveness based on historical claims payment information compared to insurance premiums for a Member.	X		
OM4.5	Ability to employ a user-configurable process to identify potential high cost Members.	X		
OM4.6	Ability to identify Members for whom insurance premiums are to be paid and automatically generate prospective premium payments to insurance companies, employers, Members, or other entities.	X		
OM4.7	Ability to allow payment of premiums to multiple payees for a single Member.	X		
OM4.8	Ability to accommodate prospective and retrospective premium payments.	X		
OM4.9	Ability to generate and transmit to Providers the content of HIPAA compliant automated premium payment reports (ASC-X12N 820), on a scheduled specified by the BMS.	X		
OM4.10	Ability to store premium assistance payment tracking details such as warrant numbers.	X		
OM4.11	Ability to make adjustments to premium payments.	X		
OM4.12	Ability to integrate all premium assistance reporting and correspondence with the EDMS component.	X		
OM4.13	**2. Prepare Medicare Premium Payment**			
OM4.14	Ability to support the payment of the Part A and Part B premiums.	X		
OM4.15	Ability to receive appropriate Medicaid Member eligibility data from all sources of eligibility determination.	X		
OM4.16	Ability to receive State Data Exchange (SDX), Enrollment Data Base (EDB) file, and/or Beneficiary Data Exchange (BENDEX) eligibility files. (The Bureau currently accesses the EDB file and downloads it directly from CMS. The file is then sent to the FA vendor. RAPIDS currently uses the Bendex and SDX files).	X		
OM4.17	Ability to perform a matching process against Member data.	X		
OM4.18	Ability to generate a two-part buy-in file, one for Medicare Part A and one for Medicare Part B.	X		
OM4.19	Ability to receive Medicare buy-in records and load on a monthly basis.	X		
OM4.20	Ability to send/receive buy-in files to/from CMS.	X		
OM4.21	Ability to automatically update eligibility information based on information received in the Medicare Enrollment Database (EDB) file.	X		
OM4.22	Ability to post buy-in changes to the appropriate Member record.	X		
OM4.23	Ability to produce buy-in reports as specified by BMS.	X		
OM4.24	Provides Buy-In Beneficiary information for program or management use, including:	X		
OM4.25	Transaction processed	X		
OM4.26	Errors identified	X		

3. Operations Management (OM) OM4. Payment Management, Capitation & Premium Preparation				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM4.27	Errors correction status	X		
OM4.28	Tracks Buy-In exceptions for those Beneficiaries who are identified as eligible, but whose premiums have not been paid.	X		
OM4.30	**3. Prepare Capitation Premium Payment**			
OM4.31	Ability to process adjustments to capitation (health plan premium) payments.	X		
OM4.32	Ability to process per-Member per-month (PMPM) capitation payment based on BMS-defined rate factors such as age, sex, category of eligibility, health status, geographic location, and other.	X		
OM4.33	Ability to establish capitation rates based on multiple risk criteria (gender, geography, etc.) and PCCM.	X		
OM4.34	Selects premium payment amount and generates PMPM payment (capitation, premium, case management fee).	X		
OM4.35	Ability to query Member-specific history of capitation payments for each applicable managed care program to which that Member belongs.	X		
OM4.36	Identifies individuals/enrollees who have terminated enrollment, disenrolled, or are deceased, and excludes those individuals from the monthly MCO capitation payment.	X		
OM4.37	Generates regular capitation payments to MCOs or PCPs, at least on a monthly basis in compliance with HIPAA-standard X12 820 Premium Payment transaction where applicable.	X		
OM4.38	Adjusts capitation payment based on reconciliation of errors or corrections or approved retroactive rates (e.g., retroactive adjustments to a particular capitation payment based on more accurate data that the MMIS obtains retroactively on Member enrollments, disenrollments, and terminations).	X		
OM4.39	Performs reconciliations of payments to MCO, PCP roster.	X		
OM4.40	Verifies correct transfer of capitation payment when Member disenrolls from one MCO and enrolls in another plan.	X		
OM4.41	Ability to generate capitation recoupments automatically, based on user-defined criteria.	X		
OM4.42	Ability to maintain Member-specific history of capitation payment activity for each applicable managed care program to which that client belongs.	X		
OM4.43	Ability to maintain edit logic to prevent duplication of capitation and fee-for-service payments for services covered under the managed care program.	X		
OM4.44	Process per-Member per-month (PMPM) for primary care gatekeeper services.	X		

3. Operations Management (OM) OM5. Payment Information Management				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM5.1	**1. Manage Payment Information**			
OM5.2	Ability to provide a Payment Data Repository to track and maintain all payment detail, including:	X		
OM5.3	Claims and adjudication history (including payment)	X		
OM5.4	Premium and capitation payment history	X		
OM5.5	HCBS claims and payment history	X		
OM5.6	Other as identified by BMS during DDI and accepted via formal change control	X		
OM5.7	**2. Inquire Payment Status**			
OM5.8	Ability to receive claim status inquiries in a variety of medium, including:	X		
OM5.9	X12 276 and 277 Transactions through portal and in batch file process	X		
OM5.10	Mail	X		
OM5.11	Phone (Agent)	X		
OM5.12	Fax	X		
OM5.13	Phone (AVRS)	X		
OM5.14	Provider Enrollment Tracking System (PETS)	X		
OM5.15	Other as identified by BMS during DDI and accepted via formal change control	X		
OM5.16	Ability to automatically assign a unique control (or identification or tracking) number to each Payment Status Request to track requests, from time of receipt to disposition.	X		
OM5.17	Ability to respond to claim status inquiries in a variety of medium, including:	X		
OM5.18	X12 276 and 277 Transactions through portal and in batch file process	X		
OM5.19	Mail	X		
OM5.20	Phone (Agent)	X		
OM5.21	Fax	X		
OM5.22	Phone (AVRS)	X		
OM5.23	Other as identified by BMS during DDI and accepted via formal change control	X		
OM5.24	Ability to provide payment inquiry response in conformance with BMS, State, and Federal policies.	X		
OM5.25	Ability to deny requests not in compliance with BMS's information access/privacy policies and HIPAA guidelines.	X		

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3. Operations Management (OM) OM6. Member Payment Information.				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM6.1	**1. Calculate Spend-Down Amount**			
OM6.2	Ability to accept and display a spend-down indicator from RAPIDS showing that the spend-down amount has yet to be met.	X		
OM6.3	Ability to automatically generate a spend-down report identifying the Members whose spend-down indicator is "Yes."		X	
OM6.4	Ability to edit against the spend-down indicator and pend for "Yes."	X		
OM6.5	Ability to provide a screen for BMS staff to enter the spend-down amount to be applied to the claim, and capture and maintain this information so that it is available for reporting.	X		
OM6.6	**2. Prepare Member Premium Invoice**			
OM6.7	Calculates and generates enrollment and premium notices to policy holders.	X		
OM6.8	Processes premium receipts from policy holders.	X		
OM6.9	Supports inquiries regarding premium collections.	X		
OM6.10	Produces premium collection reports.	X		
OM6.11	Ability to provide an Accounts Receivable function to create entries from the premium billing cycle and to post premium payment against (i.e., to bill and collect premiums).	X		
OM6.12	Ability to generate an invoice to the Member for program premiums.	X		
OM6.13	Ability to define premium rates and associate to specific benefit offerings.	X		
OM6.14	Ability to identify through Member eligibility the applicable premium rate determination in order to generate invoices for premium payment.	X		
OM6.15	Ability to prepare member premium invoices on a set schedule (as specified by the BMS).	X		
OM6.16	Ability to capture all data necessary to meet BMS, State, and Federal premium reporting requirements. (The Bureau currently collects premiums and enrollment fees for eligible MWIN participants. A description of this program is found in 2.3.2.1.6. At a minimum, the data would need to identify member detail such as Member Medicaid ID, member name and related demographics, program type, eligibility effective dates, eligibility rate code, premium amount, premium notification mail date, date of premium receipt date, past due mail dates, program termination date, reason codes for termination. This is not meant to be an all-inclusive list. The system functionality should be flexible to accommodate additional expansion populations beyond the current MWIN program if the Bureau chooses to pursue).	X		
OM6.17	Ability to integrate premium billing invoices and associated reporting with the Electronic Document Management System (EDMS) component.	X		
OM6.18	Ability to maintain an audit trail of all transactions.	X		

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3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM7.1	**1. Manage Recoupment**			
OM7.2	Ability to support multiple recoupment options, rules and terms for recovery of all overpayments.	X		
OM7.3	Ability to net against current or future payments to recover overpayments using a lump sum, percentage or repayment plan.	X		
OM7.4	Ability to assess and collect interest per business rules (as defined by BMS).	X		
OM7.5	Ability to post checks to outstanding receivable balances.	X		
OM7.6	The system is expected to include an integrated (with other system components), fully functional accounts receivable component, including all required reporting (to be defined by BMS).	X		
OM7.7	Ability to track the status of recoupment by Provider through all stages of the collection and appeals processes.	X		
OM7.8	Ability to create bank deposit. (The system should provide functionality to post Accounts Receivable (A/R) for all check payments received in the Bureau. A daily report of all entries/postings is required to accompany the checks to be deposited for each date).	X		
OM7.9	**2. Manage Estate Recovery**			
OM7.10	Ability to identify Members subject to estate recovery.	X		
OM7.11	Ability to interface with TPL vendor files.	X		
OM7.12	Ability to automatically generate a unique case identifier upon referral for Estate Recovery Case Management. Identifier methodology to be specified by BMS.	X		
OM7.13	Ability to automatically create the Case Management record (from the initial case review data) upon referral to Case Management.	X		
OM7.14	Ability to track and maintain Case Management data at the individual case level, including:	X		
OM7.15	Case number	X		
OM7.16	Case status (e.g., open, suspended, closed)	X		
OM7.17	Actions taken	X		
OM7.18	Outcomes including monetary recoveries	X		
OM7.19	Listing of case contacts/affected parties	X		
OM7.20	Chronology of significant case activity (e.g., dates of phone calls to Providers, dates of records/information received from Provider/Member/attorney), including description.	X		
OM7.21	Significant case documentation/evidence (e.g., medical records, Member interview findings, Provider credential verification)	X		
OM7.22	Other as identified by BMS during DDI and accepted via formal change control	X		
OM7.23	Ability to integrate and analyze data from external sources (e.g., vendors) in multiple media types.	X		
OM7.24	**3. Manage TPL**			
OM7.25	Ability to track and maintain contractor activity related to Third Party Liability (TPL) requirements (e.g., cost avoidance, trauma, post-payment recoveries).	X		

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM7.26	Automatically generates casualty-related claims information that can be used for follow-up to Beneficiaries, attorneys, motor vehicle department, etc. according to BMS-specified criteria.	X		
OM7.27	Edits additions and updates to the Beneficiary insurance information to prevent the addition of duplicate policies.	X		
OM7.28	Provides a mechanism to identify outdated TPL information.	X		
OM7.29	Generates and maintains an audit trail of all updates to the Beneficiary insurance data, including those updates that were not applied due to errors, for a time period specified by the State.	X		
OM7.30	Allows only authorized staff members to do manual deletes and overrides of alerts/edits.	X		
OM7.31	Ability to report TPL resources against paid claims history retroactively for five (5) years to identify recoverable funds.	X		
OM7.32	Manages accounts receivable and claims adjustments as TPL related invoices are paid.	X		
OM7.33	Provides data storage and retrieval for Third Party Liability (TPL) information; supports TPL processing and update of the information.	X		
OM7.34	Ability to support entry of free-form text field that allows narratives for each recovery case that identifies user and date/time entered (length of this text field to be determined during DDI, per BMS approval).	X		
OM7.35	Ability to display date-specific free-form narrative in chronological or reverse chronological sequence.	X		
OM7.36	Ability to identify claims subject to recoupment, based on criteria defined by BMS, and generate letters to Providers instructing them to re-bill the primary carrier.	X		
OM7.37	Ability to track post-payment recovery and adjustment of paid claims, including account receivable entries.	X		
OM7.38	**4. Manage Drug Rebate**			
OM7.39	Ability to support non-traditional drug rebates (i.e., DME, other state drug rebate programs).	X		
OM7.40	Ability to generate CMS 64 reporting related to drug rebate.	X		
OM7.41	Ability to upload external drug rebate data into the system reference file (e.g., CMS labeler contact information and pricing file, supplemental rebate pricing file).	X		
OM7.42	Ability to maintain all fields provided by CMS quarterly drug rebate file including historical data as determined by BMS.	X		
OM7.43	Ability to generate statement of accounts.	X		
OM7.44	Ability to generate quarterly utilization file for transfer back to CMS.	X		
OM7.45	Ability to generate drug rebate invoices for different rebate programs.	X		
OM7.46	Ability to compare National Drug Code (NDC) unit rebate amounts supplied by the manufacturer directly with the same information supplied by CMS.	X		
OM7.47	Ability to exclude drug expenditures (e.g., claims from the 340B pharmacies) from rebate invoicing.	X		

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM7.48	Ability to generate invoices that reference changes made to claim information reported on previously produced invoices. Corrections are to reflect original invoice quarter.	X		
OM7.49	Ability to invoice for drugs dispensed in the physician office, drugs dispensed from a pharmacy, using the NDC identifier, and eligible drugs paid through MCO.	X		
OM7.50	Ability to flag, withhold and correct invalid claims data before it reaches invoice generation.	X		
OM7.51	Ability to assess interest according to Federal requirements.	X		
OM7.52	Ability to automatically set up Accounts Receivables at the NDC level for drug manufacturers invoiced for all rebate programs.	X		
OM7.53	Ability to generate user defined reports to monitor the status of invoice or NDC detail, including but not limited to: amount collected, amount invoiced, outstanding receivables, number of disputes received and resolved, and amount collected in disputed items and non-disputed items.	X		
OM7.54	Ability to selectively produce a periodic statement of accounts for outstanding debt, including interest calculated based on CMS rules.	X		
OM7.55	Ability to record and track manufacturer disputes of drug rebate invoices at the NDC detail level.	X		
OM7.56	Ability to associate the claims with NDC level detail related to a manufacturer's dispute.	X		
OM7.57	Ability to report on all drug rebate programs individually and collectively.	X		
OM7.58	Ability to provide drug manufacturers access through the Web Portal to upload data (as approved by BMS). (A secure portal for the Drug Rebate Program would allow access by the drug manufacturers to their invoices, claims level data, payment data and statements of account. While the intent is to provide data to the manufacturer, it is conceivable that payment data could be returned by the manufacturer).		X	
OM7.59	Ability to manage reversal/adjustment claims for invoicing purposes.	X		
OM7.60	Ability to import, maintain and modify historical rebate claims, pricing and payment data.	X		
OM7.61	Ability to support and apply conversion factors.	X		
OM7.62	Ability to post payment data at the deposit, check, invoice and line item levels.	X		
OM7.63	Ability to generate user defined and ad hoc reports that meet Federal and State requirements as well as supporting the functional and technical operation of the program.	X		
OM7.64	**5. Manage Settlement**			
OM7.65	Ability to process and distinguish settlement amounts owed and payments due Provider for reporting purposes.	X		
OM7.66	The system should allow Providers access to cost settlement information via the portal (similar to Medicare).	X		

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES without custom-ization**	**Yes with custom-ization**	**NO unable to provide**
OM7.67	The system is expected to generate all required cost settlement reporting.	X		
OM7.68	Ability to apply check payment to an open receivable.	X		
OM7.69	Ability to track the status of settlement by Provider through all stages of the collection and appeals processes.	X		
OM7.70	Ability to generate cost settlement information reports online via the Provider Portal. Specifics of the report to be agreed-upon during DDI.	X		
OM7.71	Ability to internally generate all required cost settlement reporting. Specifics of the report to be agreed-upon during DDI.	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.1	**1. Manage Rate Setting**			
PG.2	Ability to compare encounter data claims and capitation fees vs. fee-for-service payment data to determine utilization and payment analysis.	X		
PG.3	Ability to calculate rates utilizing the designated fee schedule, while providing the ability to manipulate factors in the calculation, as defined by the user.	X		
PG.4	Ability to maintain a history of any rate that includes effective and termination dates.	X		
PG.5	Ability to assign budget neutrality.	X		
PG.6	Ability to assess the fiscal impact of updating rates by testing against previously paid claims.	X		
PG.7	Ability to use the pricing files such as Medicare Physician Fee Database (MPFDB) File to update Reference data without manual intervention.	X		
PG.8	Ability to automatically update Provider rate tables through an electronic means (e.g., Excel, ODBC compliant database).	X		
PG.9	Ability to accept an electronic file from a third-party entity of pricing information to assist in rate setting (e.g., TPL allowed amount).	X		
PG.10	Ability to associate Provider-specific reimbursement contracts with the Providers. Ability to accommodate various pricing files, UCR, custom fee RBRVS, PPS. (The reference to PPS encompasses all Medicare Prospective Payment Systems that the Bureau currently utilizes or may wish to utilize in the future).	X		
PG.11	System can receive an electronic update of Medicare rates for Federally Qualified Health Centers (FQHC).	X		
PG.12	Ability to pend claims awaiting approval of fee, rate and code updates.	X		
PG.13	Ability to accommodate retroactive application of rates.	X		
PG.14	Upon any change in rates, the system can provide automatic notification to an appropriate distribution list.	X		
PG.15	Ability to accommodate multiple rate-setting schedules (i.e., hospitals, long-term care facilities, intermediate care facilities for the mentally retarded (ICF/MR)).	X		
PG.16	Ability to extract information that supports rate setting functions.	X		
PG.17	System should capture and apply Member resource amount or spend-down amount for claims adjudication.	X		
PG.18	**2. Manage 1099s**			
PG.19	Ability to establish Provider affiliations in a way that accommodates actual practicing locations and Federal and State tax requirements (one 1099 per taxable entity).	X		
PG.20	Ability to produce and distribute 1099 files, documents and reports as required by the IRS. (The MMIS vendor is responsible for creating a check file that is transferred to the auditor and treasurer's office for processing payments. The file is returned to the MMIS vendor with the warrant and EFT information appended to the original file. The State agencies do not change the payment information received from the MMIS).	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.21	Ability to produce copies of 1099s.	X		
PG.22	Ability to generate corrected tax 1099s.	X		
PG.23	Ability to automatically adjust 1099 amounts from repayments of claims.		X	
PG.24	Ability to automatically adjust 1099 amounts from repayments of claims paid out and repaid in the same calendar year.	X		
PG.25	The system has the ability to produce test 1099 list and provide a reconciliation of reportable amounts for review before printing or transmitting final to IRS.	X		
PG.26	Ability to accommodate accurate 1099 processing for multiple tax IDs for the same Provider occurring in one reporting period.	X		
PG.27	**3. Perform Accounting Functions**			
PG.28	Ability to interface all claims payment and financial activities with the West Virginia Accounts Payable and Accounts Receivable system.	X		
PG.29	Ability to provide online access to accounting information based on the user's role.	X		
PG.30	Ability to provide access to financial transactions and specifically related claims or other related or source information.	X		
PG.31	Provide online inquiry of financial records based on a variety of criteria that may include:	X		
PG.32	Payee or payer identifiers and names	X		
PG.33	Payment, service, and processing dates	X		
PG.34	Claim identifiers to be defined by BMS	X		
PG.35	Remittance identifiers and dates	X		
PG.36	Ability to capture cost report information in a prescribed electronic format for financial analysis and settlement.	X		
PG.37	Ability to query the mapping from the data elements in MMIS to a State-defined reporting/financial account code.	X		
PG.38	Ability to maintain a date-effective map from the data elements in MMIS to a State-defined reporting/financial account code.	X		
PG.39	Ability to retain the State financial/reporting account code for each price (claim level, service line level, or for add-ons). Used for determining payment/adjudication decisions.	X		
PG.40	Ability to assign a valid State financial system account code prior to final payment (e.g., State fund, Medicaid, etc.).	X		
PG.41	Ability to calculate and apply interest on accounts receivable/payable account balances, as defined by the user.	X		
PG.42	Ability to maintain date-effective interest rates.	X		
PG.43	Ability to adjust interest payments when a claim that was originally paid with interest is adjusted.	X		
PG.44	Ability to apply different interest rates.	X		
PG.45	Ability to maintain all the data in the system that is necessary to generate the State financial system account code (e.g., claim information, Provider contracts, and Member characteristics).	X		
PG.46	Ability to reconcile account code balances between the system and the State financial system.	X		
PG.47	Provides method for lump-sum reimbursement, such as Disproportionate Share Hospital (DSH).	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.48	Ability to withhold A/R from current payments.	X		
PG.49	Ability to generate A/R aging.	X		
PG.50	Provides and maintains the capability to process standard financial transactions including recoupments and payouts which cover more than one claim/service.	X		
PG.51	**4. Perform Accounting Functions - Adjustments**			
PG.52	Ability to associate a transaction control number (TCN) with all claim credits and adjustments.	X		
PG.53	Ability to reverse a previously paid claim.	X		
PG.54	Ability to associate a reason code with all claim credits and adjustments.	X		
PG.55	Ability to maintain the record of the original claim when a claim credit is generated.	X		
PG.56	Ability for reversal and replacement claims to retain same log date.	X		
PG.57	Ability to maintain a minimum of three years of on-line claim history to be used for adjustment processing upon implementation (e.g., MINIMUM of 3 years available on Day One of implementation), including encounter data.	X		
PG.58	Ability to link adjustments or replacement claims to immediate predecessor or original claims.	X		
PG.59	Ability to associate all supporting documentation for gross adjustments to the transaction control numbers (TCNs) assigned to the gross adjustment.	X		
PG.60	Ability to assign specified functions at line level (e.g., ignore, warn, pend, pay, deny).	X		
PG.61	Ability to access all incoming adjustment requests and claims regardless of input media and assign a unique tracking number and an adjustment type identifier.	X		
PG.62	Ability to image claim adjustments requests from Providers (including faxes).	X		
PG.63	Ability to process returned warrants or EFTs. Functionality should include:	X		
PG.64	Re-establishment of all claims into a to-be paid status	X		
PG.65	Reinstate units and dollars for prior authorized services	X		
PG.66	Ability to place Provider on hold until bank account information updated	X		
PG.67	Other as identified by BMS during DDI and accepted via formal change control	X		
PG.68	Ability to receive and maintain all managed care retroactive and current eligibility enrollment spans and trigger retroactive adjustment claims.	X		
PG.69	Ability to trigger take backs or payments and generate the content of 820 Remittance Advice for premium payments to Providers, at BMS-defined intervals.	X		
PG.70	Ability to allow adjustments payments for retroactive eligibility.	X		
PG.71	Ability to allow adjustments due to third-party prior payment and alert the cost avoidance unit.	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.72	Ability to display both contracted agreement amount and actual payment amount.	X		
PG.73	Ability to establish weekly payment reductions or increases based on the following:	X		
PG.74	IRS levy/lien	X		
PG.75	Child Support	X		
PG.76	Other conditions as defined by BMS during DDI	X		
PG.77	Ability to process mass adjustments that may include multiple Providers.	X		
PG.78	Ability to provide easily customizable, parameter-driven mass adjustment selection and review process.	X		
PG.79	Ability to establish and provide a sandbox environment that provides the functionality to create, test, modify and store fiscal impact scenarios. At a minimum, the MMIS Integrated Test Environment (ITE) should include: - Development Test Environment - UAT Environment - Training Environment - Production Test Environment	X		
PG.80	Ability to provide internal communication capabilities (notification/explanation) tied to mass adjustments when necessary (e.g., policy initiated mass adjustments).	X		
PG.81	Ability to deny or hold payments for review or release for immediate payment.	X		
PG.82	Accept electronic reversal and replacement claims and/or adjustment claims.	X		
PG.83	Ability to track and maintain source of reversal submissions in the user interface (GUI). Reversals may be submitted via paper, electronically, or entered directly into the system.	X		
PG.84	**5. Perform Accounting Functions - Accounts Payable**			
PG.85	The Vendor is to support BMS's financial functions with the use of an accounts payable file of adjudicated claims which are paid at least weekly according to specific release criteria:	X		
PG.86	Payment release by Provider Type	X		
PG.87	Payment release by TCN	X		
PG.88	Payment release by Provider ID	X		
PG.89	Payment release by Claim Type (e.g., capitation, fee-for-service, POS)	X		
PG.90	Other as identified by BMS during DDI and accepted via formal change control	X		
PG.91	Ability to generate separate payment files for other payers using the WV MMIS (e.g., Juvenile Justice).	X		
PG.92	Ability to generate a user-defined gross payment to a Provider in lieu of a payment based on adjudicated claims.	X		
PG.93	Ability to generate multiple or expedited payments outside of the normal payment cycle.	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.94	Ability to maintain A/P payment processing aging file for managing claim-specific and Provider-specific information to disburse payments via check, Electronic Funds Transfer (EFT), Inter-Governmental Transfer (IGT) payment., Part A, Part B and Part D payments.	X		
PG.95	Ability to generate a paper remittance file, an electronic remittance voucher file and a print image form.	X		
PG.96	Ability to accommodate multiple or changing tax IDs within the payment and enrollment components of the MMIS.	X		
PG.97	Identifies Providers with credit balances resulting from claim reversal.	X		
PG.98	Ability to associate each paid claim with the corresponding warrant or ACH number, warrant amount and paid date that ties to a Remittance Advice.	X		
PG.99	Ability to net a Provider's payment against the balance in that Provider's accounts receivable account, as defined by the user.	X		
PG.100	Ability to maintain user approved repayment plans for Providers.	X		
PG.101	Ability to assign recoupments to a specific treating/servicing Provider to accommodate changes in employment.	X		
PG.102	Ability to distribute payments to a specified location regardless of the distribution location of the Remittance and Status Advice (RA).	X		
PG.103	Ability to cease a Provider's payment at the individual performing Provider or corporation level, as defined by the user.	X		
PG.104	Ability to associate the service rendered to the Provider who receives payment.	X		
PG.105	Ability to accept returned financial transactions and void the Provider payment by automatically reversing all transactions associated with the payment including claim payments, claim credits, and other financial transactions (e.g., cancelled, returned warrants).	X		
PG.106	**6. Perform Accounting Functions - Accounts Receivable**			
PG.107	Ability to establish a receivable and distinguish between principle and interest balances.	X		
PG.108	Ability to establish a receivable and net against any current disbursement.	X		
PG.109	Ability to update or modify an established A/R invoice.	X		
PG.110	Ability to query A/R invoices.	X		
PG.111	Ability to post checks to outstanding receivable balances.	X		
PG.112	Ability to define the types of entities (e.g., individual Provider, organization, corporation, etc.) responsible for an A/R account.	X		
PG.113	Ability to establish repayment plans that extend over multiple periods.	X		
PG.114	Ability to support multiple settlement options, rules and terms for recovery of all overpayments.	X		
PG.115	Ability to modify (add, delete, change, pend) any item in the A/R account.	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.116	Ability to maintain on-line inquiry to current and historical financial information with access by Member, Provider, manufacturer or other entity identification.	X		
PG.117	Ability to provide for a flexible, parameter-based, on-line query capability for financial information.	X		
PG.118	Ability to accept liens and/or orders to withhold from State and Federal entities.	X		
PG.119	Ability to apply user-defined criteria for facilitating lien and/or orders to withhold (e.g., percentage of payment, percentage of lien, flat rate).	X		
PG.120	Ability to assign a disposition on an A/R for suspending collection and interest activities (e.g., fair hearing, bankruptcy) and apply user-specified business rules.	X		
PG.121	Ability to create a bank deposit transmittal and/or summary.	X		
PG.122	Ability to maintain A/R aging Receivable file of all receivables regardless of current activity.	X		
PG.123	**7. Develop and Manage Performance Measures and Reporting**			
PG.124	The Vendor is expected to develop operations reports to demonstrate compliance with applicable performance measures, as detailed in Appendix G, Service Level Agreements, and Appendix H, Performance Measures.	X		
PG.125	**8. Monitor Performance and Business Activity**			
PG.126	The Vendor is expected to monitor performance against BMS-established performance measures, as detailed in Appendix G, Service Level Agreements, and Appendix H, Performance Measures.	X		
PG.127	The Vendor is expected to implement corrective action plans to address performance issues (i.e., when performance falls below acceptable threshold).	X		
PG.128	**9. Manage Program Information**			
PG.129	Provides, maintains and updates a database to support MARS extract functions. Updates to the database should occur, at a minimum, monthly.	X		
PG.130	System automatically maintains data integrity and verifies/reconciles data against the source systems, including payment data, and accounts for discrepancies.	X		
PG.131	Vendor is to demonstrate process for ensuring that data is representative of all data elements used for claims processing and payment and reconciled to financial control totals.	X		
PG.132	Maintains appropriate controls and audit trails to ensure that the most current data is used in all processes relying on the data repository.	X		
PG.133	Ability to accommodate reporting across all Medicaid services and Social Service payments regardless of service delivery method and financing mechanism.	X		
PG.134	Ability to schedule any report to be run at varying levels of immediacy, frequency, or user-defined condition.	X		
PG.135	Ability to correct, rerun, verify, and distribute a report for which a problem occurred, for any period in which a problem occurred, or a specified point in time.	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.136	Ability to produce all reports as defined by the BMS Master Reports List (see Procurement Library).	X		
PG.137	Ability for up to 16 BMS authorized users to create ad-hoc reports.	X		
PG.138	~~Ability to report according to current and future HEDIS administrative reporting guidelines. (The FFS Program does not currently report on any HEDIS measures).~~ Requirement deleted per Addendum 1, question 21.	N/A	N/A	N/A
PG.139	Provides the ability to report on unduplicated counts such as Members, Providers, and services.	X		
PG.140	Provides the ability to report based on a Member enrollment hierarchy established by the BMS.	X		
PG.141	Ability to display to the user the number of pages that will be printed before the user proceeds with printing a report.	X		
PG.142	Monitor the progress of claims processing activity and provide summary reports which reflect the current status of claims.	X		
PG.143	Present claims processing and payment information that demonstrates compliance with Federal prompt payment rules.	X		
PG.144	Analyze areas of program expenditure to determine cost benefit.	X		
PG.145	Analyze the frequency, extent, and type of Provider and other claims processing errors.	X		
PG.146	For reporting purposes, assigns to all claim line details line, and subline categories that correspond to the CMS 64.	X		
PG.147	Analyze Provider claim filing for timeliness, fiscal controls and ranking. Assume this would include analysis and reporting such as Top 25 Late Filing Providers, Provider Participation Analysis, Provider Top 100 Report, Denied Claims Summary Report by Provider Type, etc.	X		
PG.148	Maintains comprehensive list of standard reports and their intended use (business area supported).	X		
PG.149	Maintains a list of users of each standard report.	X		
PG.150	Retains and maintains access to reports for the period of time specified by the BMS report owner.	X		
PG.151	Ability to provide staff with access to reports on changes and modifications made to benefit plans and/or related components by beginning and end dates.	X		
PG.152	Ability to generate reports on service limitations and exclusions for each benefit plan and/or related component.	X		
PG.153	Ability to generate expenditure, eligibility and utilization data by benefit plan(s) and/or any of its components to support budget forecasts, monitoring and health care program modeling.	X		
PG.154	Provide a means of obtaining various listings of the Procedure, Diagnosis, and Formulary File.	X		
PG.155	Generate various listings of the claims processing suspense file.	X		
PG.156	Provides the Statistical Report on Medical Care: Eligibles, Members, Payments and Services (Form CMS-2082).	X		
PG.157	**10. Maintain Benefit/Reference Information**			
PG.158	Provides the comprehensive source where all current and historical reference data is maintained and updated in support of the following processes:	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.159	Provider enrollment	X		
PG.160	Medical, Dental and Pharmacy Medicaid Claims processing to ensure that claims are paid in accordance with 42 CFR 447 - Payment for Services, and non-Medicaid claims in accordance with State and Federal Policy	X		
PG.161	Payment processing	X		
PG.162	Adjustments	X		
PG.163	Prior authorizations (PA)	X		
PG.164	Maintain Procedure, Revenue, Drug, Diagnosis, and DRG data	X		
PG.165	Maintain Modifier data	X		
PG.166	Maintain Medicare Action Code data (Medicare Action Code data are action codes that are used in Medicaid cross-over processing).	X		
PG.167	Maintain Resource Based Relative Value Scale (RBRVS) data	X		
PG.168	Maintain Provider Charge file data	X		
PG.169	Maintain free-form text memo information (Each entry is expected to include identification of user and date/time entered.)	X		
PG.170	Maintain System Parameter data	X		
PG.171	Maintain Edit Code data	X		
PG.172	Identify service frequency limitations	X		
PG.173	Drug Rebate processing	X		
PG.174	Drug Rebate file data	X		
PG.175	Labeler file	X		
PG.176	Drug Rebate Claim file	X		
PG.177	NDC Summary file	X		
PG.178	Produce various reports	X		
PG.179	Other activities as specified by the BMS during the DDI phase	X		
PG.180	Provides user-friendly navigation among the various reference files.	X		
PG.181	Provides on-line inquiry capability to all current reference data.	X		
PG.182	Provides on-line inquiry capability and archive access to historical reference data as defined by the BMS Data Retention Policy.	X		
PG.183	Provides BMS-designated on-line role-based access for approval/update/edit of reference file data tracked through the Change Request process.	X		
PG.184	Ability to maintain a history of all code sets, including the source and date/time of change, version, and a history of replacements or changes in meaning.	X		
PG.185	Maintains an audit trail record that describes the change, the date of change, retroactive change, who requested the change, who authorized the change, and user id of who implemented the change.	X		
PG.186	Table design should be flexible to ensure that the MMIS is able to readily accommodate changes.	X		
PG.187	Inputs to the reference file should include (at a minimum): POS updates; CMS HCPCS updates; and online and batch updates requested by BMS.	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.188	Ability to accept on-line updates, additions, and deletions, with the ability to make changes to individual records or mass changes to groups or classes of records (e.g., across Provider type and specialty).	X		
PG.189	Ability to accept manual and automated updates, additions, and deletions by electronic transmission to all reference files, with the ability to make changes to individual records or mass changes to groups or classes of records (e.g., across Provider type and specialty).	X		
PG.190	Ability to implement automated load processes to apply code set updates when updates are made available by CMS or other data publishing sources.	X		
PG.191	Ability to support the transition to future versions of code sets (e.g., ICD-11).	X		
PG.192	All reference file updates are expected to be tested by Vendor and approved by BMS prior to moving data to production.	X		
PG.193	Ability to alert designated BMS staff upon completion of updates of reference file data. This alert should identify all changes and revisions, deletions, and replacements and provide a cross-reference.	X		
PG.194	Ability to perform mass updates, from multiple sources determined by BMS, on the test region and upon approval migrate to production on a schedule defined by BMS.	X		
PG.195	Ability to assure updates do not overlay or otherwise make historical information inaccessible. Should maintain back-up features to assure changes in parameters are maintained.	X		
PG.196	Ability to allow the tracking of changes to the reference file using on-line notes capability.	X		
PG.197	Ability to maintain effective dates for all code sets.	X		
PG.198	Ability to add values or update any code set attributes.	X		
PG.199	Ability to maintain a map of procedure codes to diagnosis codes to define valid/invalid combinations.	X		
PG.200	Ability to maintain a map of 11-digit NDC codes to J-codes (i.e., Healthcare Common Procedure Coding System (HCPCS) Level II codes) through electronic updates.	X		
PG.201	Ability to associate National Drug Codes (NDCs) with their therapeutic indicators.	X		
PG.202	Ability to maintain an on-line cross-reference between HCPCS and International Classification of Diseases-10 (10th revision)-Clinical Modification (ICD-10-CM) procedure codes.	X		
PG.203	Maintain an on-line cross-reference between ICD-10-CM and DSM diagnosis codes and DSM diagnosis, including DSM age 0-3 diagnosis.	X		
PG.204	Ability to maintain a map of ICD-10 (International Classification of Diseases, version 10) surgical procedure codes to CPT (Current Procedural Terminology) procedure codes to apply claims processing functions based on the CPT code.	X		
PG.205	Ability to maintain a map of Revenue codes to CPT procedure codes to apply claims processing functions based on the CPT code.	X		
PG.206	**11. Maintain Benefit/Reference Information - Benefit Plans**			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.207	Ability to maintain the benefit plan data repository and ensure that data is captured, stored and maintained by program per BMS specifications.	X		
PG.208	Able to create and modify multiple benefit plans that define, identify and maintain separate service profiles under each program in accordance with policy.	X		
PG.209	Ability to maintain and update effective and end dates for all benefit plans.	X		
PG.210	Ability to provide standardized testing/modeling environment or tools to determine impact of modifications to the benefit plan(s) and/or any of its components.	X		
PG.211	Ability to easily add, delete, or modify benefit plan(s) and/or its related components.	X		
PG.212	Ability to automatically notify staff (as specified by BMS) of changes to health plans and/or related components (e.g., databases, modules, rules, etc.) and their effective dates.	X		
PG.213	Ability to allow an existing benefit plan and its associated components to be copied and renamed (to facilitate the creation of a new plan).	X		
PG.214	Ability to support a hierarchy of program rules to determine which program the claim will be paid.	X		
PG.215	**12. Maintain Benefit/Reference Information - Reference File Procedure Data Set**			
PG.216	Ability to maintain a Procedure Data Set which is expected to contain the following elements:	X		
PG.217	International Classification of Disease (ICD)-9/10-CM diagnosis and procedure codes	X		
PG.218	Approved versions of Health Common Procedure Coding System (HCPCS) procedure codes	X		
PG.219	Procedure code data status (active/inactive) code segments with effective begin and end dates for each segment	X		
PG.220	History of full descriptions for procedure codes	X		
PG.221	History of short descriptions for procedure codes	X		
PG.222	Effective and term dates for all items	X		
PG.223	Diagnostic Related Groups (DRG)	X		
PG.224	NDC drug codes	X		
PG.225	HIPAA mandated code sets	X		
PG.226	HL 7 LOINC code sets	X		
PG.227	Current Dental Terminology (CDT) procedure codes	X		
PG.228	Current Procedure Terminology (CPT) procedure codes	X		
PG.229	Indicators associated with selected parameters for use in claims processing (to determine include, exclude, disregard)	X		
PG.230	Multiple modifiers and the percentage of the allowed price applicable to each modifier	X		
PG.231	Revenue Center Codes (RCC)	X		
PG.232	Revenue Center Codes (RCC) should indicate if itemizations of HCPCS codes are required for claims processing and identify the list of valid/invalid HCPCS codes	X		
PG.233	Provider charge file legacy custom rates	X		
PG.234	Managed care program covered benefits exclusion plans	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.235	Relative value units	X		
PG.236	Edit/audit criteria and disposition tables	X		
PG.237	Business rules	X		
PG.238	Ambulatory Payment Classifications (APCs)	X		
PG.239	Base units for American Society of Anesthesiologists (ASA) codes	X		
PG.240	Coding values that indicate if a procedure is covered by Medicaid or other programs	X		
PG.241	Authorized specialty and taxonomy	X		
PG.242	Required Clinical Laboratories Improvement Amendments (CLIA) certification type	X		
PG.243	PA requirements (e.g., always required, sometimes required, never required)	X		
PG.244	Valid/invalid Place Of Service (POS) limitations	X		
PG.245	Recipient age/gender restrictions	X		
PG.246	Contraindicated edits	X		
PG.247	Pre and post-operative days	X		
PG.248	Once-in-a-lifetime indicator	X		
PG.249	Never events (TBD) HAC	X		
PG.250	Two digit place of service	X		
PG.251	Co-pay indicator, and associated data including the co-payment amount/per service unit and/or aggregate out-of-pocket co-payment thresholds for the service	X		
PG.252	Aid category, rate code, RAPIDS program code, or MAS/BOE code	X		
PG.253	Family planning indicator (method defined by BMS)	X		
PG.254	Emergency indicator	X		
PG.255	Claim type	X		
PG.256	Diagnosis code requirements including the list of valid/invalid diagnosis codes and if diagnosis is required (header/line) for claims adjudication	X		
PG.257	Units of service	X		
PG.258	Review indicator	X		
PG.259	Tooth number or letter	X		
PG.260	Tooth surfaces	X		
PG.261	EPSDT indicator	X		
PG.262	Anesthesia base values	X		
PG.263	Duplicate check	X		
PG.264	Indicator of TPL actions, such as cost avoidance, benefit recovery or pay, by procedure code.	X		
PG.265	Indication of MCO carve-outs	X		
PG.266	Procedures manually priced or manually reviewed	X		
PG.267	Limits of the procedure	X		
PG.268	Indication of non-coverage by third-party payers	X		
PG.269	Information such as accident-related diagnosis codes for possible TPL, Federal cost-sharing	X		
PG.270	Indicators for surgical, bi-lateral surgical, and endoscopy procedures	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.271	Indication of when or whether claims for the procedure can be archived from on-line history (such as once-in-a-lifetime procedures)	X		
PG.272	Payment Type (one-time, repetitive, invoiced)	X		
PG.273	Post-operative day(s) parameter used for determining bundling policy for surgical claims/visits	X		
PG.274	Indicate if referring Provider number is required for the procedure code	X		
PG.275	Indicate if multiple surgery pricing (based on the modifier) applies to the procedure code and the extent to which Multiple Surgery (MS) pricing is applicable (the MS rule followed by business rules, canned or customized to meet BMS needs)	X		
PG.276	Non-reportable indicator	X		
PG.277	**13. Maintain Benefit/Reference Information - Reference File Drug Data Set**			
PG.278	Ability to accommodate updates to the Drug Data Set from sources including: contracted drug data and pricing service; the CMS Drug Rebate file and future State rebate program updates; and updates from BMS staff as needed.	X		
PG.279	Vendor is expected to procure the Drug Reference database for use in claims processing.	X		
PG.280	Ability to import CMS drug rebate file and use it for claims processing as directed by BMS.	X		
PG.281	Provides a notification to BMS that drug code and pricing changes need manual review.	X		
PG.282	Automatically implements drug code and pricing changes upon approval of BMS.	X		
PG.283	Maintains current and historical coverage status and pricing information (including effective and termination dates) on legend drugs and Over The Counter (OTC) items.	X		
PG.284	Ability to maintain a Drug Data Set which is expected to contain the following:	X		
PG.285	Eleven digit NDC	X		
PG.286	Brand name	X		
PG.287	Generic name	X		
PG.288	Name of manufacturer and labeler codes	X		
PG.289	Add date	X		
PG.290	Begin date	X		
PG.291	Effective date	X		
PG.292	CMS termination date	X		
PG.293	Obsolete date	X		
PG.294	Specific therapeutic class codes and descriptions	X		
PG.295	Route of administration	X		
PG.296	Identification of strength, units, quantity, and dosage form (powder, vial, liquid, cream, capsule) on which price is based	X		
PG.297	Standard packaging indicators, size and description	X		
PG.298	Previous NDC	X		
PG.299	Minimum dosage units and days	X		
PG.300	Maximum dosage units and days	X		
PG.301	Generic indicator	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.302	Generic code number (GCN)	X		
PG.303	Generic sequence number (GSN)	X		
PG.304	DEA code	X		
PG.305	Unlimited date-specific pricing segments which include all prices needed to adjudicate drug claims records in accordance with BMS policy	X		
PG.306	Indicators for multiple dispensing fees	X		
PG.307	Identification of CMS Drug Rebate, Medical Assistance Administration (MAA) Rebate program status and corresponding dates	X		
PG.308	CMS unit of measure	X		
PG.309	Quantity field for pharmacy claims (allow for decimal units)	X		
PG.310	Indicators for controlled drug, over-the-counter (OTC)	X		
PG.311	DESI/LTE indicator (drug efficacy study index, less than effective)	X		
PG.312	Preferred drug list status	X		
PG.313	Indicators for schedule assigned to controlled drugs	X		
PG.314	Drug Utilization Review (DUR) functions (e.g., high dose, low dose, drug to drug interaction)	X		
PG.315	Date-specific, BMS-specific restrictions on conditions to be met for a claim to be paid including (but not limited) the following and any combinations thereof: maximum/minimum days supply; quantities; refill restrictions; preferred versus non-preferred indicators; recipient age/gender restrictions; prior authorization requirements; place of service for medical claims	X		
PG.316	Pricing indicators to accommodate the following reimbursement methodologies: Federal Upper Limit (FUL); State Maximum Allowable Cost (SMAC); Wholesale Acquisition Cost (WAC); Estimated Acquisition Cost (EAC); Average Wholesale Price (AWP); AWP-minus; WAC-plus; and other pricing methodologies as they become available	X		
PG.317	Other as identified by BMS during DDI and accepted via formal change control	X		
PG.318	**14. Maintain Benefit/Reference Information - Reference File Revenue Code File**			
PG.319	Ability to maintain a Revenue Code File with a code data set that contains at a minimum, the following elements:	X		
PG.320	Revenue code date-specific pricing segments, including, effective begin and end dates, and allowed amount for each segment	X		
PG.321	Revenue code status code segments with effective begin and end dates for each segment	X		
PG.322	Indicators associated with selected parameters to designate whether the code should be included, excluded, or disregarded in claims processing	X		
PG.323	Complete narrative descriptions of revenue codes.	X		
PG.324	Indication of TPL actions, such as cost avoidance, benefit recovery, or pay, by revenue code	X		
PG.325	Indication of non-coverage by third-party payers	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.326	Information such as accident-related indicators for possible TPL, Federal cost-sharing indicators, Medicare coverage, and allowed amounts	X		
PG.327	**15. Maintain Benefit/Reference Information - Reference File Pricing Data Set**			
PG.328	Ability to transmit and/or provide on-line inquiry access to pricing files for outside vendors and entities determined by the BMS.	X		
PG.329	Ability to configure the reference file to allow the same procedure code to be priced differently (e.g., based on age of consumer for the same date span).	X		
PG.330	Ability to adjust and maintain pricing data for all health plans and/or benefit packages and identify and calculate payment amounts according to rates and rules established by BMS for various categories of pricing methods, for claim types other than retail pharmacy claims, including:	X		
PG.331	Fee schedule	X		
PG.332	Maximum allowable fee per service (note: some situations require paying Federal portion of fees)	X		
PG.333	Percent of charge (billed amount) pricing	X		
PG.334	Multiple rates for all Providers and Provider types (as identified by BMS)	X		
PG.335	Interim and final rates, per Provider	X		
PG.336	Per diem rates for BMS-specified Provider types	X		
PG.337	Capitated rates for MCOs and PCCM services	X		
PG.338	Case-by-case pricing (by report, manually priced, etc.)	X		
PG.339	PA pricing fee schedule	X		
PG.340	PA pricing case-by-case	X		
PG.341	Enhanced or adjusted incentive payments as determined by BMS-defined pricing rules (e.g., dental pediatric incentive, HPSA pricing)	X		
PG.342	Per diem rates, assigned to each LTC Provider with a corresponding date span for pricing	X		
PG.343	Anesthesia pricing	X		
PG.344	LTC facility daily rate, room and board charges	X		
PG.345	LTC Prospective Payment System (PPS) rates	X		
PG.346	LTC nursing rate	X		
PG.347	Case mix adjusted rates for long term care facilities	X		
PG.348	Payment rates and effective dates for each rate, per facility	X		
PG.349	Consumer-specific pricing based on consumer location (i.e., hospice), monthly cost caps per consumer (i.e., for waiver programs)	X		
PG.350	Medicare pricing or payment rates	X		
PG.351	Procedure code modifier pricing	X		
PG.352	Drug cost plus dispensing fee per prescription	X		
PG.353	Different rates for transplants and organ acquisition costs	X		
PG.354	Assistant-at-Surgery pricing	X		
PG.355	Package size pricing	X		
PG.356	Individual consideration pricing (e.g., hospital outliers)	X		
PG.357	Ambulatory Surgical Center (ASC) group pricing as determined by BMS	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.358	VFC (Vaccines for Children program) pricing and rates by procedure code	X		
PG.359	National Drug Code (NDC) (used for pricing hospital claims)	X		
PG.360	Transportation pricing	X		
PG.361	Non-specified formula pricing, where non-specified formula pricing would refer to having a PA price a claim	X		
PG.362	Other as identified by BMS during DDI and accepted via formal change control	X		
PG.363	Ability to maintain the following hospital-specific inpatient and outpatient rate data, by effective date(s) including:	X		
PG.364	Inpatient DRG rate components	X		
PG.365	Inpatient and outpatient cost to charge ratios	X		
PG.366	Other hospital specific payment components such as per diems, percentages	X		
PG.367	Ability to accommodate multiple outpatient hospital reimbursement methodologies based on business rules provided by BMS, including:	X		
PG.368	Outpatient prospective payment	X		
PG.369	Per discharge/visit	X		
PG.370	Percent of charge	X		
PG.371	Fee-For-Service (FFS) procedure code prices for outpatient hospital care	X		
PG.372	Line level and revenue center code pricing	X		
PG.373	Other as identified by BMS during DDI and accepted via formal change control	X		
PG.374	Ability to accommodate multiple inpatient hospital reimbursement methodologies based on business rules provided by BMS, including:	X		
PG.375	DRG	X		
PG.376	Per discharge/visit	X		
PG.377	Per diem	X		
PG.378	Percent of charge	X		
PG.379	Line level and revenue center code pricing	X		
PG.380	Other as identified by BMS during DDI and accepted via formal change control	X		
PG.381	**16. Maintain Benefit/Reference Information - Reference File ICD-CM Coding Set**			
PG.382	Ability to maintain a Diagnosis set that utilizes ICD-CM coding sets. The diagnosis data set is expected to contain, at a minimum:	X		
PG.383	Age	X		
PG.384	Gender	X		
PG.385	Family planning indicator	X		
PG.386	Prior authorization indicator	X		
PG.387	EPSDT indicator	X		
PG.388	TPL trauma and emergency trauma codes	X		
PG.389	Inpatient length of stay criteria	X		
PG.390	Accident/trauma indicator	X		
PG.391	Begin date	X		
PG.392	End date	X		
PG.393	Add date	X		

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
PG.394	Description of the diagnosis	X		
PG.395	Primary and secondary diagnosis code usage	X		
PG.396	Indicators associated with selected parameters to designate whether they should be: included, excluded, or disregarded in claims processing	X		
PG.397	Covered	X		
PG.398	Not covered	X		
PG.399	Effective dates for all items	X		
PG.400	Indication of non-coverage for certain eligibility groups	X		
PG.401	Indication of non-coverage by managed care organizations	X		
PG.402	Cross reference to procedure codes	X		
PG.403	Performance, utilization, and program integrity reviews	X		
PG.404	Participation in Member care management	X		
PG.405	Other as identified by BMS during DDI and accepted via formal change control	X		

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
CM.1	**1. Manage Medicaid Population Health**			
CM.2	Ability to query both clinical and claims data for Members in both MCO and FFS populations in order to analyze performance of current programs and to conduct "what-if" analyses.	X		
CM.3	Ability to access and query data from other governmental entities (outside of BMS, including but not limited to HIE, HIX, and CMS) in order to:	X		
CM.4	Design and improve programs for potential as well as existing Medicaid Members	X		
CM.5	Coordinate decision-making and program development across agencies and offices in support of common care management goals	X		
CM.6	Query data and extract reports to analyze effectiveness of Medicaid dollars granted to other agencies/programs in support of care management goals	X		
CM.7	Provide training - BMS expects the Vendor to provide training in the use of data analysis and toolset for purposes of care management	X		
CM.8	Ability to use MMIS data to support population health analyses.	X		
CM.9	Ability to receive population health data from various external entities. Data should include:	X		
CM.10	Census data	X		
CM.11	Vital statistics	X		
CM.12	Immigration data	X		
CM.13	Public health data	X		
CM.14	Statewide Health Information Exchange	X		
CM.15	National Health Information Network	X		
CM.16	Other as identified by BMS during DDI and accepted via formal change control	X		
CM.17	Ability to track and maintain detail for population health initiatives, including:	X		
CM.18	Originator/source of inquiry	X		
CM.19	Data source/s used	X		
CM.20	Strategy (or strategies) developed in response to data analysis	X		
CM.21	Changes to benefits	X		
CM.22	Changes to reference data	X		
CM.23	Record of communication materials	X		
CM.24	Time period/case schedule of review	X		
CM.25	Other as identified by BMS during DDI and accepted via formal change control	X		
CM.26	The system should support the entry of free-form text field (number of characters as approved by BMS during DDI) associated with each request/analysis, including identification of user and date/time entered.	X		
CM.27	Ability to display free-form narrative in chronological or reverse chronological sequence.	X		
CM.28	**2. Establish Case**			
CM.29	Ability to automatically or manually populate, maintain and display multiple indicators at the Member level (e.g., disease state management, TBI, MR/DD).	X		

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
CM.30	Ability to use claims history information to support care management program eligibility determination (e.g., Disease Management and Disability Determinations).	X		
CM.31	Ability to use historical data to identify potential participants for specific programs, including historical data from the following:	X		
CM.32	Medicaid Waiver program case management - Home and Community Based Services (HCBS) and other	X		
CM.33	Disease management	X		
CM.34	Catastrophic cases	X		
CM.35	Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	X		
CM.36	Population management	X		
CM.37	Other as identified by BMS during DDI and accepted via formal change control	X		
CM.38	Ability to support flexible rules-based logic (as specified by BMS) to determine care management program eligibility criteria for:	X		
CM.39	Individual Member	X		
CM.40	Family	X		
CM.41	Target populations	X		
CM.42	Other as identified by BMS during DDI and accepted via formal change control	X		
CM.43	Ability to generate a high-cost Member report to determine potential participation in a care management program.	X		
CM.44	Ability to allow user to specify values/range of values when performing program participant data search. A user may limit values for any combination of the following:	X		
CM.45	Target population characteristics (e.g., Member age, location, specific medical conditions)	X		
CM.46	Data requirements (e.g., time period)	X		
CM.47	Data elements presented in reporting (e.g., procedure codes, diagnosis codes)	X		
CM.48	Other as identified by BMS during DDI and accepted via formal change control	X		
CM.49	Ability to identify clients of special or State-funded programs, such as waiver, case-management, Aging and Disability Services Administration (ADSA) programs, Health Resources and Services Administration (HRSA) programs, and other assistance programs, with effective dates and other data required by the State.	X		
CM.50	Ability to support flexible rules-based logic (as specified by BMS) to determine program/s appropriate for each Member.	X		
CM.51	Ability to track and maintain Member treatment (care) plans and Health Improvement Plans, including the following detail:	X		
CM.52	Member detail (name, ID, etc.)	X		
CM.53	Identifies care needs as specified in the Health Improvement Plan	X		
CM.54	Care Management Program (e.g., EPSDT, Disease Management)	X		
CM.55	Provider type/s	X		
CM.56	Provider detail of Provider/s associated with case (name PIN, contact info, etc.)	X		

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
CM.57	Patient-Centered Medical Home (PCMH)	X		
CM.58	Program starting and end dates	X		
CM.59	Care setting	X		
CM.60	Services to be delivered	X		
CM.61	Services delivered detail (including cost & date)	X		
CM.62	Frequency of service/s	X		
CM.63	Expected results	X		
CM.64	Review detail, including dates	X		
CM.65	Other as identified by BMS during DDI and accepted via formal change control	X		
CM.66	Ability to provide role-based access (defined by BMS) to Member treatment plans.	X		
CM.67	Ability to close the program case and automatically notify* appropriate parties (including Member and Provider) if the Member chooses not to enroll in the care management program. *(BMS to determine notification method; may include letter or e-mail.)	X		
CM.68	Ability to set a program maximum number of unduplicated participants (as specified by BMS) for care management programs.	X		
CM.69	Ability to create a waiting list when the maximum number of unduplicated participants has been reached for a program.	X		
CM.70	Ability to automatically generate a notice/alert (defined by BMS) when number of unduplicated participants enrolled in a program exceeds the specified maximum.	X		
CM.71	Ability to automatically generate a notice/alert (defined by BMS) when unduplicated enrollment reaches a BMS-specified percentage of maximum enrollment.	X		
CM.72	Ability to manually override program maximum enrollment.	X		
CM.73	**3. Manage Case**			
CM.74	Ability to track and report the number of unduplicated participants in all care management programs.	X		
CM.75	Ability to accept and update care management screening data fields from claim and encounter data at least weekly.	X		
CM.76	Ability to track and maintain program Provider qualification requirements for each care management program.	X		
CM.77	Ability to match the care management periodicity schedule with FFS billing, managed care encounter data, and Health Outcome Measures.	X		
CM.78	Ability to automatically deny participation for Providers not meeting care management program qualification requirements.	X		
CM.79	Ability to monitor program data to determine if the services approved in the plan of care are provided.	X		
CM.80	Ability to provide on-line role-based access (as assigned/decided by BMS) to case management data, including:	X		
CM.81	Program data and imaged documentation	X		
CM.82	Member information (e.g., hospitalizations, LTC facility, pharmacy, PA information, State Plan services)	X		
CM.83	Claims data	X		
CM.84	Historical case, claims and enrollment data	X		

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
CM.85	Eligibility information	X		
CM.86	Benefit packages	X		
CM.87	Provider information (e.g., outpatient services, waiver services by type, waiver services by Provider and by Member)	X		
CM.88	Case notes	X		
CM.89	Case activity codes	X		
CM.90	Other as identified by BMS during DDI and accepted via formal change control	X		
CM.91	Ability to search on-line care management data (according to role-based access defined by BMS) by any of the following: Member name, Member ID, and/or Provider ID.	X		
CM.92	Ability to provide Case Managers role-based access (as assigned/decided by BMS) to case management data. Case Managers can be defined as any of the following:	X		
CM.93	BMS staff	X		
CM.94	Nurses	X		
CM.95	Other State agencies	X		
CM.96	Contractors	X		
CM.97	Social workers	X		
CM.98	Other entities as defined by BMS	X		
CM.99	Ability to maintain Member-level EPSDT records with functionality that:	X		
CM.100	Includes user configurable periodicity schedules	X		
CM.101	Maintains tracking data, by Member, including notification and screening dates, screening results, referral details	X		
CM.102	Stores summary and detail EPSDT activities and services		X	
CM.103	Generates initial and follow-up EPSDT notices, based on periodicity schedules	X		
CM.104	Track immunization records and status for children from birth to age eighteen (18)	X		
CM.105	Track services provided as a result of EPSDT	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.1	**1. General/Technical**			
POS.2	Ability to provide a system capable of easy modifications and updates based on current technology to insure integrity and drug coverage within BMS guidelines.	X		
POS.3	The Pharmacy POS is expected to support all pharmacy functions, files and data elements necessary to meet the requirements in this RFP.	X		
POS.4	Ability to maintain an easy to read audit trail of all database changes/updates accessible through online inquiry, with a date, time, reason and user ID.	X		
POS.5	Ability to support the following inputs:	X		
POS.6	Claims history data	X		
POS.7	Member data	X		
POS.8	National Provider Identifier (NPI) validation	X		
POS.9	Provider data	X		
POS.10	Reference file data	X		
POS.11	Drug utilization review (DUR) reporting parameters	X		
POS.12	National Council on Prescription Drug Program (NCPDP) Version 5.1, and batch Version 1.1, or the most current HIPAA compliant version of electronic claims and hard copy submitted claim information	X		
POS.13	HIPAA compliant electronic Prior Authorization requests and hard copy Prior Authorization requests, to include an automated prior authorization process using NCPDP Standards (Version 5.1 and any future releases). Currently, BMS uses an automated prior authorization process through the services of a vendor using NCPDP P1-P4 transactions. Requests for drugs not included in the auto PA process could be submitted electronically via the Web Portal to the current drug prior authorization services vendor that receives them into its automated fax system.		X	
POS.14	Online prescription data from Providers for Prospective Drug Utilization Review (ProDUR)	X		
POS.15	Automated preferred drug data file updates	X		
POS.16	ProDUR criteria	X		
POS.17	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.18	The Vendor is expected to maintain and update the Pharmacy Provider file, including (at a minimum) the following fields: the pharmacy NPI; pharmacy Provider type and pharmacy specialty, pharmacy physical address, fax, and phone numbers; and others as defined by BMS during DDI.	X		
POS.19	Ability to perform print screen on all Pharmacy POS screens directly from the system.	X		
POS.20	Ability to link to specific information (e.g., Provider, Member, Drug, PA, etc.) within and across data fields as specified by BMS (for example, drill-down capability among Prescriber, Provider, Member, etc.).	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.21	Provide a free-form memo field (number of characters as approved by BMS during DDI) associated with drug reference file maintenance. Each entry is expected to include identification of user and date/time entered.	X		
POS.22	The system should support ad hoc reporting on the memo field based on criteria as defined by BMS (e.g., type of memo, user and date range).	X		
POS.23	The Pharmacy POS is expected to maintain batch controls and audit trails on all pharmacy claims processing activities.	X		
POS.24	The Pharmacy POS is expected to assign a unique control number to every claim at the time when the record is processed.	X		
POS.25	The Vendor should store electronic record of every claim and attachment at the Vendor site in accordance with the BMS Data Retention Policy.	X		
POS.26	The Pharmacy POS is expected to have the ability to identify those individuals who performed a force or override on an error code.	X		
POS.27	The Pharmacy POS is expected to provide audit trail capabilities for any changes to the system.	X		
POS.28	Ability to set minimum and maximum quantity limits on each drug with no additional charge.	X		
POS.29	At a minimum, ability to support paid, denied, duplicate pay, duplicate reverse, rejected, reversed and rejected reversed claims.	X		
POS.30	**2. General/Technical - Help Desk & User Support**			
POS.31	The Vendor is to supply a POS Pharmacy Help Desk dedicated to the West Virginia account. (The current pharmacy POS clinical prior authorization services vendor is expected to continue to provide drug prior authorization services only, under a separate contract. The Vendor is expected to assume the POS Pharmacy Help Desk role and processes).	X		
POS.32	The system should support a notes functionality -- in regard to help desk activity	X		
POS.33	Ability to provide secure online access to current, updated source documents, Vendor developed policy/procedure manuals, system documentation, Provider manuals and forms for contract and BMS staff, including document search capabilities.	X		
POS.34	Ability to store current, updated source documents, Vendor developed policy/procedure manuals, system documentation, Provider manuals and forms in electronic format accessible via PC workstation.	X		
POS.35	**3. General/Technical - Inputs/Interfaces**			
POS.36	All claims data from the Pharmacy POS system should be passed by an interface file to the MMIS (on a schedule determined by BMS) for reporting, payment and remittance voucher generation.	X		
POS.37	Ability to allow the Pharmacy POS real-time access to Pharmacy and Medical/Dental claims databases.	X		
POS.38	Ability to support interfaces with external systems, including (but not limited to):	X		
POS.39	Retro DUR vendor	X		
POS.40	DSS/DW (Decision Support System/Data Warehouse)	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.41	CMS and/or their agents	X		
POS.42	Commercial drug file vendor	X		
POS.43	Other as identified by BMS during DDI and accepted via formal change control (the Vendor is expected to exhibit a willingness to support BMS defined interfaces)	X		
POS.44	Ability to support the following online processing of pharmacy claims through networks provided by contracted switch vendors:	X		
POS.45	Transmission and online real-time processing of pharmacy claims	X		
POS.46	Real-time access to Member and Provider eligibility information	X		
POS.47	Prior Authorization processing	X		
POS.48	Third Party Liability (TPL) processing and response	X		
POS.49	Respond to Drug Utilization Review (DUR) alerts	X		
POS.50	Notification of co-payment requirements	X		
POS.51	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.52	Pharmacy POS should support an eligibility transaction through network Providers to provide or support Provider queries on eligibility. (The POS should support NCPDP eligibility request transactions).	X		
POS.53	**4. Drug File**			
POS.54	The Pharmacy POS drug file is expected to have the capability to indicate preferred drug status.	X		
POS.55	The Pharmacy POS drug file is expected to have the capability to indicate prior authorization requirements.	X		
POS.56	Ability to develop, implement and maintain the BMS's customized drug database.	X		
POS.57	Ability to, at a minimum, support all data elements provided by a commercial drug file vendor for each drug. (BMS prefers the vendor use First DataBank (FDB) and the AWP pricing file from Medispan. Currently, all clinical and therapeutic policies are based on FDB nomenclature, while AWP pricing is supported by using Medispan file.	X		
POS.58	Ability to maintain a master drug data file, which contains an entire list of products available including legend and Over the Counter (OTC) drugs, as well as others as specified by the BMS.	X		
POS.59	Ability to maintain, at a minimum, all standard drug-specific data elements used by pharmacy claims processors and the BMS-specific data elements.	X		
POS.60	Ability to provide for electronic update of the drug database from a commercial drug file vendor on at least a weekly basis or as directed by the BMS. (BMS does not expect to be purchasing/leasing the commercial drug file. The Vendor is expected to be responsible for this contract. First DataBank is the current vendor and Medispan's AWP pricing file was added in September 2011).	X		
POS.61	Ability to overwrite data transferred from commercial drug file vendor.	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.62	The Pharmacy POS is expected to have the ability to protect manual changes from automatic updates from the drug database vendor.	X		
POS.63	Ability to allow user-defined Drug file data elements in addition to those provided by commercial drug file vendor.	X		
POS.64	Ability to provide online, real-time update capability for changes to specific drug codes on the database at the direction of the BMS.	X		
POS.65	Ability to manually update term dates of drugs.	X		
POS.66	Ability to provide the BMS online inquiry window access to the Master Drug Data files, and access to pending changes that are to be used to update the Master Drug Data files.	X		
POS.67	Ability to view all database elements that are found in the drug file records.	X		
POS.68	Ability to provide an automated audit trail system to document reference database changes approved by the BMS, as well as documentation of the change and the reason for change.	X		
POS.69	Ability to maintain history of the deleted NDCs from the drug reference file.	X		
POS.70	Ability to generate report of changes made on Drug Reference File (including date of change), including date, time, reason and user ID.	X		
POS.71	Ability to import the CMS drug file and reconcile with the drug database file according to BMS established criteria. (BMS expects that drug termination dates, DESI information, and rebate status published by CMS are used/considered when processing POS claims. BMS expects that CMS' data, when different from the drug file data, would overlay the drug file data, if approved by BMS. BMS expects there to be an automated process for applying this data).	X		
POS.72	**5. Claims Processing - General**			
POS.73	Ability to provide and maintain a pharmacy claims processing system with the capability to process electronic and paper transactions.	X		
POS.74	Ability to monitor and track all claims processing activities.	X		
POS.75	Ability to process all claims in a real-time mode via POS technology.	X		
POS.76	Ability to allow system users to define which fields are displayed as part of a POS claim screen.	X		
POS.77	The Pharmacy POS is expected to support the universal claim form for paper submittals.	X		
POS.78	Ability to provide a system to process paper claims (including those with attachments if allowable by NCPDP) and maintain edits and audits identical to those in the POS system.	X		
POS.79	Ability to accept DEA on paper claim (either NPI or DEA is acceptable as a prescriber identifier on paper only).	X		
POS.80	Ability to support multiple transactions within 1 transmission from a Provider, based on current NCPDP standards.	X		
POS.81	On-line access to Member claim profile information that includes, but not be limited to:	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.82	Drugs with descriptions	X		
POS.83	Narrative denial reasons	X		
POS.84	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.85	Ability to limit benefits on a Member-by-Member basis (i.e., individual member basis), per BMS approval, for limitations such as therapeutic categories, optional services and others defined as BMS.	X		
POS.86	The Pharmacy POS should respond with reject codes for each transaction within a transmission as defined by NCPDP standard.	X		
POS.87	Ability to deny any claim without valid eligibility information on file.	X		
POS.88	Ability to verify Member eligibility using demographic data as determined by BMS.	X		
POS.89	Ability to identify Medicaid vs. Non-Medicaid Members.	X		
POS.90	Ability to support a pharmacy lock-in capability for each Member when necessary. Lock-in to one pharmacy Provider.	X		
POS.91	Ability to support a customizable prescriber lock-in capability for each Member when necessary. Lock-in to one prescribing Provider for certain therapeutic classes.	X		
POS.92	Ability to capture and display HMO plan information (fields for display to be defined by BMS).	X		
POS.93	Ability to edit all FFS claims submitted for Members identified to have third-party coverage, including Medicare, according to BMS policies.	X		
POS.94	Ability to process claims when Date of Service does not exceed 12 months from the date the prescription was written.	X		
POS.95	Ability to set a maximum day supply as defined for BMS.	X		
POS.96	Ability to allow exceptions to the maximum day supply.	X		
POS.97	Ability to support the current NCPDP standard "Reversal" message which is to effectively 'debit' the named claim.	X		
POS.98	**6. Claims Processing - Edits/Audits**			
POS.99	Ability to process pharmacy claims, at a minimum, using all edits currently defined by the BMS.	X		
POS.100	The Pharmacy POS should perform real-time edit/audit processing.	X		
POS.101	Ability to modify edits and audits as necessary or as defined by the BMS when policy or coverage changes are implemented.	X		
POS.102	Ability to perform adjudication of unique claims (i.e. by-pass edits/audits) as specified by the BMS.	X		
POS.103	Ability to deny or override claim edits and audits in accordance with BMS determined guidelines.	X		
POS.104	Ability to identify and exclude from coverage certain National Drug Code (NDC) numbers as required by the BMS.	X		
POS.105	Ability to restrict a Provider to specific drugs they can prescribe (in accordance with BMS-specified list defined during DDI).	X		
POS.106	Ability to exclude prescriber NPIs when the OIG (Office of Inspector General) or BMS has determined they are ineligible for participation.	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.107	Ability to limit dollar amounts as defined by BMS.	X		
POS.108	Ability to provide an edit to alert pharmacies when incorrect units are billed for drugs based on package size including those with decimals.	X		
POS.109	Ability to edit controlled substance claims in accordance with Federal regulations.	X		
POS.110	Ability to limit coverage by age, gender, quantity, and edits going backwards and forwards, and other as determined by BMS.	X		
POS.111	Ability to apply the Federal rebate requirements.	X		
POS.112	Ability to approve for payment exceptions to the Federal rebate requirements as defined by BMS.	X		
POS.113	Ability to edit and deny on certain NDC levels or therapeutic classes for drugs contraindicated during pregnancy.	X		
POS.114	Ability to limit drugs based on diagnosis or drug history.	X		
POS.115	All brand name multi-source drugs, which have a therapeutically equivalent generic available, should be denied for payment. A suitable generic drug is to be substituted, unless the Dispense as Written (DAW) is submitted per BMS guidelines.	X		
POS.116	Ability to recognize a preferred brand and not require the submission of a DAW code, as determined by BMS.	X		
POS.117	Ability to allow the BMS to define use criteria for use of DAW codes.	X		
POS.118	**7. Claims Processing - Benefit Plans**			
POS.119	Ability to configure claims processing benefit plans, as defined by the BMS.	X		
POS.120	Ability to process pharmacy claims using plan limitations as defined on the date of service.	X		
POS.121	Ability to support limits on scripts per month following benefit coverage rules (as defined by BMS).	X		
POS.122	Ability to apply, at the minimum, the primary, secondary coverage hierarchy (as defined by BMS) to claims processing.	X		
POS.123	Ability to block coverage of a benefit for certain Members as determined by BMS.	X		
POS.124	**8. Claims Processing - Coordination of Benefits (COB)/Third Party Liability (TPL) Requirements**			
POS.125	Ability to deny any claim that should be submitted for Medicare payment first (where the Member is identified as Medicare eligible).	X		
POS.126	Ability to allow Providers to submit a third party's carrier identification number and plan/policy numbers for insurance carriers not listed on the Member eligibility file. (BMS currently contracts with a vendor that uses the POS information to research unreported TPL. Once identified, the vendor updates the BMS eligibility files. BMS may identify other methods of collecting eligibility information in the future).	X		
POS.127	Ability to edit to ensure that TPL has been satisfied in accordance with BMS policies.	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	Description of Requirement	YES without custom-ization	YES with custom-ization	NO unable to provide
POS.128	Pharmacy POS Coordination of Benefits (COB) for pharmacy claims is expected to be able to deny a claim when other insurance or Medicare coverage is present.	X		
POS.129	Ability to accept TPL information in a submitted claim, per NCPDP standards.	X		
POS.130	Capable of tabulating the one or more TPL payments towards the Medicaid cost of the claim.	X		
POS.131	Ability to not wrap around the Medicare Part D Benefit. (Wrap around references payment of drugs not covered by Part D plan formularies. BMS does not pay any Medicare Part D copayment or cover any drugs not covered by Part D plan formularies, other than the CMS defined list of drugs that are excluded by Part D and remain the responsibility of Medicaid).	X		
POS.132	Ability to capture the reject reason for the denial by the primary payer.	X		
POS.133	Ability to recognize the co-payment requirement from the primary insurance and calculate the Medicaid payment per BMS requirements.	X		
POS.134	Ability to deny hospice claims unless for a non-hospice covered drug. Hospice is considered a third-party payer.	X		
POS.135	Ability to support reject codes submitted from a Provider for each TPL submitted per NCPDP standard.	X		
POS.136	**9. Claims Processing - Compounds Requirements**			
POS.137	Ability to support the requirement that at least one ingredient is a covered legend drug.	X		
POS.138	Ability to edit for PA and quantity limits, and other edits as required by BMS, for each line of the compound.	X		
POS.139	Ability to pay a compound claim whose ingredients may include a non-allowable NDC; OTC priced at lowest determined cost; DME items and non-rebate drugs priced at $.00.	X		
POS.140	Ability to support processing of compounds containing up to 25 ingredients per prescription.	X		
POS.141	Ability to price compound ingredients based on the individual prices of each ingredient quantity contained in the compound.	X		
POS.142	A compound drug containing a DESI (also known as Less than Effective Drug Efficacy Study Implementation -- LTE DESI) ingredient should be denied. (All drugs that are CMS DESI 5 or 6 designation should be denied for payment when billed as a single ingredient or if billed as an ingredient in a compounded prescription).	X		
POS.143	**10. Claims Processing - Refills**			
POS.144	Ability to limit the number of 3 day Emergency fills during the life of a prescription as specified by a configuration parameter.	X		
POS.145	Ability to enforce 11 refills per prescription within 12 months resulting in a total of a maximum of 12 fills in 12 months (for non-controlled substances)	X		
POS.146	Ability to enforce 5 refills per prescription within 6 months for controlled substances.	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.147	Ability to enforce early refill limits using different percentages of supply used across different drug categories as determined by BMS.	X		
POS.148	Ability to restrict replacement lost/stolen drugs in order to disallow the pharmacy to enter override code per BMS policy. Current BMS policy requires a call to the help desk for approval.	X		
POS.149	**11. Drug Utilization Review (DUR)**			
POS.150	Ability to provide and support point-of-sale with prospective DUR edits.	X		
POS.151	Ability to use existing Medicaid Member pharmacy claim history records to evaluate the current prescription for possible interactions between the patient's active history prescriptions and the drug being currently prescribed.	X		
POS.152	Ability to use ProDUR communications that comply with current specifications used in NCPDP Version 5.1 or the most current HIPAA compliant version.	X		
POS.153	Ability to provide online access to Prospective Drug Utilization Review (ProDUR) criteria/screening data files.	X		
POS.154	Ability to support the following requirements for ProDUR:	X		
POS.155	Support an edit process that should be parameter or table-driven and be flexible	X		
POS.156	Provide the capability to update system parameters without complex programming within one (1) business day of receipt of request	X		
POS.157	Provide BMS users with role-based access to DUR data (on-line) for the purpose of displaying module groupings (therapeutic classes), dosing, and other criteria used for editing.	X		
POS.158	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.159	**12. Drug Utilization Review (DUR) - Claims Review**			
POS.160	The DUR Clinical Modules should be configurable and customizable and provide edits per BMS policy. The modules should include (at a minimum):	X		
POS.161	Drug Drug Interaction (DD)	X		
POS.162	Therapeutic Duplication (TD)	X		
POS.163	Ingredient Duplication (ID)	X		
POS.164	Early Refill (ER) if applicable	X		
POS.165	Pregnancy Precaution (PG)	X		
POS.166	High Dosage (HD)	X		
POS.167	Maximum Duration (MX)	X		
POS.168	Breastfeeding Precaution (SX)	X		
POS.169	Low Dosage (LD)	X		
POS.170	Late Refill (LR)	X		
POS.171	Drug/Allergy alerts	X		
POS.172	Ingredient/therapeutic duplication crossover	X		
POS.173	Other as identified by BMS during DDI and accepted via formal change control	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.174	RxDUR should have capability to modify the ON/OFF status of clinical modules. (BMS expects the Vendor's solution to have the flexibility to set to "ignore" status such DUR edits as late refill or pregnancy for certain therapeutic classes, but be able to apply them to other therapeutic classes. An example is to deny ACE inhibitors for members who are pregnant, but do not deny Penicillins for members who are pregnant).	X		
POS.175	Ability to implement a ProDUR system using online real-time intervention at the POS with clinical edits to detect, at a minimum, maximum/minimum daily dosages for all applicable NDCs.	X		
POS.176	Ability to capture and store chronic disease states in the Member file.	X		
POS.177	**13. Drug Utilization Review (DUR) - Alerts & Overrides**			
POS.178	Ability to display multiple POS messages as a return response to the billing Provider.	X		
POS.179	Ability to user-define text of messages to be returned to pharmacies.	X		
POS.180	Ability to user-define business rules which allow different messages under different circumstances.	X		
POS.181	Ability to apply alerts according to BMS specifications.	X		
POS.182	For each alert/denial, the ability to include, at a minimum, the following information (to the Provider):	X		
POS.183	Alert conflict type (e.g., drug allergy alert)	X		
POS.184	Alert severity (e.g., minor, major, etc.)	X		
POS.185	Available data related to the alert (e.g., other drug or condition in conflict).	X		
POS.186	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.187	Ability to support a role-based override capability for all edits.	X		
POS.188	Ability to support special situations where State/Federal programs/exceptions exist with "soft edits" to allow Provider override.	X		
POS.189	Ability to support "hard edits" to prevent Provider override.	X		
POS.190	Ability to support a special "BMS Management Override" for paper claims where normal editing is bypassed.	X		
POS.191	Ability to require the Provider to enter codes for actions taken in response to the drug interaction alerts/warnings and the outcomes of those actions in accordance with NCPDP response codes. The system should maintain these acknowledgment codes in history, as well as report them when requested by the BMS.	X		
POS.192	Ability to user-define additional text to accompany standard NCPDP DUR reject codes and their associated return messages.	X		
POS.193	Ability to edit against data elements in a Provider file of the prescriber identified in the prescriber ID field of a submitted claim for the purpose of overriding or producing claim (e.g., not requiring PA for scripts written by certain doctors, or denying a claim within a certain drug class when written by a specific prescriber).	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.194	Ability to override PA/Electronic Prior Authorization (EPA) requirement based on submitted diagnosis code or previously recorded chronic disease regardless of the claim type the diagnosis was submitted on.	X		
POS.195	Ability to produce a report, upon request, listing all ProDUR alerts encountered for specified Members, Providers, and/or prescribers.	X		
POS.196	Ability to systematically by-pass or suppress Pro-DUR alerts based on prescriber/Provider/Member/program and/or drug file parameters as defined by the BMS.	X		
POS.197	**14. Drug Utilization Review (DUR) - Default Screening**			
POS.198	The initial values for DUR Default Screening Parameters page should be set as specified by the BMS.	X		
POS.199	Capability for modification of the default Screening Parameters.	X		
POS.200	Ability to rank the severity of adverse events.	X		
POS.201	Ability to modify the ranking of Severity Events.	X		
POS.202	Ability to establish initial Severity Rankings as specified by the BMS.	X		
POS.203	Ability to reject claims when certain drug combinations are used (as defined by BMS).	X		
POS.204	Capability of posting or not posting DUR events to the Provider, as determined by BMS.	X		
POS.205	**15. Drug Utilization Review (DUR) - Reporting**			
POS.206	Ability to generate the following reporting:	X		
POS.207	Alerts/claims denials by reason (e.g., therapeutic duplication, drug/drug interaction, excessive utilization)	X		
POS.208	Cost saving and cost tracking reports (e.g., savings amounts, co-pays).	X		
POS.209	Drug file update reporting (e.g., therapeutic class, update descriptions, low/high dose criteria)	X		
POS.210	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.211	**16. Prior Authorization (PA) - Processing**			
POS.212	Ability to process PAs using the NCPDP standard guidelines. (Full support of processing PAs using NCPDP Standards is desired. BMS acknowledges that most PA requests currently are included with claims submission. However, the proposed solution should reach into the future and should support D.0 and any subsequent version during the life of the contract).	X		
POS.213	Ability to utilize prior authorization information in claims processing.	X		
POS.214	Ability to approve a 3-day Emergency Fill without a Prior Authorization. This fill should not count towards the refill count of the prescription. (A 3-day supply of medications is allowed to be dispensed to members for drugs that require prior authorization, per Federal regulations. The current system allows a 3-day supply to be processed using NCPDP standard codes).	X		
POS.215	Ability to provide edits in the claims processing system to identify drugs requiring prior authorization.	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.216	Ability to integrate with the BMS Prior Authorization call center vendor (Currently the PA Vendor enters drug prior authorization records directly into the POS system. The Vendor is expected to provide this functionality to the PA Vendor and to provide support to the PA Vendor for the PA module).	X		
POS.217	Ability to automatically generate and track prior authorization using a unique identifier.	X		
POS.218	Ability to maintain prior authorization at the eligibility group level, program or plan (i.e., prior authorization criteria should be applied to different defined groups. BMS currently has the capability to apply PA criteria to different drugs, within different eligibility plans. Example: Drug X requires PA for Medically Needy. Drug X does not require PA for ADAP).	X		
POS.219	Ability to edit for Prior Authorization in accordance with BMS policies and guidelines. (Prior authorization criteria is currently applied to different defined groups. BMS currently has the capability to apply PA criteria to different drugs, within different eligibility plans. Example: Drug X requires PA for Medically Needy. Drug X does not require PA for ADAP. On the Med/Dent side, PA criteria policies and guidelines are contained in the Provider Manuals).	X		
POS.220	Ability to maintain a map of NDC code, where the map would be provided by BMS or designee, to diagnosis code to edit for valid/invalid combinations. (There is no current mapping of NDCs and diagnostic criteria. In the future, BMS desires this capability in order to allow certain drugs to process only if the pharmacy enters an appropriate diagnosis code approved by BMS).	X		
POS.221	Ability to set PA requirements at various BMS determined levels (e.g., NDC, therapeutic class).	X		
POS.222	Ability to administer prior authorization processing in a real-time mode.	X		
POS.223	Ability to accept online real-time entry and update of prior authorization requests. (The current pharmacy POS clinical prior authorization services vendor has access to the POS PA module and enters PA information directly into the pharmacy processing system).	X		
POS.224	Ability to deny claims where the NDC is not covered. (Even though a PA is indicated at the BMS-specified level, the NDC is checked to see if it is a covered drug.)	X		
POS.225	Ability to apply the PA requirements effective on the date of service.	X		
POS.226	Ability to match the prior authorization to the claim. The Pharmacy POS should not always require that a Provider submit a PA number before processing a POS claim.	X		
POS.227	Ability to allow BMS to specify criteria for requiring the Provider to supply a PA number before the transaction may be processed. (In the current system, providers do not have to enter a PA number when submitting a POS claim. However, the current system can require a PA number should BMS wish to require the PA number. Providers obtain the PA numbers manually).	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.228	Ability to support emergency PA capability (as defined by BMS, using NCPDP standards). (This requirement is the same as a 3-day emergency fill for drugs that require a prior authorization).	X		
POS.229	Ability to provide a mechanism for the Vendor and the State to enter Prior Authorization data, based on role-based security as determined by BMS.	X		
POS.230	Ability to provide on-line access to all prior authorization information.	X		
POS.231	Ability to accept on-line, real-time entry and update of PA determinations.	X		
POS.232	Ability to utilize prior authorization restrictions to include, but not limited to:	X		
POS.233	Drug data (e.g., NDC (9 to 11 digits), HIC, GCN sequence)	X		
POS.234	Member data	X		
POS.235	Provider data	X		
POS.236	Day specific, or span dates of the prior authorization	X		
POS.237	Frequency restrictions	X		
POS.238	Dollar/unit dispensing limitations (the POS should have the ability to limit prescriptions based on a dollar threshold amount and to limit prescriptions based on dispensed units)	X		
POS.239	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.240	Ability to link to eligibility data when reviewing the PA request.	X		
POS.241	Ability to automatically identify and update active or pended PA records when a reference file has been updated (e.g., drug code, drug category). (Claims are not pended in the Pharmacy POS system. BMS expects the POS system to be capable of updating the PA parameter (generic sequence number, generic code, etc) when the drug file changes the parameter, so that PA requirements and processing are maintained).	X		
POS.242	Ability to require and process PA for service to Member in LTC. (The same level of editing/auditing that are done for pharmacy claims outside of a LTC, but the LTC would be a separate eligibility group with distinct PA requirements).	X		
POS.243	Ability to "grandfather" Members on identified services when a new PA requirement is identified. (BMS currently uses a Preferred Drug List. In the past, it has been desired to allow current users of a drug to continue, but new users require a prior authorization. An example is Zyprexa. Current users were allowed to continue to receive this drug, but new users were required to receive a prior authorization for coverage of the drug).	X		
POS.244	Ability to add back the unused units if a claim is reversed	X		
POS.245	Ability to generate denial notices to Members.	X		
POS.246	**17. Prior Authorization - Automated Prior Authorization**			
POS.247	Ability to provide automated approval of authorizations based upon any Federal, State, and BMS policy and guidelines, for use in determining if pre-established criteria for selected drugs have been met. The data queried is expected to include diagnosis codes, procedure codes and pharmacy claims data (for both fee-for-service and encounter data).	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.247a	Ability to provide an integrated automated prior authorization system which can incorporate Federal, State and BMS policy and guidelines and determine if pre-established criteria for selected drugs has been met through a review of historical claims data. The data should include pharmacy claims, medical claims and diagnosis codes.	X		
POS.247b	Ability to automatically adjudicate claims for drugs requiring prior authorization for which criteria has been met.	X		
POS.247c	Ability to send a message to the Prior Authorization Help Desk to request manual review of claims for drugs not meeting criteria for automatic approval. The Prior Authorization Help Desk should have access to the prior authorization criteria and steps performed in the automated PA review process.		X	
POS.248	Ability to search up to twenty-four (24) months of member pharmacy and medical claims and diagnosis codes. (Medical claims should include out-patient visits, in-patient admissions and procedure codes).	X		
POS.249	Ability to identify and retain once-in–a lifetime codes (such as hysterectomy, etc.) as identified by BMS for review in prior authorizations.	X		
POS.250	Ability to provide table-driven criteria that is customized and can be adapted within at least ten (10) days of BMS' request to meet changes in pharmacy policy and criteria updates.	X		
POS.251	Ability to provide data analysis tools and analysis by the MMIS Vendor on an ongoing basis to identify clinical and utilization issues that may warrant new screening criteria.	X		
POS.252	Ability to perform automated prior authorization review while meeting POS system performance metrics requirements for the adjudication of claims.	X		
POS.253	**18. Pricing**			
POS.254	Ability to price all claims in accordance with BMS policies and guidelines.	X		
POS.255	Ability to accommodate and calculate payments applying various co-pay/cost sharing arrangements as defined or approved by the BMS.	X		
POS.256	Ability to pay different dispensing fees based on criteria established by the BMS.	X		
POS.257	Ability to support a Medicaid AWP (average Wholesale Price - Department of Justice) pricing methodology	X		
POS.258	Ability to enforce the reimbursement of only one dispensing fee per drug entity, per Member, per calendar month for Long Term Care (LTC) patients.	X		
POS.259	Ability to apply selected pricing methods for each claim payment and display in the claim record what method was used to determine final payment amount up to, but not to exceed, final claim charge.	X		
POS.260	Ability to display on a denied claim the pricing method that would have been used and the amount of the claim if it would have paid.	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.261	**19. Pricing - Pricing Formulas**			
POS.262	Ability to utilize industry standard pricing including, at a minimum:	X		
POS.263	AWP (Average Wholesale Price)	X		
POS.264	Medicaid AWP (average Wholesale Price - Department of Justice)	X		
POS.265	SMAC (State Maximum Allowable Cost)	X		
POS.266	WAC (Wholesale Acquisition Cost)	X		
POS.267	ASP (Average Sales Price)		X	
POS.268	FUL (Federal Upper Limit)	X		
POS.269	Direct price pricing where appropriate	X		
POS.270	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.271	Ability to apply pricing algorithms to determine which of several pricing methods (such as AWP-14%, AWP-50%, SMAC, FMAC, etc.) are applicable to a specific NDC and determine which method yields the lowest net cost.	X		
POS.272	Compound prescriptions are to be reimbursed with an additional $1.00 Dispensing Fee.	X		
POS.273	Ability to manage the 340-B pricing as defined by BMS.	X		
POS.274	Ability to support different dispensing fees to different types of pharmacies as defined by BMS.	X		
POS.275	Ability to support a DAW 1 code and reimburse at the brand rate.	X		
POS.276	**20. Pricing - TPL and Co-Pay Processing**			
POS.277	Ability to deny any claim whose TPL is less than or equal to a parameter configured by the BMS (currently $0.00).	X		
POS.278	Ability to price POS claims with TPL amounts according to NCPDP standards and BMS policy. Ability to support, at a minimum, the application of data from 433-DX in conjunction with other coverage codes 2, 3, and 4.	X		
POS.279	Ability to support primary payer reject codes as defined by BMS.	X		
POS.280	Ability to support multiple co-pay requirements based upon the total price or status of the drug.	X		
POS.281	Ability to maintain co-pays based on BMS policy for various eligibility groups or product designation.	X		
POS.282	**21. Financial Processes**			
POS.283	Ability to include on-line access to the following:			
POS.284	Recoupments	X		
POS.285	Voids	X		
POS.286	Refunds made	X		
POS.287	Request for additional information sent	X		
POS.288	Number of outstanding requests pending	X		
POS.289	Other as identified by BMS during DDI and accepted via formal change control	X		
POS.290	Ability to reprocess pharmacy claims when needed.	X		
POS.291	Ability to perform mass claims reprocessing.	X		
POS.292	Ability to update the FFS claims payment to track all recoupment, refund and adjustment activity.	X		

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
POS.293	Ability to reimburse pharmacies as approved by the BMS in accordance with applicable Federal regulations.	X		
POS.294	Ability to provide a method to pay pharmacists an incentive (based upon rules approved by BMS).	X		
POS.295	**22. Reporting - General**			
POS.296	Ability to generate standard reports (as defined by BMS during DDI) and customized reports.	X		
POS.297	Ability to support an online/on-demand Member history report. The results should contain enough information to reflect the following:	X		
POS.298	A drug profile history, and should be in a format which can be either stored or displayed on an online screen.	X		
POS.299	A drug utilization history, and should be in a format which can be either stored or displayed on an online screen.	X		
POS.300	Ability to export reports for enhanced manipulation and analysis.	X		
POS.301	Ability to provide for the electronic delivery of reports to identified destinations.	X		

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7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.1	**1. Change Control**			
GT.2	Ability to provide an automated software modifications change request tracking system.	X		
GT.3	The system should enable BMS to control and monitor system change requests.	X		
GT.4	Change requests are expected to include all necessary documentation (as defined by the BMS-approved change management plan).	X		
GT.5	Ability for BMS to set and change priority levels on individual change requests.	X		
GT.6	Ability for BMS to track process metrics and other detail, including:	X		
GT.7	The estimated and actual hours allocated to each change request	X		
GT.8	Specific personnel assigned to each change request	X		
GT.9	Scheduled completion date for each change request	X		
GT.10	Total cost (if maximum allowable hours exceeded)	X		
GT.11	Total approved operations charge increase (if any)	X		
GT.12	A separate total for equipment requirements (if applicable) related to the modification	X		
GT.13	**2. Data Retention, Archival, Retrieval and Purge**			
GT.14	Ability to ensure that data is retained, archived, purged, protected from destruction and accessible, according to State and Federal requirements and in accordance with the BMS Data Retention Policy.	X		
GT.15	The Vendor is to ensure that hard copy documents are retained, stored, imaged, archived, and destroyed according to State and Federal requirements and in accordance with the BMS Data Retention Policy.	X		
GT.16	Ability for BMS to specify/modify auto archive rules.	X		
GT.17	Ability to provide archival and purge processes that do not degrade or interrupt the system.	X		
GT.18	Ability to easily retrieve archived data for online review, export and reporting.	X		
GT.19	Ability to restore archived data for reviewing, copying and printing.	X		
GT.20	**3. Disaster Recovery and Business Continuity**			
GT.21	Ability to provide a Disaster Recovery/Business Continuity Plan that complies with Federal, State, Department and Bureau rules, regulations and applicable policies and procedures, including at a minimum:	X		
GT.22	Daily back-up which is adequate and secure for all computer software and operating programs; databases; files; and system, operation, and user documentation (in electronic and non-electronic form)	X		
GT.23	Full and complete back-up copies of all data and software on tape and/or disk	X		
GT.24	Storage of all back-up copies in a secure off-site location	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.25	Routine testing to verify the completeness, integrity, and availability of back-up information	X		
GT.26	Support for immediate restoration and recovery of lost or corrupted data or software from a disaster event	X		
GT.27	Provide for back-up processing capability at a remote site(s) from the primary site(s) such that normal payment processing, as well as other State defined systems and services can continue in the event of a disaster or major hardware problem at the primary site(s).	X		
GT.28	Ability to provide sufficient transaction logging and database back-up to allow it to be restored. If multiple databases are used for work item routing and program data, restoration should ensure that databases are synchronized to prevent data corruption.	X		
GT.29	Ability to provide point-in-time recovery of data to the last completed transaction.	X		
GT.30	Ability to allow for continued use of the system during back-up.	X		
GT.31	The Vendor is to perform back-ups during non-peak processing hours, minimizing the impact to operational activities.	X		
GT.32	**4. Problem Management**			
GT.33	Ability to write all errors to an error log.	X		
GT.34	Ability to allow for a BMS administrator to view, filter, sort and search the error log.	X		
GT.35	Ability to allow for an administrator (Vendor personnel) to archive error log entries based upon user-defined criteria.	X		
GT.36	Ability to allow for a user to define an alert message to be executed upon the occurrence of an error.	X		
GT.37	The Vendor is to provide record-level reporting of inaccurate processing results (e.g., claims processed without required consent on file, valid claims denied).	X		
GT.38	**5. Release Management**			
GT.39	Major releases are to be evaluated and approved by BMS prior to application.	X		
GT.40	The Vendor is to send notification to BMS when releases are available to be evaluated.	X		
GT.41	The Vendor is to provide BMS with detailed documentation that lists all fixes and functionality for each release.	X		
GT.42	The Vendor is to proactively notify the System Administrator regarding which releases of third-party software (JAVA virtual machine, Internet Explorer, Mozilla, Safari, etc.) are known to create problems with the current version of the vendor software.	X		
GT.43	The Vendor is to maintain version control and provide BMS with current system and user documentation, and operating procedures manuals.	X		
GT.44	Ability to allow centralized deployment of system updates and system maintenance.	X		
GT.45	**6. Security Management**			
GT.46	Comply with all Federal, State, Department and Bureau rules, regulations and applicable policies and procedures related to security.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.47	Ability to anticipate and provide a flexible solution that is positioned to effectively meet the requirements of current and future HIPAA security regulations.	X		
GT.48	Ability to provide a role-based Single Sign On (SSO) solution.	X		
GT.49	Requests for access are to come from an authoritative source(s) as defined by BMS.	X		
GT.50	Ability to require that all users (including all vendor support staff members) have a unique user ID and password, where:	X		
GT.51	Required passwords are to expire on a staggered schedule and can be reset at any time by appropriate personnel and/or automated system reset.	X		
GT.52	Passwords are to be strong passwords (e.g., contain caps/numbers, cannot use prior passwords, etc.).	X		
GT.53	Passwords are to be stored in encrypted form.	X		
GT.54	Restriction of application and/or function within an application through role-based security. Role assignments are to be used to determine which user categories have permission to access which application and/or function within an application.	X		
GT.55	Ability to provide the following three types of controls to maintain the integrity, availability, and confidentiality of Protected Health Information (PHI) data contained within the system: These controls are to be in place at all appropriate points of processing.	X		
GT.56	**Preventive Controls:** Controls designed to prevent errors and unauthorized events from occurring.	X		
GT.57	**Detective Controls:** Controls designed to identify errors and unauthorized transactions which have occurred in the system.	X		
GT.58	**Corrective Controls:** Controls to ensure that the problems identified by the detective controls are corrected.	X		
GT.59	Allow properly authorized users to configure and maintain all system settings from any workstation on the local/wide area network using a browser.	X		
GT.60	Ability to provide audit trails of all updates to the security system (add/change/delete) by log-on ID (or batch update identifier), date and time of the change, and source of entry (workstation ID), including all attempted updates.	X		
GT.61	The system's import and export capabilities are to provide user-level security options to control access to sensitive information.	X		
GT.62	Ability to support file, record, and field-level security.	X		
GT.63	Ability to provide document-based security.	X		
GT.64	Ability to update all security roles automatically when a change in the "master" role is made.	X		
GT.65	Ability to provide functional security to control what processes can be performed by certain users.	X		
GT.66	Ability to allow local/central System Security Administrators to add and change permissions for local/central system access.	X		
GT.67	Ability to prohibit display of passwords on the sign-on screen when entered by the user.	X		
GT.68	Ability to log and report all unauthorized access attempts by terminal ID, user ID, date, and time.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.69	Ability to allow System Administrator to re-set user passwords.	X		
GT.70	Ability to allow users to change their passwords.	X		
GT.71	Ability to log a user off a system if there is no activity within a thirty (30) minute period of time, or other period of time designated by BMS.	X		
GT.72	Ability to terminate access if there is no activity on a user account within thirty (30) days, or other period designated by BMS.	X		
GT.73	Ability to generate a periodic report (as scheduled by BMS) of upcoming user account terminations.	X		
GT.74	Ability to immediately disable access to any user or user group after a predetermined number of attempts to log-on.	X		
GT.75	Ability to ensure that all applications comply and are compatible with existing State and Federal guidelines preventing unauthorized access.	X		
GT.76	Employ a security approach that integrates MMIS components to provide role-based access with a single log-on.	X		
GT.77	Ability to provide an audit trail of record changes, including user and date of change.	X		
GT.78	Ability to implement audit trails to allow information on source documents to be traced through the processing stages to the point where the information is finally recorded.	X		
GT.79	Ability to trace data from the final place of recording back to its source of entry.	X		
GT.80	The system is to comply with all HIPAA final, future rules as they become final and amendments to final rules (e.g., Privacy and Security, Transaction and Code Sets, National Provider Identifier).	X		
GT.81	Ability to transmit and receive HIPAA-compliant transactions using multiple methods (e.g., web-based, dial-up, batch file).	X		
GT.82	Ability to transmit and receive HIPAA-compliant transactions using a variety of devices including PCs and touch tone phones.	X		
GT.83	The system is to comply with the implementation of HIPAA compliant privacy and security measures across all DHHR systems and business functions as they impact or interact with the MMIS.	X		
GT.84	The system is to support multiple versions of HIPAA implementation guides concurrently (e.g., 4010/5010) as per HIPAA Transaction and Code Set (TCS) Rule.	X		
GT.85	**7. Standards**			
GT.86	The system is expected to be flexible and readily adaptable to changing State and Federal requirements.	X		
GT.87	The Vendor is to provide BMS with an inventory of all hardware and software to be placed within the State government infrastructure.	X		
GT.88	The Vendor is expected to support current technologies for data interchange (e.g., XML).	X		
GT.89	Client desktop software is to work with new desktop operating system patches and upgrades based upon BMS patch management policies (see Procurement Library).	X		
GT.90	The system is to use a relational database management system (RDBMS).	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.91	**8. Support**			
GT.92	The Vendor is expected to provide a technical help desk, accessible to users via phone.	X		
GT.93	The Vendor is to provide web-based support, with a searchable database of common problems, to assist end-user in facilitating resolution of error messages.	X		
GT.94	The system is to have the "built-in" capability to provide BMS authorized support through remote access to the application.	X		
GT.95	Ability to allow for BMS-defined severity levels for support.	X		
GT.96	The following describe desired capabilities of the Vendor's support tool:	X		
GT.97	Provide functionality that creates, edits, sorts and filters tickets or electronic records of calls made to the Call Center to be used by both Vendor Help Desk and BMS staff.	X		
GT.98	Ability to create tickets that track the caller, the question(s) or issue(s), the resolution or response, the Vendor and BMS staff responding to the ticket, date(s), time(s) and status (open or closed).	X		
GT.99	Ability to add electronic attachments to a ticket.	X		
GT.100	Ability to allow configuration of call routing and delegation criteria, and severity, prioritization and escalation criteria.	X		
GT.101	Include knowledge base, Frequently-Asked-Questions (FAQ) components, and phone scripts that can be updated manually or via automatic imports.	X		
GT.102	Ability to facilitate mass e-mail and fax notifications to enrolled providers.	X		
GT.103	Ability to allow the recording of inbound and outbound communications with the ability to retain recordings as specified by BMS.	X		
GT.104	The Call Center should have a central database for call tracking records that can be queried by both Vendor and BMS users.	X		
GT.105	Ability to use MMIS data repositories to automatically display information regarding the caller.	X		
GT.106	Ability to capture date-specific and user-specific free form text for each call center ticket.	X		
GT.107	Provide role-based system training for BMS personnel, their vendors and their business partners upon request of BMS.	X		
GT.108	Provide training to BMS or its subsequent vendor regarding:	X		
GT.109	Computer operations, including production control monitoring procedures	X		
GT.110	Controls and balancing procedures	X		
GT.111	Extension routines (pre/post SQL)	X		
GT.112	Other manual operations as necessary	X		
GT.113	**9. System Integration**			
GT.114	Ability to access all current and historical Member, Provider, Contractor (e.g., HMO) and other data necessary to meet the functional requirements outlined in this document.	X		
GT.115	MMIS modules and applications are to integrate successfully and effectively with minimal or no customization.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.116	Utilize open architecture standards and scalability to promote integration throughout all MMIS business processes and sub-processes.	X		
GT.117	Provide a user-friendly, common "look and feel" which gives users a seamless MMIS experience across the "core system," including (at a minimum) the Member Management, Provider Management, Claims Processing, Reference File, and TPL modules, and maintains common user elements across the entire MMIS whenever possible.	X		
GT.118	Data changes made in one part of the system should automatically populate other parts of the system so as to avoid duplicate data entry.	X		
GT.119	All on-line claim/encounter information is to be available to authorized users regardless of the functional business area where the data is stored.	X		
GT.120	Ability to "lock" a claim to prevent concurrent updates to the same claim.	X		
GT.121	Adjudicated claims are not to be changed outside an approved adjustment process. Once a claim is adjudicated and in a final status, the information is to remain static while it is displayed (e.g., users may not cut claim information from claim lines/data).	X		
GT.122	Ability to maintain an integrated repository of Member information, including a single unique identifier (which is not the SSN), for all Members where payments are made from the new MMIS system.	X		
GT.123	Ability to maintain an integrated repository of Provider information, including a single unique identifier (NPI), for all Providers.	X		
GT.124	**10. System Interfaces**			
GT.125	Ability to interface and/or integrate with the systems and applications as specified in the Integration Points Table of this document. (See the following Procurement Library folder/file: Interfaces/WV_MMIS_External_Interfaces.pdf).	X		
GT.126	The system is to receive and send electronic interface information from and to the State's eligibility systems, other agencies, and BMS's outside Vendors (as specified in the Integration Points Table of this document).	X		
GT.127	Ability to accept eligibility data from multiple source systems into a Vendor supplied common eligibility interface component. The common eligibility interface component is to edit for data accuracy, completeness, redundancy, etc., according to specified business rules, reformat the data and provide a single interface to the MMIS. The common eligibility interface component is to also assure data delivery.	X		
GT.128	The system is to interface with and provide data to a Decision Support System/Data Warehouse.	X		
GT.129	Ability to produce required Federal and State data sharing, including (but not limited to) the following:	X		
GT.130	Program management reports (formerly known as Management and Administrative Reporting Subsystem (MARS))	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.131	Program Integrity Reports (formerly known as Surveillance and Utilization Review Subsystems (SURS)	N/A	N/A	N/A
GT.132	Medicare Modernization Act (MMA)	X		
GT.133	Medicaid Statistical Information System (MSIS)	X		
GT.134	The system is to accept the same Provider electronic billing data set required by the Medicare program for crossover claims from COBA.	X		
GT.135	Ability to employ online real-time or batch updates of data between the MMIS and other systems, depending on the interface requirements.	X		
GT.136	Ability to produce a listing on an as-requested basis of all submitters with their submitter ID.	X		
GT.137	Ability to maintain the submitter ID on the claim record.	X		
GT.138	Able to accept and process or generate all HIPAA mandated transactions, other versions or standards that may be mandated, and other transactions, including all current and future releases of the following, such as HIPAA v.5010, D.0, by the mandated deadlines:	X		
GT.139	**Health Care Claims**	X		
GT.140	ASC X12N 837 Health Care Claim: Professional	X		
GT.141	ASC X12N 837 Health Care Claim: Institutional	X		
GT.142	ASC X12N 837 Health Care Claim: Dental	X		
GT.143	National Council for Prescription Drug Programs (NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1, Release 0	X		
GT.144	**Eligibility for a Health Plan:**	X		
GT.145	ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response	X		
GT.146	**Health Care Claim Status:**	X		
GT.147	ASC X12N 276/277 Health Care Claim Status Request and Response	X		
GT.148	**Referral Certification and Authorization:**	X		
GT.149	ASC X12N 278 Health Care Services Review - Request for Review and Response	X		
GT.150	**Health Plan Premium Payments:**	X		
GT.151	ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products	X		
GT.152	**Enrollment and Dis-enrollment in a Health Plan:**	X		
GT.153	ASC X12N 834 Benefit Enrollment and Maintenance	X		
GT.154	**Health Care Payment and Remittance Advice:**	X		
GT.155	ASC X12N 835 Health Care Claim Payment/Advice	X		
GT.156	**Coordination of Benefits:**	X		
GT.157	ASC X12N 837 Health Care Claim: Professional	X		
GT.158	ASC X12N 837 Health Care Claim: Institutional	X		
GT.159	ASC X12N 837 Health Care Claim: Dental	X		
GT.160	**National Council for Prescription Drug Programs:**	X		
GT.161	(NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1	X		
GT.162	**Acknowledgements:**	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.163	ASC X12 824: Application Reporting Version 4010/5010	X		
GT.164	ASC X12 277: Health Care Payer Unsolicited Claim Status (Claims in Process Report)	X		
GT.165	**New transaction content to include:**	X		
GT.166	ASC X12N 269: Health Care Coordination of Benefits Request and Response	X		
GT.167	ASC X12N 270/271: Health Care Eligibility/Benefit Inquiry and Response (with commercial insurance carriers)	X		
GT.168	ASC X12N 274: Health Care Provider Inquiry and Information Response Guide	X		
GT.169	ASC X12N Health Care Provider Credentialing Implementation Guide	X		
GT.170	ASC X12N Health Care Provider Directory Implementation Guide	X		
GT.171	ASC X12N Health Care Provider Information Implementation Guide	X		
GT.172	ASC X12N Additional Information to Support a Health Care Services Review	X		
GT.173	ASC X12N 275: Additional Information to Support a Health Care Claim or Encounter	X		
GT.174	ASC X12N 841: Specifications/Technical Information	X		
GT.175	The system is to accommodate future versions of the HIPAA electronic PA transactions.	X		
GT.176	The system is to comply with all HIPAA EDI standards adopted by the BMS.	X		
GT.177	The Vendor is to provide for both an online DDE (direct data entry) process and receipt of electronic prior authorizations.	X		
GT.178	Ability to receive electronic data from another source and create an authorization (i.e., OHFLAC data for nursing home, ICFMR via web application).	X		
GT.179	Ability to use high speed data transfer functionality to send and receive information (where available).	X		
GT.180	Ability to reflect updates to MMIS (e.g., when procedure codes and/or modifiers which require prior authorization have been deleted and/or replaced with new or revised HIPAA-compliant codes) without interruption to service.	X		
GT.181	Vendor should ensure that file standardization is supported by all interfaces, so that data standards are maintained according to BMS-specified and Federally mandated file specifications for data element lengths, field format, and type.	X		
GT.182	Ability to use FTP, web interface, or other industry standard electronic means (such as Gentran, Connect: Direct) or media to transfer files, as approved by the BMS.	X		
GT.183	Ability to schedule and support file transfer as requested and agreed upon by the Bureau.	X		
GT.184	Ability to automatically populate the appropriate data elements when supplied in any approved electronic format, including the execution of the necessary edits, business rules, and calculations.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.185	Ability to include balancing control information when required by the BMS. The BMS is to approve the format along with the file layout, media, naming conventions, trailer records and other interface processing details.	X		
GT.186	Ability to generate load statistics which include the number of records, time taken, successes and failures, and exceptions. These statistics are to be saved to the system for reporting purposes.	X		
GT.187	Ability to generate exception files, when necessary, for manual edits, error corrections, and additions to the interface records by Vendor or BMS/State users, prior to being loaded within the MMIS.	X		
GT.188	The Vendor is to implement edits, processes and reporting to eliminate undesired duplication of records and transactions, including:	X		
GT.189	Automatically edit fields for reasonableness, validity, format and consistency with other data present in update transaction.	X		
GT.190	Transaction reconciliation reporting for file/data reconciliation with external data sources (e.g., totals and detail information, difference reports, change reports).	X		
GT.191	Ability to generate error reports at the summary and detail levels that include all data necessary to resolve errors.	X		
GT.192	Ability to reload or resend records if they have not been applied correctly to the appropriate data repository.	X		
GT.193	Ability to detect duplicate files or records and isolate them for manual review and further processing.	X		
GT.194	Ability to incorporate a method to view and edit interface files for investigation and further processing.	X		
GT.195	Ability to provide a method to "roll back" data to a pre-interface status.	X		
GT.196	Ability to create messages that accurately describe errors received as a result of a data transfer.	X		
GT.197	Ability to provide ad-hoc query capability against interface source files.	X		
GT.198	Ability to export records identified by BMS, when required by the BMS.	X		
GT.199	The system is to create and retain an audit trail of all interface activity in accordance with BMS Data Retention Policy.	X		
GT.200	**11. Workflow Management**			
GT.201	Ability to include comprehensive workflow management functionality that supports:	X		
GT.202	Definition, and possibly modeling, of workflow processes and their constituent activities.	X		
GT.203	Run-time control functions concerned with managing the workflow process in the Medicaid environment and sequencing the various activities to be handled as part of each process.	X		
GT.204	Run-time interactions with users and Information Technology (IT) application tools for processing the various activity steps.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.205	Ability to support a role-based interface for process definition that leads the user through the steps of defining the workflow associated with a business process, and that captures all the information needed by the workflow engine to execute that process to include:	X		
GT.206	Start and completion conditions	X		
GT.207	Activities and rules for navigation between them	X		
GT.208	Tasks to be undertaken by BMS staff involved in the process	X		
GT.209	Authorized approvers	X		
GT.210	References to applications which may need to be invoked	X		
GT.211	Definition of other workflow-relevant data	X		
GT.212	Ability to support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.	X		
GT.213	Ability to incorporate simple low-level workflow processes into more complex higher-level workflow processes.	X		
GT.214	Ability to support supervisory operations for the management of workflow including:	X		
GT.215	Assignments/re-assignments and priorities	X		
GT.216	Status querying and monitoring of individual documents and other work steps or products	X		
GT.217	Work allocation and load balancing	X		
GT.218	Approval for work assignments and work deliverables via a tiered approach	X		
GT.219	Ability to take necessary action or provide notification when corrective action is needed, including the ability to modify or abort a workflow process	X		
GT.220	Monitoring of key information regarding a process in execution, including:	X		
GT.221	Estimated time to completion	X		
GT.222	Staff assigned to various process activities	X		
GT.223	Any error conditions	X		
GT.224	Ability to utilize automated workflow to transfer documents to BMS for review, editing, and approval, and back to external stakeholders for re-writes and production.	X		
GT.225	Ability to use workflow management functionality to route and assign cases to the appropriate State and county staff and offices.	X		
GT.226	**12. Test Environments**			
GT.227	Ability to maintain four regions/environments: (1) a development test region/environment, (2) a user acceptance test (UAT) region/environment, (3) a production region/environment, and (4) a training region/environment, all of which are to be independent regions. Under no circumstances should the development test, UAT, and training regions be housed on the same hardware as the production region. The training region should include all data elements that are in the production region, and contain sufficient and representative data records for training purposes. Vendors are not to invoke additional license fees for the test, UAT, and training environments.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.228	Vendor should use a UAT region/environment that would mirror all programs in production through the life cycle of the claim, to include reports and the financial records. (This region/environment should be one of the four major regions/environments described in GT.227).	X		
GT.229	Vendor should use utilities to assist in identifying selected claim samples to use for testing (i.e., identify claims that currently test true for a specified edit).	X		
GT.230	Ability to create MMIS data (Provider, health plan, Member or claim) in a test environment, as needed for testing.	X		
GT.231	Ability to modify MMIS data (Provider, health plan, Member or claim) in a test environment, as needed for testing, in compliance with Federal guidelines.	X		
GT.232	Ability to maintain a test case library with search capability that is cross-referenced to the code (i.e., edit) that it tests.	X		
GT.233	**13. Automated Voice Response System (AVRS)**			
GT.234	The AVRS is to support the following Provider inquiries:	X		
GT.235	Prior Authorization status	X		
GT.236	Check Medicaid Member eligibility, third party insurance and managed care coverage for a specific date.	X		
GT.237	Query coverage limitations for the Member.	X		
GT.238	Query the co-pay requirement for a service.	X		
GT.239	Query Member restrictions.	X		
GT.240	Query for status of any claim or PA request they submit whether electronically or manually submitted.	X		
GT.241	Query warrant status and amounts.	X		
GT.242	Query Remittance Advice information.	X		
GT.243	The AVRS is to support the following Member inquiries:	X		
GT.244	Check Medicaid Member eligibility for a specific date.	X		
GT.245	Query and update managed care enrollment.	X		
GT.246	AVRS system is to be compatible with the State's phone systems and with industry telephony standards. (State's telephone systems consist of POTS, PBX, and IP telephony phone systems).	X		
GT.247	Ability to provide separate toll-free AVRS telephone numbers for Providers, Members, and other entities as identified by the BMS.	X		
GT.248	Ability to validate the AVRS caller/user (according to BMS defined criteria).	X		
GT.249	The AVRS should accept payment inquiries based on either NPI or Provider ID.	X		
GT.250	Ability for callers using the contact/call center management system to transfer to the AVRS system.	X		
GT.251	The system should use automated menus, including an easily accessible option for reaching a live operator.	X		
GT.252	**14. Call Center**			
GT.253	Ability to provide separate toll-free Call Center telephone numbers for Providers, Members, and other entities as identified by the BMS.	X		
GT.254	The Vendor is expected to require Provider to give NPI or atypical provider identifier, at a minimum, before responding to inquiries.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.255	Ability to authenticate the caller/user (per BMS specified criteria).	X		
GT.256	Ability, as applicable, to auto-populate call center screens with caller information when the call representative answers the call. Would include ability to access contact and correspondence history, as well as information such as Accounts Receivable detail, benefits information, and enrollment status.	X		
GT.257	~~Ability to use automated repeat call options.~~ Requirement deleted per Addendum 1, question 8	N/A	N/A	N/A
GT.258	Ability to integrate with an automated phone messaging system.	X		
GT.259	~~Ability to use automated message purge function with activity reporting.~~ Requirement deleted per Addendum 1, question 9	N/A	N/A	N/A
GT.260	Ability to define phone routing that allows the system to forward calls to the individual/entity (internal and external agencies included) capable of handling the caller’s needs.	X		
GT.261	Ability to configure navigation paths and prompts based on the caller's anticipated information needs.	X		
GT.262	Ability to record customized messages directed to selected Provider or Member groups.	X		
GT.263	Ability to route or transfer calls (as defined by the user) without having to redial (e.g., call may be transferred to an external agency, such as an enrollment broker, without additional phone charges to the caller).	X		
GT.264	Ability to configure navigation paths and prompts based on information from the MMIS (e. g., transfer call based on Provider specialty).	X		
GT.265	**15. Contact Management**			
GT.266	The Vendor is to provide a contact management system for managing communications with BMS staff, Providers, Members (current and potential), health plans, and other entities as identified by the BMS.	X		
GT.267	Ability to manage all MMIS related contacts (telephone, email, web portal, AVRS, mail, fax, etc.).	X		
GT.268	Ability to maintain a record (including an audit trail) of all contacts.	X		
GT.269	Inquiry responses are expected to be provided to the requestor in the same mode that it was received; therefore, the system is expected to have the ability to identify and maintain a record of the format/media of incoming communications.	X		
GT.270	Ability to query on the history of each contact.	X		
GT.271	Ability to view related contact records from a single contact record.	X		
GT.272	Ability to assign a unique tracking or control number to each contact.	X		
GT.273	Ability to accommodate searches on contact records by characteristics such as contact type, Member ID, caller phone number, Provider number, Provider name, contact tracking/control number, and any combinations thereof.	X		
GT.274	Ability to use caller phone number and/or ID number to access related MMIS data and previous contacts.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.275	The system is expected to receive and track summary level mailing data from the enrollment broker for reporting purposes.	X		
GT.276	Ability to upload attachments to contact records.	X		
GT.277	Ability to link scanned images to contact records to provide one view of all related materials (e.g., images, letters, and interactions).	X		
GT.278	Ability to provide correspondence functions to include the following:	X		
GT.279	Template development and the ability for users to select desired correspondence from a list of available templates	X		
GT.280	Display, print, and save correspondence via the EDMS component of the MMIS	X		
GT.281	Regenerate correspondence	X		
GT.282	Allow users to suppress or allow auto generation of correspondence based on user configurable event-driven criteria	X		
GT.283	Allow users to insert and override address information on correspondence	X		
GT.284	Allow users to add free form text to individual or groups of correspondence	X		
GT.285	Other as identified by BMS during DDI and accepted via formal change control	X		
GT.286	Ability to provide an electronic RTP tracking system to allow the ability to catalogue, track and report on RTP (return-to-Provider) documentation (e.g., Sterilization/Hysterectomy forms, claims, etc.).	X		
GT.287	**16. EDI Portal**			
GT.288	Ability to support Electronic Data Interchange (EDI) transactions for all EDI users and trading partners. Transactions should include, but not be limited to:	X		
GT.289	Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant)	X		
GT.290	Interactive Claims Inquiry (276/277 – DDE compliant)	X		
GT.291	Interactive Claim Submission (DDE compliant) to allow a Provider to submit a claim, including HIPAA/EDI compliant responses	X		
GT.292	Remittance Advice (RA) (835)	X		
GT.293	Interactive claim submission (837 transactions)	X		
GT.294	Ability to support an EDI Translator and Validator.	X		
GT.295	**17. Electronic Document Management System (EDMS)**			
GT.296	Integrate EDMS functionality into the MMIS that supports, at a minimum, the following capabilities:	X		
GT.297	Document management	X		
GT.298	Content management	X		
GT.299	Records management	X		
GT.300	Document capture and imaging	X		
GT.301	Document-centric collaboration	X		
GT.302	Workflow management including document workflow	X		

7. General and Technical (GT)

Req #	Description of Requirement	YES without custom-ization	YES with custom-ization	NO unable to provide
GT.303	Ability to store both electronic and imaged paper documents and make them available on-line through a single user interface to promote a total view of current and historical information.	X		
GT.304	Provide multiple search options (e.g., Structured Query Language (SQL), various index search options, content-based searches, etc.) to view contents.	X		
GT.305	Ability to track all versions of each document.	X		
GT.306	Ability to present users with the latest revision of a document with the option to view previous versions.	X		
GT.307	Ability to support the management of documents created in BMS standard office applications.	X		
GT.308	Ability to allow drag-and-drop functionality to be used when creating or editing a document.	X		
GT.309	Ability to include, at a minimum, the following document management capabilities:	X		
GT.310	Accessible letter templates and forms	X		
GT.311	On-line, updateable templates that allow users to customize on an as-needed basis	X		
GT.312	Store documents and files	X		
GT.313	Generate materials in both hard copy and electronic format, including forms and letters	X		
GT.314	Ability to create letter templates and forms for the following areas:	X		
GT.315	Provider enrollment materials	X		
GT.316	General correspondence/notices for Providers and Members	X		
GT.317	Letters (financial, denial, EOMB, etc.)	X		
GT.318	Coordination Of Benefits (COB) letters	X		
GT.319	Managed Care Plan/Care Management Plan (MCP) letters	X		
GT.320	Prior Authorization (PA) letters	X		
GT.321	Ability to generate pre-populated forms.	X		
GT.322	Ability to easily match up related documents such as claims and supporting attachments in a many to one relationship.	X		
GT.323	Ability to support cataloging/indexing of all imaged documents.	X		
GT.324	Ability to utilize bar code technology that minimizes manual indexing and automates the retrieval of scanned documents.	X		
GT.325	Provide backup capability for manually indexed scanned documents.	X		
GT.326	Ability to use imaging/document management technology that handles multiple types of letters, forms, publications, and other BMS designated documents, and automates workflow processing to include:	X		
GT.327	Provider enrollment materials and licensure	X		
GT.328	Claim forms and attachments	X		
GT.329	PA forms and attachments	X		
GT.330	COB/TPL (including Medicare)	X		
GT.331	Provider correspondence including but not limited to RTP	X		
GT.332	Member correspondence	X		
GT.333	Contractor correspondence	X		
GT.334	Business partner correspondence	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.335	Web portal correspondence	X		
GT.336	Member enrollment materials	X		
GT.337	Notices	X		
GT.338	Letters	X		
GT.339	Audit materials	X		
GT.340	Others as identified by BMS and accepted via formal change control	X		
GT.341	**18. Reports**			
GT.342	Ability to download reports in various formats, such as PDF, Excel, Word, etc.	X		
GT.343	Ability to export reports for enhanced manipulation and analysis.	X		
GT.344	Provide integrated print capability for any interface page within the MMIS.	X		
GT.345	The Vendor is to provide a searchable data dictionary.	X		
GT.346	Ability and flexibility for multiple simultaneous users to create and run in near real-time, ad hoc and canned reports without going through a formal change control process.	X		
GT.347	Provide for the electronic delivery of reports to identified destinations.	X		
GT.348	Provide role-based access to BMS staff to view reports and current manuals online.	X		
GT.349	Ability to produce multi-dimensional, flexible, ad hoc reports across business functions which meet the following reporting needs:	X		
GT.350	Financial reporting	X		
GT.351	Budget forecasting	X		
GT.352	Fiscal planning and control	X		
GT.353	Claims payment accuracy	X		
GT.354	Cash flow	X		
GT.355	Timely reimbursement analysis	X		
GT.356	Recipient cost and user of services	X		
GT.357	Cost/benefit analysis	X		
GT.358	Third party recovery	X		
GT.359	Prescription drug policy	X		
GT.360	Cost and user of prescription drugs	X		
GT.361	Recipient participation	X		
GT.362	Eligibility and benefit design	X		
GT.363	Geographical analysis	X		
GT.364	Program planning	X		
GT.365	Policy analysis	X		
GT.366	Federal waiver program evaluation	X		
GT.367	Program performance monitoring	X		
GT.368	Provider reimbursement policy	X		
GT.369	Institutional rate-setting	X		
GT.370	Medical assistance policy development	X		
GT.371	Provider participation	X		
GT.372	Service delivery patterns	X		
GT.373	Adequacy of and access to care	X		
GT.374	Quality of care	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.375	Outcomes assessment	X		
GT.376	Disease management	X		
GT.377	External reporting	X		
GT.378	Public information	X		
GT.379	Managed Care Plan (MCP) planning and analysis	X		
GT.380	Ability to generate a listing of all standard on-line reports available, the description of each report, and provide a link to the most recent report.	X		
GT.381	Provide a process by which reports may be delivered by email in accordance with HIPAA rules.	X		
GT.382	Provide archival storage of reports that complies with BMS records retention standards.	X		
GT.383	Ability to store reports for rapid retrieval.	X		
GT.384	Provide ability for users to extract data, manipulate the extracted data, and specify the desired format and media of the output.	X		
GT.385	Ability to display consistent BMS-approved headers and footers.	X		
GT.386	Ability to identify and use consistent report fields.	X		
GT.387	Ability to provide a user-friendly way to schedule when, with what frequency, or on what regular days within a month various reports are generated and disbursed.	X		
GT.388	Ability to track and store detailed information regarding all reporting requests including, but not limited to:	X		
GT.389	Who requested the information	X		
GT.390	Date	X		
GT.391	Time	X		
GT.392	What the report included	X		
GT.393	Report storage upon completion	X		
GT.394	Route the entire history on-line.	X		
GT.395	Ability to categorize and organize reports by source system, data content, purpose, frequency and other staff selected options.	X		
GT.396	Ability to search the reports repository by date, time, report title, report ID, run date and key words.	X		
GT.397	Ability to highlight, cut, paste, and print any selection of the report.	X		
GT.398	Ability to sort the reports list by date, time report title, run date, and other criteria.	X		
GT.399	Ability to establish and apply archival and purge parameters to reports.	X		
GT.400	Ability to easily and flexibly create new reports through an automated and user-friendly report writer tool.	X		
GT.401	Ability to use identifier mathematical functions format and manipulate data within reports.	X		
GT.402	**19. User Interface - MMIS User Screens**			
GT.403	Ability to incorporate systems navigation technology that allows all users to move freely throughout the system.	X		
GT.404	The system user interface is to be compatible with user defined display settings.	X		
GT.405	Provide integrated print capability for any interface page within the MMIS.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.406	Include at minimum the following features and capabilities:	X		
GT.407	Drill down and look up functionality to minimize re-entry of information across multiple screens.	X		
GT.408	Multi-tasking and multiple window capability, including split screens.	X		
GT.409	Search capabilities to allow retrieval by Provider, Member, ad pay, procedure code, NDC or others as defined by BMS.	X		
GT.410	Ability to tab and mouse through data fields and screens.	X		
GT.411	The system should provide menus that are understandable by non-technical users and provide secure access to all functional areas.	X		
GT.412	Ability to incorporate a non-restrictive environment for experienced users to directly access (direct call) a screen or to move from one screen to another without reverting to the menu structure.	X		
GT.413	The system should provide an online help system, available from any screen and any screen field, that provides a description of and the processing performed by a screen or window, data entry format and restrictions, explanation of error messages and other information helpful to the user.	X		
GT.414	Ability to generate drop-down lists to identify options available, valid values, and code descriptions, by screen field.	X		
GT.415	Ability to utilize the following standards for all screens, windows, and reports:	X		
GT.416	All headings and footers standardized	X		
GT.417	Current date and local time displayed	X		
GT.418	All references to dates displayed consistently throughout the system	X		
GT.419	All data labels and definitions consistent throughout the system and clearly defined in user manuals and data element dictionaries	X		
GT.420	All MMIS generated messages should be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text	X		
GT.421	**20. User Interface - Notifications/Alerts**			
GT.422	Ability to generate alerts to notify staff of possible options when known running process(es) may result in problems (e.g., timeouts, slowed processing).	X		
GT.423	Ability to generate alerts when changes are made to policies and procedures and system tables or functionality.	X		
GT.424	Ability to generate alerts when the anticipated return time on a query or report job exceeds a defined time limit.	X		
GT.425	Ability to generate alerts that assist in monitoring time-sensitive activities.	X		
GT.426	Ability to generate alerts to a user-defined group or individual.	X		
GT.427	Ability to generate alerts to notify staff when they need to take action in connection with workflow events.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.428	**21. Web Portal**			
GT.429	Provide and maintain a secure website with authentication and encryption to protect interactions and transactions. This should include, at a minimum, the use of Secure Sockets Layer, or SSL. The authentication process should be verified through a third party that has registered and identified the server.	X		
GT.430	Web portal functionality should address the needs of a variety of entities/stakeholders, including Medicaid consumers (including current and potential Members), Providers, and other business partners as specified by BMS.	X		
GT.431	Web applications are to satisfy the Priority 1 Checkpoints from the Web Content Accessibility Guidelines 1.0 developed by the World Wide Web Consortium (W3C), as detailed at: http://www.w3.org/TR/WCAG10/full-checklist.html.	X		
GT.432	Ensure web portal design, development, implementation and operations are in accordance with State and Federal regulations and guidelines related to security, accessibility, confidentiality, and auditing.	X		
GT.433	Information and documentation captured via the web portal is expected to conform to the user access, user inquiry, update, retention, archival, and other relevant data management specifications outlined in this RFP.	X		
GT.434	Include secure and non-secure tabs.	X		
GT.435	Provide public information without requiring authentication.	X		
GT.436	Provide Internet security functionality to include firewalls, intrusion detection, and encrypted network/secure socket layer.	X		
GT.437	Handle PHI through authentication, along with encryption methods to secure PHI.	X		
GT.438	Ability to display and require the user to accept web site terms of agreement when entering the web portal.	X		
GT.439	Utilize an authentication process to handle multiple layers of security levels as defined by BMS.	X		
GT.440	Establish user access to predefined BMS levels such as page level, field and data element level.	X		
GT.441	The system is to provide a protected web site with secure passwords and log-ons to include:	X		
GT.442	Instructions on how to use the secure site	X		
GT.443	Site map	X		
GT.444	Contact information	X		
GT.445	Send users their initial password via email and require that they change their password at next sign-on.	X		
GT.446	Provide the ability to expire a password in a given number of days according to BMS standards.	X		
GT.447	Provide self-service password resets.	X		
GT.448	Prohibit the display of passwords at the sign-on screen when entered by the user.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.449	Notify MMIS users at regular intervals defined by BMS that security access tables are to be cleared unless otherwise directed. (This is in reference to any security access tables the Vendor may propose as part of their solution, where an example may be a user log table).	X		
GT.450	Delete account profiles after a period of inactivity as defined by BMS.	X		
GT.451	Inactive users should not be deleted from history.	X		
GT.452	Allow Providers to be authorized to access only their own claim information.	X		
GT.453	Ability to require qualifying information (e.g., Provider number, prior authorization number, Member number, date of service, or claim number) to access various information via the web portal.	X		
GT.454	Include static and easily updated Web pages.	X		
GT.455	Include a desktop environment with browser capability for easy navigation.	X		
GT.456	Provide a user interface that allows all users to move easily throughout the system.	X		
GT.457	Support a menu and control system with highly flexible navigation.	X		
GT.458	Provide a user-friendly menu system that is easily navigable by the non-technical user while not restricting direct access to any screen to experienced users.	X		
GT.459	Provide user interface features and capabilities including:	X		
GT.460	Pull down menus and window tabs	X		
GT.461	Scalable true type screen and printing fonts	X		
GT.462	Upper and lower case alphabetic characters	X		
GT.463	Ability to tab and mouse-click through data fields and screens	X		
GT.464	Use the following standards for all screens, windows, and reports:	X		
GT.465	Maintain a consistent theme throughout the site and standardize all headings and footers with index tabs as identified by BMS.	X		
GT.466	Display current date and time in a system-wide consistent format.	X		
GT.467	Utilize data labels and definitions in a system-wide consistent manner and as defined in user manuals and data element dictionaries.	X		
GT.468	Generated messages are to be available in both mixed font and mixed case formats.	X		
GT.469	Screens should distinguish between production and test environments.	X		
GT.470	Comply with the American Disabilities Act (ADA) development standards for user screens.	X		
GT.471	Comply with the Older Americans Act development standards for user screens.	X		
GT.472	All generated messages are to be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text.	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.473	Conform to any State, Department or Bureau specified standards regarding the look and feel of the web.	X		
GT.474	Support multiple communication lines and provide fail-over capability.	X		
GT.475	Provide growth capacity for high volumes of activity.	X		
GT.476	Ability to interface, receive, send, and download specified content and reporting information directly from/to entities such as Provider associations, vendors, and other State agencies.	X		
GT.477	Include email address in the authorization table. The confidentiality of email addresses is to be protected and only used for official State business.	X		
GT.478	Allow for (HIPAA-compliant) email submission by user initiated from a link on the website.	X		
GT.479	Provide flexible web-based reporting that meets external reporting needs and requirements defined by BMS.	X		
GT.480	Ability to ensure that web portal field definitions comply with system field definitions.	X		
GT.481	Provide inquiry capabilities for categories including:	X		
GT.482	Prior Authorization (PA)	X		
GT.483	Remittance Advice (RA)	X		
GT.484	Provider 1099 information	X		
GT.485	Other as identified by BMS during DDI and accepted via formal change control	X		
GT.486	Ability to generate tracking numbers for web portal-submitted Provider enrollment applications and updates.	X		
GT.487	Ability to provide interactive/dynamic online forms that may be completed and submitted online, completed and printed for hard copy submission (i.e., mail, fax), or printed to be completed by hand and submitted in hard copy format.	X		
GT.488	Ability to allow users to download or print a copy of completed submitted forms.	X		
GT.489	Ability to accept electronic attachments via the web portal and match them to the corresponding system record (including enrollment applications).	X		
GT.490	Ability to require applicants to state that they meet the State-defined Provider eligibility rules (WV code referencing digital signature: http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=39a&art=1).	X		
GT.491	The web portal should allow authorized users to perform Electronic Data Interchange (EDI) transactions, such as, but not limited:	X		
GT.492	Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant)	X		
GT.493	Interactive Claims Inquiry (276/277 – DDE compliant)	X		
GT.494	Interactive Claim Submission (DDE compliant) to allow a Provider to submit a claim, including HIPAA/EDI compliant responses	X		
GT.495	Remittance Advice (RA) (835)	X		
GT.496	Interactive claim submission (837 transactions)	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.497	Other transactions as specified by BMS (which may include, but not necessarily limited to: eprescribing, personal health record, health information exchange of lab and/or clinical data)	X		
GT.498	Provide the capability to display confirmation messages for requestor transactions.	X		
GT.499	Provide help screens and tutorials (e.g., guides to the Provider enrollment and Prior Authorization processes).	X		
GT.500	Provide on-line option for end-users to report any technical problems with the web application and web pages.	X		
GT.501	Ability to report and maintain web portal activity statistics (as defined by the BMS). For instance: new and repeat visitors, number/percent of abandoned enrollment applications, etc.	X		
GT.502	**22. Web Portal - Long Term Care (LTC) Provider Rate Submission & Inquiry**			
GT.503	Ability to allow Providers to submit and upload to BMS (via the web portal) the following:	X		
GT.504	Cost reports	X		
GT.505	Provider acceptance of the verification report	X		
GT.506	Rate reconsideration requests	X		
GT.507	Provider correspondence	X		
GT.508	Ability to accept and transfer specified files to and from Providers to the MMIS via the web portal.	X		
GT.509	Ability to send cost report verification to user if no errors are found during edits and supply Providers with a method to agree to the verification.	X		
GT.510	Ability to provide a private document page that displays a list of the available documents for each logged-in Provider.	X		
GT.511	Ability to upload rate information in batch or in bulk (i.e., reimbursement rates information that it is provided to RAPIDS. Vendor should propose the most economical format).	X		
GT.512	Ability to provide Provider-specific inquiry access to secured information. Vendor should propose the more economical format. The pay-to amounts are expected to be provided to the Vendor. Examples include:			
GT.513	Automated Cost Report (ACR) (data and reports)	X		
GT.514	Error reports as part of the cost verification process	X		
GT.515	Rate setting package report	X		
GT.516	Cost verification report	X		
GT.517	Provider acceptance of the Verification report	X		
GT.518	MDS error/authorization reports	X		
GT.519	Individual Assessment Form (IAF) scores	X		
GT.520	IAF error reports	X		
GT.521	**Web Portal - Patient Care Web Portal**			
GT.522	Ability to provide system functionality that allows Providers access to Member claims data (pharmacy, medical and MCO encounter data) for the purposes of coordinating patient care and reducing duplications in medical procedures, diagnostic testing and medications	X		

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES without custom-ization**	**YES with custom-ization**	**NO unable to provide**
GT.523	Provides access only for designated healthcare providers, e.g. prescribers and pharmacists, through an authorized log in to access their patient's medical and pharmacy history. This information should be protected so that it can only be accessed with the correct combination of the member's Medicaid Identification Number, birth date, and name.	X		
GT.524	Is updated at a minimum of once weekly with claims data (medical and pharmacy) in order to provide access to current patient history for Medicaid prescribers and providers. This data is expected to be in an easily readable format.	X		
GT.525	Displays twenty-four (24) months of fee-for-service and MCO encounter data that includes, but is not limited to, medical, pharmacy, laboratory, x-ray, institutional, emergency room visits, outpatient visits, diagnosis codes, procedure codes, member demographic information, medical providers identified by name and NPI number, DEA and DEAX numbers, and pharmacy providers identified by name and NPI number.	X		
GT.526	Meets all Health Insurance Portability and Accountability Act HIPAA requirements for the protection of Medicaid member's personal health information (PHI). Accepts web-based prior authorization requests on smart forms, created in the LiveCycle, program for creating forms with expandable text fields, and transfers them to the Prior Authorization Help Desk for processing through a secure and HIPPA compliant electronic method of transmission.	X		

14.3 Business Organization

RFP Requirement 4.1.5: Vendor's Organization.

Molina provides the requested business organization information in this section.

Business name	Molina Medicaid Solutions
Federal tax identification number	27-1510177
Business address	200 Oceangate, Suite 100, Long Beach, CA 90802
Licenses	Provided in sections 14.3.1, 14.3.2, and 14.3.3 are copies of Molina's West Virginia Business Registration Certificate and notifications of good standing with the Unemployment Compensation Division and Workers Compensation program.
Subcontractor detail	As detailed in Proposal Section 11.0, Molina's proposed subcontractors for this procurement are: • GTESS Corporation • Thomson Reuters
Financial information	Molina Medicaid Solutions, LLC is not a publicly held corporation. Instead, it is a wholly owned subsidiary of Molina Healthcare, Inc., a Delaware corporation. The Molina Medicaid Solution organization, current contracts, customer base and associated customers' size, and specialization and expertise have been provided in Proposal Section 7 Vendor Capacity, Qualifications, References, and Experience. Molina Medicaid Solutions was, formerly, a division of Unisys, Inc. In May 2010, the division of Unisys that is now Molina Medicaid Solutions was acquired by Molina Healthcare, Inc. (MOH), a New York Stock Exchange traded company, that now operates as a wholly-owned subsidiary of Molina Healthcare, Inc. Molina Medicaid Solutions has been in the Medicare/Medicaid processing business since 1979 and employs over 1,000 people. The latest audited financial reports and other reported information regarding the parent corporation can be found on EDGAR at: http://www.sec.gov/cgi-bin/browse-edgar?company=&match=&CIK=MOH&filenum=&State=&Country=&SIC=&owner=exclude&Find=Find+Companies&action=getcompany A complete copy of Molina's audited financial information (contained in its 10-K filings for 2009, 2010, and 2011) is also contained on our submitted electronic version CD.

14.3.1 West Virginia Business License

A copy of Molina's West Virginia Business Registration Certificate is provided below.

WEST VIRGINIA
STATE TAX DEPARTMENT

BUSINESS REGISTRATION CERTIFICATE

ISSUED TO:
MOLINA INFORMATION SYSTEMS, LLC
DBA MOLINA MEDICAID SOLUTIONS
1600 PENNSYLVANIA AVE
CHARLESTON, WV 25302-3932

BUSINESS REGISTRATION ACCOUNT NUMBER: **2237-4478**

This certificate is issued on: **01/23/2012**

This certificate is issued by
the West Virginia State Tax Commissioner
in accordance with Chapter 11, Article 12, of the West Virginia Code

The person or organization identified on this certificate is registered
to conduct business in the State of West Virginia at the location above.

This certificate is not transferrable and must be displayed at the location for which issued.

This certificate shall be permanent until cessation of the business for which the certificate of registration was granted or until it is suspended, revoked or cancelled by the Tax Commissioner.

Change in name or change of location shall be considered a cessation of the business and a new certificate shall be required.

TRAVELING/STREET VENDORS: Must carry a copy of this certificate in every vehicle operated by them.
CONTRACTORS, DRILLING OPERATORS, TIMBER/LOGGING OPERATIONS: Must have a copy of this certificate displayed at every job site within West Virginia.

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14.3.2 Notification of Good Standing with West Virginia's Unemployment Compensation Division

A copy of the notification regarding Molina's good standing with West Virginia's Unemployment Compensation Division is provided below.

Earl Ray Tomblin, *Governor*
Russell L. Fry, *Acting Executive Director*
Keith Burdette, *Cabinet Secretary*

January 23, 2012

MOLINA INFORMATION SYSTEMS, LLC
1600 PENNSYLVANIA AVE
CHARLESTON WV 25302-3932

Account Number: 64204-5

Dear Employer:

Workforce West Virginia has, at your request, researched their records and has found this account is in compliance with the West Virginia Unemployment Compensation Law.

Very truly yours,

Wade Wolfingbarger

Wade Wolfingbarger
UC Assistant Director

cac

Compliance and Enforcement Section, Unemployment Compensation Division
112 California Ave, PO Box 2633, Charleston, WV 25329-2633
Telephone: 304-558-2451 Fax: 304-558-6532

An agency of the Department of Commerce
An equal opportunity employer/program and auxiliary aids are available upon request to individuals with disabilities.
www.workforcewv.org

14.3.3 Notification of Good Standing with West Virginia's Workers Compensation Program

A copy of the notification regarding Molina's good standing with West Virginia's Workers Compensation program is provided below.

STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

EARL RAY TOMBLIN
Governor

MICHAEL D. RILEY
Acting Insurance Commissioner

January 25, 2012

Molina Information Systems, LLC
DBA Molina Healthcare, Inc.
200 Oceangate
Suite 100
Long Beach, CA 90802

To Whom It May Concern:

As requested, this letter is to serve as notification that Molina Information Systems, LLC dba Molina Healthcare, Inc. has a current WV workers' compensation policy and does not owe any debt to the WV Offices of the Insurance Commissioner, therefore they are considered to be in compliance at this time.

Sincerely,

Deborah Tincher
Director of Employer Coverage

Employer Coverage
Post Office Box 11682
Charleston, West Virginia 25339-1682

We are an Equal Opportunity Employer

Telephone (304) 558-6279
Facsimile (304) 558-5586
www.wvinsurance.gov

14.4 Description of Roles, Responsibilities, and Skill Sets

RFP Requirement 4.1, bullet 8, 3.2.3.5.2

Roles and responsibility charting is a way of systematically clarifying functional roles and positions as well as setting expectations for each role. This charting ensures accountability with the person responsible for specific project work. The roles and responsibility chart is an ever-changing document as the needs of the project emerge. **Table 14.4-1** details the roles, responsibilities, and skill sets for each organizational chart position found in Proposal Section 8.0.

Table 14.4-1: Roles, Responsibilities, and Skill Sets

A clear definition of the roles and responsibilities within an organization is critical to success, allowing each team member to understand their position and the oversight of each area within the project.

ROLE	RESPONSIBILITIES	SKILL SET
	Key Personnel	
MMIS Account Manager	• Serves as a liaison with the Bureau during all phases of the contract; is available and responsive to Bureau requests for consultation and assistance; at a minimum, performs the following: • Represents Molina upon request, at meetings and hearings of legislative committees and interested governmental bodies, agencies and offices • Manages integration between Medical/Dental and POS staff and functions • Oversees the MMIS Replacement DDI and Certification Phases and all sub-phases • Provides timely and informed responses to operational and administrative inquiries • Maintains positive client relationships • Delegates authority to the Medical/Dental Deputy Account Manage/Operations Manager when not available • Meets with BMS staff or such other person as the Bureau may designate on a regular basis to provide oral and written status reports and other information as required • Administers all Molina resources dedicated to MMIS operation to ensure contract objectives are met • Oversees SLAs and other contractual requirements • Monitors quality assurance reviews to ensure that contract objectives are met • Oversees and coordinates all subcontractor and consultant activities • Directs ongoing operations activities and serves as final authority for all personnel and operations decisions • Responds to operational and administrative	• Bachelors degree • Eight years experience working in a management position, with at minimum, four of those years in a management position at a Medicare or state-level Medicaid program • Excellent verbal and written communication skills • Must be proficient in conflict resolution • Ability to abide by Molina’s policies • Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA) • Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers, subcontractors, and customers • Knowledge of legislative process • Knowledge of state and national politics • Knowledge of governmental processes • Knowledge of health care policy, particularly in relationship to Medicaid

ROLE	RESPONSIBILITIES	SKILL SET
	problems as appropriate in the administration of Molina site activities • Provides personal leadership that encourages employee productivity and responsiveness to the needs of the customer • Ensures programs are established to comply with all relevant federal, State and local regulations	
Medical/ Dental Deputy Account Manager/ Operations Manager	• Fills the role of the MMIS account manager in that person's absence • Plays an active role in day-to-day management of the account so as to be knowledgeable and aware of all issues, concerns and requirements including integration management between medical/ dental and POS • Serves as the operations manager, managing staff assigned to all operational business activities, day-to-day operations of the MMIS and fiscal agent operations	• Bachelor's degree or four years directly relevant experience • Five years of Medicaid operations or Medicaid fiscal agent operations experience or other large healthcare claims processing organization • Preference given to candidates with Medicaid fiscal agent operations experience
Medical/ Dental Application Manager	• Manages configuration activities for modifications and enhancements • Monitors routine system maintenance • Oversees changes in rate or fee schedules • Monitors changes required to remain compliant with federal regulations and standards • Manages changes initiated by the Bureau to achieve strategic objectives, implement new programs, and mature business capabilities	• Bachelor's degree or four years demonstrated experience in a state or fiscal agent Medicaid environment • Five years of Medicaid MMIS experience • Highly knowledgeable in quality assurance/control procedures • Strong documentation and reporting background • Proactive problem management skills • Experience and incident change management • Candidates with implementation experience in Health PAS preferred
Medical/ Dental Systems Manager (Systems Management Lead)	• Plans, develops, tests, implements, and maintains the West Virginia MMIS • Assists with management of MMIS Replacement DDI • Assists with management of certification tasks • Manages systems staff, including the modification and enhancement pool	• Bachelor's degree, preferably in computer science, information systems, or related field, or four years experience in the position for a state Medicaid agency or fiscal agent • Eight years of directly relevant experience managing an organization unit within a Medicaid agency or fiscal agent or other large healthcare claims processing organization
POS System Manager	• Manages day to day client interaction planning and implementation, additions, changes and major modifications in support of pharmacy applications • Initiates and implements improvements in	• Bachelors degree in computer science or related field, including business data programming, business systems analysis, computer accounting, computer and information systems, computer servicing technologies, information systems

ROLE	RESPONSIBILITIES	SKILL SET
	all areas of IT responsibility • Serves as the main point of contact on all pharmacy technical and subject matters • Relays relevant information to customers and staff in a timely manner • Is accessible and responsive when unexpected circumstances require prompt attention	management, data processing, or computer engineering • Four years related experience may substitute for a degree • Ten plus years in one or more business aspects of information systems development. Hands-on experience of applications programming • MS Project, MS Office Suite, SQL, technical knowledge of pharmacy architecture and applications • Excellent verbal and written communication skills
Pharmacy Manager	• Analyzes and configures BMS pharmacy policy • Provides clinical support for policy development • Communicates with pharmacy providers • Conducts POS user training • Participates in provider workshops • Provides direction to the POS help desk • Plans, develops, tests, implements and maintains the West Virginia MMIS pharmacy solution, including POS • Assists with management of the MMIS pharmacy POS replacement DDI and certification, including all sub-phases	• Bachelor's degree in pharmacy (PharmD preferred) or four years directly relevant experience • Five years demonstrated management experience in retail pharmacy setting that includes directly supervising staff, and knowledge of outpatient drug dispensing and billing procedures • Preference will be given for additional experience in health care benefits management, including administration of clinical pharmacy benefits and related services; operational experience with state pharmaceutical assistance program(s) or other publicly-financed health program(s) such as Medicaid that includes administration and payment of pharmacy claims • Staff supervision skill • Unrestricted West Virginia pharmacy license
Drug Rebate Manager	• Manages drug rebate operations/personnel to include complete or partial technical and operational duties. Includes managing tasks within the drug rebate business/system application, including problem resolution, quality control, performance and client relationship • Coordinates and documents the requirements, specifications, design and testing efforts for drug rebate implementations • Prepares and maintains documents required for drug rebate operations and system modifications • Prepares training materials and trains State/Molina staff on drug rebate operations	• Bachelor's degree or five years management experience in a Medicaid pharmacy or drug rebate program that included direct supervision of staff • Three years experience managing Medicaid rebate operations • Preference given to candidates with experience in operation of system being bid • Personnel management skill • PharmD preferred • Project/program management • Knowledge of federal/state drug rebate regulations and best practices • Microsoft Office Suite, especially Excel, and PRIMS

ROLE	RESPONSIBILITIES	SKILL SET
	• Prepares and maintains desk level procedures for drug rebate operations • Manages staff productivity/performance • Communicates with customers to provide first-class support/response • Manages client relationships for rebate • Responsible for the implementation, maintenance, and all day-to-day operations of the Drug Rebate Program while complying with State and Federal guidelines • Responsible for the oversight and coordination of the Drug Rebate Program • Serves as a direct liaison to the Bureau for the Drug Rebate Program and is responsive and available to Bureau request for consultation and assistance • Assists in support of policy development; Conducts user training • Provides assistance to the help desk on rebate questions • Attends meetings/calls to provide rebate program information to the Bureau or its designees	• Excellent verbal and written communication skills
Provider/ Member Services Manager	• Manages and provides direct oversight of the activities of: enrollment, provider/member relations, provider training and outreach, and associated help desk business areas for medical/dental and POS • Assists in the development of internal desktop processes and policies and procedures. Develops and implements training programs and educational materials • Directs the assigned department on policy and procedures related to claims/ providers/members • Manages a team of representatives that includes recruitment, development, and motivation of staff • Initiates and communicates a variety of personnel actions that includes employment, termination, performance reviews • Conducts salary reviews and disciplinary actions • Facilitates meetings with the customer/ client and the necessary management team to discuss provider/member issues; offers	• Bachelor's degree or four years demonstrated experience as a provider/member services manager for a Medicaid agency or fiscal agent operation • Three years of experience with a Medicaid fiscal agent or large healthcare claims processing organization performing provider/member services • Supervisory experience in a call center operations environment • Four or more years experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of health care policy and direction • Strong analytic and problem solving abilities • Builds positive and collaborative relationships • Leadership qualities • Ability to multi-task in a high paced environment • Excellent verbal and written communication • Maintain confidentiality and comply with

ROLE	RESPONSIBILITIES	SKILL SET
	suggestions for improvement and/or changes; assists with the implementation of changes • Assists providers with problem solving and resolution of more complex claims and other issues; advises providers of new protocols, policies and procedures • Proactively resolves problems to ensure compliance with contract terms and resolve problems due to system issues • Researches and coordinates the resolution of provider claims • Researches and analyzes call center data and create reports for results and recommendations • Works collaboratively with the quality improvement department to review the accuracy, completeness, and verification of provider/member calls	Health Insurance Portability and Accountability Act (HIPAA) • Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers
Medical/ Dental Quality Manager	• Oversees all QA functions, including deliverable review, accuracy of reports, system enhancement documentation, and review of test results • Communicates with providers on an as-needed basis	• Bachelor degree or four years of directly relevant experience • Four years experience as a quality manager for a state Medicaid agency or fiscal agent • Experience in development and maintenance of a vigorous ongoing quality control function encompassing data entry, job balancing, system output, data integrity validation, system control, accounting • Provider communication skills
Financial Manager	• Manages the onsite financial operations team; responsible for the day-to-day activities of the financial accounting system • Handles all accounts payables and account receivables as well as works with and provides analysis for the Flexi financial system • Ensures that all financial transactions are properly administered and monitored, including accounts payable, accounts receivable as well as weekly, monthly, quarterly and annual financial reports that support the MMIS • Provides analytical support and analysis of the financial system surrounding adjudication and payment processing • Oversees the day-to-day financial adjustment team including personnel and related claim and the Flexi financial system processes	• Bachelor's degree in accounting, business administration or economics or equivalent experience • Five years experience managing an organizational department or unit responsible for the accounting, budget and/or reporting function of a large commercial healthcare claims processing organization, Medicaid agency, or a similar government project • Preferred MMIS financial management and accounting experience • Knowledge of implementing financial claims adjustments and monitoring the processes • More than one year SQL Server processing and coding

ROLE	RESPONSIBILITIES	SKILL SET
	• Develops, reviews, and distributes various reports as needed • Develops, reviews and updates policies and procedures as needed • Monitors financial processing issues based on claims payment by using SQL Server Studio and reviews package processing error logs • Manages all financial functions, reporting, including daily, monthly and other cyclical financial processes, and supports the budget process for Medical/Dental and POS	
EDI/Web Portal Manager	• Oversees electronic data interchange activities • Provides support for HIPAA transaction compliance • Develops and maintains implementation guides for medical/dental and POS processes • Supports expanding health information initiatives for medical/dental and POS, including HIE and ePrescribing	• Bachelor Degree or four years demonstrated experience as an Electronic Data Interchange (EDI) and/or Web Portal Manager for a State Medicaid Entity and/or Medicaid fiscal agent and/or other large healthcare claims processing organization • Five years of demonstrated experience as follows: • Three years of which should be in the development, implementation and/or support of EDI functionality within a Medicaid Agency and/or Medicaid Fiscal agent in a State or other US territory • Development, implementation and/or providing operational support for ongoing HIPAA transaction compliance for a large healthcare claims processing organization; and/or • Experience providing operational support for ongoing HIPAA transaction compliance • Development and support of policies, procedures, for the review and maintenance of implementation guides • Preference given to candidates with Medicaid Fiscal Agent operations experience
Reports Manager	• Manages the report development and analysis for medical/dental and POS • Recommends establishment of new or modified reporting methods and procedures to improve report content and completeness • Confers with persons originating, handling, processing, or receiving reports to identify problems and to gather improvements	• Bachelors degree or four years related experience in a healthcare claims processing organization • Four years work experience, preferably in claims processing environment and/or healthcare environment • Three years management or team leadership experience • Strong knowledge of SQL 2005/2008

ROLE	RESPONSIBILITIES	SKILL SET
	• Examines and evaluates purpose and content of business reports to develop new, or improve existing format, use, and control • Reviews reports to determine basic characteristics, such as origin, format, and purpose or function of report • Evaluates findings, using knowledge of workflow, operating practices, record retention schedules • Prepares and issues instructions concerning generation, completion, and distribution of reports according to new or revised practices, procedures, or policies • Defines a full software development lifecycle for the analytics team, including full testing methodology, detailed plans for conducting unit testing, detailed deployment plans • Drives team efficiency looking for ways to increase the efficiency • Maintains management/technical skills that can be utilized in the field to solve complex problems • Maintains a Best Practices document available to all team members on SharePoint • Tasks developers, manages staff for workloads • Develops and implements reports with repeatable processes to satisfy federal CMS reporting requirements • Maintains best practices for report distribution and archiving that complies with federal and State statutes • Monitors continuous improvements of established reports in production Creates reports to meet user requirements using Microsoft SQL Reporting Services and Crystal Reports • Provides documentation for best practices, lessons learned • Maintains SharePoint sites	SSRS report development • Familiar with relational database concepts, and SDLC concepts • Strong knowledge of SQL 2005, Microsoft Reporting Services and Crystal Reports • Ability to effectively assign tasks to staff and to prioritize tasks according to project needs • Development, implementation, and/or analysis of reports utilized in the support and/or operations of a Medicaid Agency in a State or other US territory • Development, implementation and/or analysis of reports utilized in the support and/or operations of a Medicaid Fiscal Agent which is performing operations in a State of equivalent scope to West Virginia • Development, implementation, and/or analysis of reports utilized in the support and/or operations of a large healthcare claims processing organization • Development, implementation, and/or monitoring of policies, processes and/or procedures and/or documentation for report development, generation, review and/or loading into a production reports database • Preference given to candidates with Medicaid fiscal agent operations experience • Solid understanding of Health PAS architecture and processing • Strong knowledge and hands-on experience with developing and implementing reports • Excellent problem solving, organizational and oral/written communication skills • Strong analytical, technical, interpersonal and relationship management skills • Must be highly motivated and results-oriented and work effectively multiple departments • Good software development and customer service skills
Medical/ Dental Project Manager	• Leads the vendor's project management activities for medical/dental inclusive of integration management with POS	• Bachelor's degree or four years related experience • PMP certification or industry recognized project management certification preferred • A total of four years of demonstrated experience in:

ROLE	RESPONSIBILITIES	SKILL SET
		• Project Management of a project that encompassed the full system development lifecycle from initiation through post implementation within a Medicaid agency in a state or other US territory; and/or • Project Management of a project that encompassed the full system development lifecycle from initiation through post implementation within a Medicaid fiscal agent which is performing operations in a state or other US territory • Preference given to candidates with Medicaid fiscal agent operations experience
POS Project Manager	• Leads project management activities for POS inclusive of integration management with medical/dental • Oversees DDI, implementation, certification, system enhancement, and upgrades • Oversees implementation of new requirements to assure that deliverables are timely, meetings and action items are documented, and proper resources are identified in order to meet requirements and timelines	• Bachelor's Degree or four years related experience in project management activities for a Medicaid agency or fiscal agent • PMP certification or industry recognized project management certification preferred • Five years project management experiences • Two years managing an MMIS POS project encompassing full life cycle development
Registered Nurse	• Identifies significant opportunities for clinical or financial improvement in medical/medication management • Develops and designs interventions that improve or maintain quality of care and reduce overall cost of care when possible • Assists in evaluating effectiveness of interventions • Serves as a clinical consultant for the Bureau for both medical/dental and POS	• Bachelor of Science in nursing (Master's Degree preferred) • Active license as a registered nurse in West Virginia • Knowledge of professional nursing principles and techniques, medical terminology, hospital routines and equipment • Knowledge of medications, including narcotics • Utilization review experience preferred • Two years experience in medical knowledge related to appropriate patient care • Thorough understanding of coding procedures and guidelines • Excellent verbal and written communication skills • General PC skills and Microsoft Outlook skills
Certified Professional Coder	• Leads the Procedure Code Workgroup, reviews and advises on all Medical/Dental and POS coding updates released quarterly, and is responsible for	• An Associate's or Bachelor's degree or equivalent experience • AHIMA (preferred), Certified Professional Coder (CPC), or other industry-recognized

ROLE	RESPONSIBILITIES	SKILL SET
	interpreting medical terminology in order to create numerical codes for insurance and medical statistics purposes for Medical/Dental and POS • Reviews and researches billed unlisted procedure codes to determine if a more specific code exists • Supplies cover and pricing information to client medical director regarding unlisted codes • Conducts meetings with state client to discuss procedure code coverage and ensure coding decisions are implemented • Owns archive of all procedure code Workgroup (PCW) agendas, minutes, and related materials • Maintains HIPAA reason and remark code lists and provide code updates to the HIPAA code workgroup, when necessary • Supports the claims department by working edit reports as assigned • Provides provider relations with coding issues and updates to be shared with providers to ensure timely and accurate claim payment • Maintains a library of code books and relevant resources to be available to personnel, when necessary • Serves as a resource for the client and co-workers with question related to coding issues	certification • Understands CPT and ICD codes, particularly the surgical codes, in order to convert terminology to numeric codes • Proficiency in assigning accurate medical codes throughout a wide range of services • Experience in integrating coding and reimbursement rule changes • Experience with AHA Coding Clinic guidelines • Knowledge of anatomy, physiology and medical terminology • Proficient in MS Office Suite
Continuously Dedicated Staff		
POS Quality Manager	• Oversees all quality assurance functions and responsibilities including (but not limited to) deliverable review, accuracy of reports, system enhancement documentation, and review of test results • Communicates with providers on an as-needed basis	• Bachelor's degree or four years related experience in quality control activities for a Medicaid agency or fiscal agent • Five years experience in quality control of a claims billing system, three of which are with a Medicaid agency or fiscal agent • Experience includes data entry, system output verification, job balancing, data integrity validation, system input control and accounting, provider communications, claims payment, internal controls and quality checks
Data Conversion Specialist	• Manages all data conversion activities for Medical Dental and POS • Provides guidance to other MMS teams regarding ETL questions and issues • Provides guidance to the Infrastructure team for ETL application server	• Bachelor's degree or four years demonstration experience as a claims conversion analyst or specialist • Five years experience managing data conversion for MMIS implementation project or health care information systems

ROLE	RESPONSIBILITIES	SKILL SET
	architecture requirements and disk capacity/performance needs • Mentors other team members in areas of expertise • Develops and manages packages and applications • Packages ETL packages for deployment to development, test, and production environments • Identifies, develops, and documents processes and procedures • Automates processes where appropriate • Participates in the ETL on-call rotation • Ensures that assigned tasks are completed on or ahead of schedule. Prioritizes assigned tasks appropriately • Informs the team lead and central engineering management of project issues; escalate issues in a timely manner, and ask for assistance when needed • Communicates effectively with a variety of audiences including management, peers, and members of other MMS teams. Tailors the message to the audience • Understands our processes and procedures, communicates processes and procedures to other groups, and enforces adherence to processes and procedures • Solves complex issues in innovative ways	• Prefer Medicaid fiscal agent operations experience • Three years ETL design and/or development experience • Three years database experience in SQL environment • Three years with ETL tools such as SSIS, Informatica, DataStage or Ab Initio • Analytical skills in a SQL environment • ETL design and development knowledge • Database knowledge utilizing tools such as SSIS, Informatica, DataStage, or Ab Initio • Excellent verbal and written communication skills
Interface Specialist	• Manages all interface development and implementation activities for medical/dental and POS	• Bachelor's degree or four years of directly relevant experience • Three years experience in systems integration, messaging components, and interface development for MMIS project or healthcare information systems • Preference given to candidates with Medicaid fiscal agent operations experience
Support Staff		
Trainer and Documentation Specialist (Manager)	• Develops training curricula, training materials, and facilitates training sessions and technical and/or documentation for medical/dental and POS • Reviews site policies, operating procedures, work instructions, forms, etc. for format consistency • Reviews documents and written external communication for format, consistency, and compliance with existing procedures	• Bachelor Degree or four years demonstrated experience in training multiple classes and in documenting letters, statements of work, manuals, etc. • Two years experience creating and producing technical and user documentation • One year experience in the management of documentation version control procedures and web-based documentation experience

ROLE	RESPONSIBILITIES	SKILL SET
	• Maintains revision control and a tracking spreadsheet for all controlled documents • Ensures all submitted change request forms, required signoffs/signatures and documentation components are accurate and complete • Performs site word processing and graphics tasks • Trains staff on document control policies and procedures • Proofreads and edits documentation and correspondence to the State and other external entities • Reviews policies, procedures, work instructions, forms, etc. for format consistency	• Excellent MS Word, Excel, PowerPoint and Adobe skills • Detail oriented and organized • Excellent editing, verbal, and written communication skills • Prefer Medicaid fiscal agent operations experience • Excellent presentation and facilitation skills
Medical/ Dental Ad Hoc Reporting Analyst	• Analyzes report data for trending purposes and reporting those variances to BMS • Gathers business requirements • Develops, quality checks, and delivers reports to BMS for approval	• Bachelor's degree or four years relevant experience as data or reports analyst for a large healthcare claims processing organization • Three years demonstrated experience in development and support of data analysis within a Medicaid agency or fiscal agent in a state of similar scope as West Virginia, • Development or generation of reports and analysis of the same in support of a large healthcare claims processing organization • Development and support of policies, processes, and procedures for the review and maintenance of billing manuals • Prefer Medicaid fiscal agent operations experience
POS Reporting Analyst	• Analyzes report data for trending purposes and reporting those variances to BMS • Gathers business requirements, report development, QA, and delivery of reports to BMS for approval • Creates reports to meet user requirements using Microsoft SQL Reporting Services • Writes and maintains database stored procedures • Writes documentation for best practices, lessons learned, release notes, DDI documents • Performs other duties as assigned by the Team Lead and Analytics Manager • Provides peer review and unit test reports • Successfully completes training courses set forth by analytics team manager	• Bachelor's degree or four years relevant account or financial experience • Three years experience supporting data analysis for Medicaid or other health care programs • SSRS report development experience preferred • Strong knowledge of SQL 2005/2008 • Familiar with relational database concepts, and client-server concepts • Knowledge of Medicaid IT systems, Microsoft Reporting Services, or Crystal Reports experience • SSIS or DTS experience • Developing knowledge of a MITA area and CMS requirements • Experience with Rational tools

ROLE	RESPONSIBILITIES	SKILL SET
	• Maintains SharePoint sites • Works independently or cooperatively with other software developers • Functions as a technical consultant or researcher	• Strong analytical, technical, and interpersonal skills required
Finance Report Analyst	• Analyzes report data for trending purposes and reports those variances to BMS • Gathers business requirements, report development, QA and delivers reports to BMS for approval • Assists the client with creating the allocation process for fund distribution • Participates in financial requirements workshops for the purpose of gathering financial business needs and stakeholder requests • Develops financial requirements specifications using industry best practices ensuring that the requirements and related business rules are complete, consistent, concise, comprehensible, traceable, feasible, unambiguous, and testable • Facilitates peer reviews of financial requirements documents • Participates in peer reviews of work products derived from financial requirements specifications to ensure that the requirements were interpreted correctly • Manages changes to base line financial requirements using established project change control processes and tools • Assists in the creation of objectives, agendas and other meeting materials in preparation for financial workshops • Supports the development and test teams as needed, providing walkthroughs, answering questions, creating data, etc. • Manages and reports status of ancillary components such as database scripts, interfaces, etc. • Identifies ways to assist product management in product planning through financial requirements development and analysis • Proposes new product features and updates	• Bachelor's degree or four years relevant experience as a financial reporting analyst for a large healthcare program • Three years experience preparing financial analysis for a Medicaid program or other healthcare program • Preference given to those with experience working in the product being bid • Familiar with CMS financial reporting • Good interviewing skills, ability to talk with various user groups about their needs and ask the right questions to glean essential requirements information • Excellent analytical skills, ability to evaluate information to reconcile conflicts, decompose high-level information into details, and distinguish user requests • Ability to lead requirements workshops and make "real-time" changes to artifacts • Ability to effectively communicate features and requirements to stakeholders and technical staff • Excellent organizational, interpersonal and verbal and written communication skills • Ability to work with the vast array of information gathered during elicitation and analysis and to cope with rapidly changing information • Ability to help negotiate priorities and to resolve conflicts among project stakeholders (such as customers, product management, and engineering)
Drug Rebate Analyst	• Performs monthly medical/dental claims load into PRIMS (Pharmacy Rebate Information Management System) • Performs monthly formulary load into PRIMS	• Bachelors degree or four years data analysis and reporting experience in a Medicaid or other healthcare program • Three years experience performing data analysis and reporting

ROLE	RESPONSIBILITIES	SKILL SET
	• Performs monthly provider load into PRIMS • Performs monthly pharmacy claims load into PRIMS • Creates the appropriate Medicaid invoice item activity record to account for CMS prior period rate adjustments • Creates the appropriate Medicaid supplemental invoice item activity record to account for prior period rate adjustments • Creates the appropriate invoice item activity record to account for a prior period claim reversals for both Medicaid and Medicaid supplemental • Creates and prints the invoices when requested by the State • Performs invoice verification running reports to verify invoice amounts • Generates invoice mailings by printing invoices for the different Medicaid programs • Checks entry and payment posting/reconciliation for Medicaid, Medicaid supplemental, and JCode invoices • Has responsibility for analyzing report data for trending purposes and reporting those variances to BMS and gathering business requirements, report development, QA and delivery of reports to BMS for approval	• Microsoft Office Suite, especially Excel, and PRIMS • Excellent verbal and written communication skills • Prefer a strong background/emphasis in finance
Other Named Staff		
HIPAA Compliance Officer	• Develops, maintains and revises policies and procedures on the appropriate use and disclosure of PHI and other HIPAA standards • Provides guidance to subsidiary staff regarding state-specific privacy requirements and helps ensure policies and procedures are matched with appropriate processes and controls to promote compliance • Assists in managing the organization's privacy incident response process including investigation, mitigation, reporting, training and remediation • Performs ongoing monitoring of Business Associates Agreements and third party data sharing/use agreements • Plans and conducts audits and reviews to assess departmental and business unit	• Bachelors degree or equivalent experience • Three years experience in healthcare compliance or information privacy compliance • Knowledge of HIPAA, HITECH and other healthcare privacy laws • Appropriate knowledge of information privacy and/or security, preferably including CIPP certification • Auditing experience • Knowledge and understanding of legislative/regulatory process and the technology environment regarding privacy • Proficiency with PC-based applications, thorough knowledge of Microsoft Office Suite (including Access, Excel, PowerPoint and Word), MS Visio, and MS Project • Ability to learn new information systems

ROLE	RESPONSIBILITIES	SKILL SET
	compliance with HIPAA and contractual requirements and accreditation standards • Assists with the development and provision of HIPAA privacy and security training, education and awareness • Initiates, facilitates and promotes activities to foster privacy and security awareness within Molina Healthcare • Maintains current knowledge of applicable federal and state privacy laws and accreditation standards, and monitors advancements in information privacy technologies to ensure organizational adaptation and compliance	and software programs • Ability to assess and mitigate risks and, if required, independently review controls • Strong written and verbal communication skills • Strong analytical, organizational, and project management skills
DDI Coordinator	• Facilitates communication and coordination between the Bureau and the Vendor • Participates in all areas of account operations and DDI • Reviews deliverables	• Bachelor's degree or equivalent experience in the healthcare field per contract requirements • Requires system, technical/operational and program experience • Five plus years of MMIS experience
Other Staff		
Accounting Analyst	• Works with and provides analysis for the Flexi financial system • Performs accounts payable and accounts receivable transactions and generates weekly, monthly, quarterly, and annual financial reports that support the MMIS • Performs analysis of the financial system surrounding adjudication and payment processing • Performs financial adjustments • Supports the budget process for Medical/ Dental and POS	• Bachelor's degree in accounting, business administration or economics or equivalent experience • Preferred MMIS finance and accounting experience • Knowledge of implementing financial claims adjustments and monitoring the processes
Administrative Assistant	• Maintains, processes, tracks, and reconciles expense reports in a timely and accurate manner for upper management • Processes new hire setup/termination paperwork (i.e. credit cards, cellular phones, security clearance, etc.) • Schedules travel arrangements for manager and upper management • Manages calendars including scheduling appointments, meetings, confirming appointments, recognizing and resolving conflicts, and ensuring that meeting logistics are addressed and communicated to attendees • Coordinates meetings/lunches including catering, equipment and supplies needed,	• High School diploma or GED • Five years office/clerical experience • Excellent proficiency with Microsoft Office Suite and/or other software packages such as Visio, Citrix, Siebel, Kronos, and Concur • Ability to multitask • Ability to prioritize and manage workload to ensure primary responsibilities are met before secondary responsibilities • Excellent organizational skills • Ability to interact and support team-members and leadership at all levels • Excellent verbal and written communication skills

ROLE	RESPONSIBILITIES	SKILL SET
	etc. • Creates meeting agendas and other site related documents • Updates Web portals on a daily basis or as needed • Prepares complex reports; maintaining records requiring classification and compilation of varied information • Participates and takes meeting minutes as needed • Effectively interacts with individuals in a broad range of situations in an increasingly challenging and complex work environment • Orders business supplies as needed • Processes facility requests • Processes incoming, outgoing mail and shipments	
Auditor	• Conducts audits to assess departmental compliance with standards • Audits Medicaid contract requirements and regulatory requirements • Compiles audit results and reports to appropriate oversight committee / department head(s) • Revises and develops audit tools to reflect current standards, contract requirements and regulations • Communicates clearly and effectively with staff on compliance reporting requirements, ad hoc requests, and other communiqués • Investigates and reports on suspected recipient and provider waste, abuse, and fraud • Assists instances of suspected fraud	• Bachelor's degree or equivalent experience • Three to five years management experience preferred • Knowledge of Medicaid contract and requirements • Effective verbal and written communication skills • Ability to develop, organize, analyze and implement procedures • Effective interpersonal skills • Management negotiation skills • Familiarity with standards
Automated/ Manual Testers	• Creates and executes test cases and documents results of test execution • Generates test data using automated test facility • Collects data to run manual tests from Health PAS users • Documents defects from test case execution • Tracks defects and code drops related to assigned solution component; helps ensure their completion and incorporation into all related documentation	• Bachelors Degree and/or equivalent experience • Four plus years test experience • Thorough knowledge of Medicaid components • Excellent interpersonal and verbal and written communication skills
Business	• Assists with modifications and future	• Bachelor's degree or experience in

ROLE	RESPONSIBILITIES	SKILL SET
Analyst	enhancements of Health PAS • Performs data conversion activities • Develops and maintains business operations process models based on the MITA business areas/processes • Leads requirements to COTS specification workshops	analyzing business requirements for Medicaid, Medicare or a large health payor can be substituted for the Bachelor's Degree on a year-for-year basis • Three years of experience in analyzing business requirements for Medicaid, Medicare or a large health payor • In depth knowledge of MITA standards • Knowledge Health PAS components • Specific knowledge of claims, enrollment, and/or authorizations in a Medicaid environment • Possesses analytical and creative problem solving skills • Excellent verbal and written communication skills
Business Architects (claims, utilization management, member, third party liability, provider, reference, finance)	• Provides advanced leadership and solution designs for specified MITA business areas • Creates and presents DDI project training for project Boot-camp sessions for internal and external staff • Continuously works with solution teams to improve processes and delivery for their functional MITA business areas • Facilitates or presents MITA Business process end-to-end solutions in initial Requirements to COTs Specification (RCS) workshops, serving as a role model for MITA systems analysts to lead subsequent sessions • As needed, works with the cross-functional teams or Health PAS component owners to define the design for MITA business process end-to-end solutions for specific functions • Manages and mentors the MITA Systems Analysts reporting up to them to coordinate team tasks and deliver on-time work packages for steady state engineering tasks • Provides support to site management for new initiatives and meetings • Provides performance reviews, coaching, mentoring, and conflict resolution for team • Provides support, when needed, of product development, pre-sales, and business development • Creates product design requests for critical functionality to be added to the QNXT product to eliminate the need for gap processes	• Bachelor's degree or equivalent experience • Seven plus years experience one or more business aspects of MMIS development or other areas of healthcare system development • Advanced to expert leadership skills • Advanced critical thinking and problem solving skills • Strong familiarity with change management; project management; and technology management • Dedicated to knowledge sharing with team and customer • Advanced Medicaid and QNXT knowledge; and advance knowledge of business process models • Moderate to advanced knowledge of other Health PAS COTS software • Strong healthcare system knowledge • Excellent presentation skills • Excellent verbal and written communication skills • Advanced knowledge of business process models

ROLE	RESPONSIBILITIES	SKILL SET
Business Automation Analyst	• Establishes and maintains telecommunications and connectivity • Investigates, evaluates, recommends and implements upgrades to business processes • Able to translate policy statements in to business processes • Understands Medicaid processes	• Bachelor's degree or equivalent experience • Strong knowledge of networks, security, and IT infrastructure • Experience with government health care systems preferred
Certification Manager	• Coordinates all activities of certification • Trains staff in use of CMS Checklist • Understands overall operations of system • Schedules all meetings for certification activities • Ensures all artifacts of the testing and operations are archived • Responds to follow up activities • Trains staff in presentation to CMS reviewers	• Bachelor's degree or equivalent experience • Seven plus years experience in MMIS development or other areas of healthcare system development • Advanced to expert leadership skills • Advanced critical thinking and problem solving skills • Health PAS experience preferred • Recent certification experience preferred • Excellent verbal and written communication skills
Change Manager	• Defines, documents, and follows the specific process for each of the change categories • Maintains and follows change management procedures • Establishes and follows prioritization business rules, project scope, and implementation timeline • Monitors change request (CR) tracking in RQMS and maintain updates to tracking information • Establishes and follows criteria for scope changes, statements of work, cost estimates, and invoicing • Reports to site leadership on CR performance measurements • Develops strong customer relationships based on mutual respect and rigorous business rules • Works with site leadership and finance to ensure timely invoicing of billable CRs and report profitability of these CRs monthly • Holds all resources accountable for on-time and on-budget delivery of CRs	• Bachelor Degree or equivalent experience • Five years experience in project management, software implementation, or system change management • Strong client-facing and relationship skills required, including proven ability to manage and disposition conflict resolution • Demonstrated ability to work effectively in a matrix organization and to get things done without direct authority. Comfortable working in a geographically disperse environment • Demonstrated written and verbal communication skills with customer, offsite support groups, and internal department heads • Healthcare claims processing experience strongly preferred
Claims Manager	• Maintains responsibility for claims payment activities including claims resolution, claims adjustments, and claims data entry • Oversees mailroom operations, including	• Bachelor's degree or equivalent experience • Five years experience as a claims operations manager in a healthcare environment

ROLE	RESPONSIBILITIES	SKILL SET
	scanning, keying, mail sorting, document printing, and mailing • Administers prior authorization activities • Maintains oversight for the management of financial activities and state fund disbursements • Develops and oversees claims processing operations and all associated manual processes • Develops and coordinates changes and enhancements and identifies the impacts these modifications have on the claims module • Manages claims processing staff • Establishes and maintains relationships with the State • Communicates with providers concerning complex claims adjudication processes • Manages the daily operations of the claim department and mailroom • Meets with the State regarding policy and procedures • Ensures external claims data vendors meet contractual obligations • Ensures that all quality standards are met to assure claims processing accuracy • Delegates and prioritizes task assignments of claims and mailroom staff • Evaluates processes for improvement • Supports all initiatives in improving overall efficiency	• Strong knowledge of medical claims payment systems • Thorough understanding of CPT/HCPCS and ICD-9 coding procedures and guidelines • Knowledgeable in Microsoft office products such as word and excel • Excellent verbal and written communication skills
Claims Resolution Specialist	• Processes claim forms, adjudicates for allocation of deductibles, co-pays, co-insurance maximums and provider reimbursements • Follows adjudication policies and procedures to ensure proper payment of claims • Resolves pending claims based on Medicaid rules and regulation established for final processing • Meets established production requirements consistently • Maintains an accuracy rate of 98 percent or better	• High School diploma or GED • One to two years general office experience in a claims environment • Knowledge of Microsoft Office products • General knowledge of personal computer • Good verbal and written communication skills
Claims Supervisor (Lead)	• Supervises claims processing staff and monitors daily operations according to client policies and procedures • Delegates and prioritizes task assignments	• High School Diploma or equivalency • Working knowledge of mailroom operations • Five years supervision/lead in a claims

ROLE	RESPONSIBILITIES	SKILL SET
	of staff • Updates desktop procedures • Maintains productivity to ensure staff meet production standards	processing environment
Controller	• Ensures that all financial transactions for the contract are properly administered and monitored, including accounts payable, accounts receivable as well as weekly, monthly, quarterly and annual financial reports that support the MMIS • Provides analytical support and analysis of the financial system surrounding adjudication and payment processing	• BA/BS in accounting, business administration or equivalent experience • Three to five years working in healthcare finance operations with at least two years of financial analysis and management experience • Knowledge of implementing financial claims adjustments and monitoring the processes • More than one year SQL Server processing and coding
Data Architect	• Understands database management systems and tools used by the DBA group and recommends innovative approaches to solving issues and improving existing processes • Recommends database tools that could benefit our projects • Researches and prototype approaches for improving database efficiency and performance, then documents and rolls out successful approaches to the DBA project teams • Recommends database server architecture requirements and works with infrastructure on building database servers • Determines database disk capacity and speed requirements and work with Infrastructure on implementation • Tunes and troubleshoots databases and database applications • Identifies database processes that can be automated and rolls out automation techniques to the DBA project teams • Participates in the DBA on-call rotation • Provides technical leadership and guidance to the DBA team • Trains DBAs in new or unfamiliar database features and performance tuning techniques • Assists DBAs in solving complex technical issues • Establishes, documents, and rolls out database processes and procedures • Provides recommendations, alternatives,	• Bachelor's degree or equivalent experience • Three to five years of MS SQL Server 2005 database administration in a production environment • Five to seven years of hands-on relational database experience • Database architecture or capacity planning experience • Advanced to expert level SQL Server 2005/2008 administration and tuning skills • Experience with large databases up to two terabytes in size and a solid understanding of the effects of various factors on the health and performance of large, transactional SQL Server databases • Excellent problem solving skills • Solid understanding of Health PAS architecture and processing and of how database architecture and design relates to larger project objectives • Self-motivated, takes initiative to identify, communicate, and resolve potential issues • Excellent verbal and written communication skills

ROLE	RESPONSIBILITIES	SKILL SET
	and guidance to management, DBA team leads, and other account teams regarding database questions and issues	
Data Conversion and Interfaces Manager	• Develops conversion and interface strategy • Manages the data conversion and interfaces requirements, design, construction, testing and implementation activities • Provides overall direction to interface and conversion resources • Establishes objectives and oversees the progress against interface and conversion tasks in the work plan • Collaborates with data suppliers to assure availability of data to facilitate the execution of conversion tasks in the project schedule • Provides day-to-day direction to the conversion team • Defines and validates the customer business requirements and solution requirements for data conversion • Develops the data mappings for the required data conversion from the source database to the target database • Designs, tracks and reports the integration of data between the Health PAS solutions and produce comparative reports for previous periods of operation • Supports testing for data conversion • Assists client in developing business rules for situations where a straight conversion is not feasible • Crosswalks data to allow continued application of all edits, audits, service authorizations, drug exception requests, rebates, calculations, and to meet all other system processing requirements	• Bachelor's degree or equivalent experience • Three to five years healthcare experience • Three to five years project management experience • Strong knowledge of the lifecycle development process in reference to requirements gathering and software development • Strong knowledge of a project management tool such as Primavera or Microsoft Project • Strong knowledge of Microsoft SQL Server • Strong knowledge of a Structured Query Language (SQL) such as Microsoft SQL Server T-SQL • Working knowledge of word processing and spreadsheet software such as Microsoft Word and Excel • Working knowledge of the Rational Tool Set • Excellent verbal and written communication skills
Database Administrator	• Oversees Health PAS database administration, backups, and recoveries, verifying the security and integrity of the database • Creates and maintains database schema definition, performance tuning, and capacity planning • Collaborates with other systems and operations units to maximize the value of the data and determine the impact of changes on Health PAS • Verifies that databases and data	• Bachelor's degree or equivalent experience • five years hands-on relational database experience • Two years experience as an SQL Server database administrator in a production environment. Familiarity and comfort with ordinary maintenance tasks such as moving temporary databases, migrating databases, changing server configuration parameters, and dropping/adding users and logins

ROLE	RESPONSIBILITIES	SKILL SET
	dictionaries are updated according to specified schedules • Executes development scripts to update the database • Works with team members to resolve database questions or problems • Coordinates systems resource availability with database analysts, system and application programmers, and other users • Maintains industry-recognized policies, procedures, and standards relating to database management	• Solid understanding of relational theory and how it applies to production environments • Advanced to expert level SQL Server 2005/2008 administration and tuning skills • Experience with large databases up to two terabytes in size and a solid understanding of the effects of various factors on the health and performance of large, transactional SQL Server databases • Excellent problem solving skills • Ability to lead complex database-related technical tasks, identify and resolve potential issues, and drive tasks to successful completion on or ahead of schedule
Desktop Support	• Provides the technical support of telephony systems, for local MMS customers and/or employees • Applies basic diagnostic techniques to identify problems, investigate causes and recommend solutions to correct common failures and support of local telephony systems • Orders and sets up new staff equipment • Provides upgrades of phone systems to Molina standards	• Associate's Degree or equivalent experience • Three to five years experience with telephony systems
Desktop Support Analyst	• Provides technical support of hardware, systems, subsystems and/or applications for customers and employees • Reviews, analyzes, and evaluates information technology systems operations • Applies basic diagnostic techniques to identify problems, investigate causes and recommend solutions to correct common failures and support of PCs and applications • Maintains personal computers and desktops and disposes of obsolete equipment • Supports on-call as required on a rotating basis 24/7	• Associate's Degree or equivalent experience • Three to five years computer experience • Knowledge of Windows 2000/2003/2008 Server administration • Knowledge of 2005 R2 virtual server • Computer room/network/phone and printer support skills • Personal computer hardware and applications support skills
Document/ Process Specialist	• Designs, develops and implements customized functionality for at least one integrated solutions component to accommodate business processes related to that integrated solutions component • Identifies the need for and develops new integrated solutions functionality to accommodate new business processes and	• Bachelor's degree or equivalent experience • Combined five to ten years of health care, system engineering, and project management experience • Business analysis and modeling knowledge, applying technical solutions to business processes

ROLE	RESPONSIBILITIES	SKILL SET
	procedures as they are introduced to the solution • Assists and mentors peers with understanding integrated solution components, technical architecture, custom development, and operations support • Represents the Integrated Solution as a new implementation lead or existing customer support lead, potentially managing junior integrated solutions resources	• FileNET configuration of document classes, indices and distribution queues (Storage Manager) • Knowledge of one or more of the following: Venetica (Process Manager), Cincom (Letter Manager), ASG Cypress (Report Distribution Manager), Apropos AVRS, Call Center Toolsets (Contact Manager) • Knowledge of Microsoft Structured Query Language (SQL), VB Script, Visual Basic for Applications (VBA) Java Script, HTML and extensive knowledge of Markup Language (XML), and Active Server Pages (ASP • Knowledge of project management • Excellent verbal and written communication skills
Drug Rebate Analyst	• Performs ongoing support of the PRIMS projects, including user interface and database modifications, application and database performance tuning, and ad hoc report creation • Serves as technical lead on any PRIMS implementation, including database design and development, application/GUI design and development, data conversion and migration planning and development, and system testing • Advises on all technical matters for PRIMS projects • Trains new technical staff on application maintenance and improvements • Monitors day-to-day activities of technical staff working on application and serves as primary technical contact with other engineering groups supports PRIMS operations	• Bachelor's Degree or equivalent experience • Minimum of five years SQL development/administration experience • Minimum five years reporting tools experience • Minimum five years Medicaid drug rebate experience • Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers, customers, and other stakeholders
Drug Rebate Technical Lead	• Responsible for all technical aspects of the Rebate system, which includes, but is not limited to, the development, testing, implementation, and maintenance of a system that will accommodate all rebate activities	• BA/BS degree in Computer Science, Information Systems, or related field. Four years of demonstrated experience performing systems and/or software engineering activities, two years of which are direct experience related to the system being proposed
EDI Call Representative	• Coordinates the set up and approval of providers, clearinghouses, and billing agencies for the Web portal including the completion of agreements and transaction forms • Validates, researches and resolves daily	• High School Diploma or GED • Provider Relations experience • Microsoft Word, Excel, Outlook and Internet • Excellent verbal and written

ROLE	RESPONSIBILITIES	SKILL SET
	EDI data received from providers, clearing houses, and billing agencies • Resolves problems related to specific EDI documents that generate 997, TA1 and 824 errors • Works with vendors/trading partners to identify, define, develop, and implement changes to correct errors • Manages EDI projects and communicate directly with providers, clearinghouses and billing agencies in a call center setting • Reads, understands and professionally communicates Extensible Markup-language (XML) data and ANSI X12 format including 835 and 837 Professional, Institutional and Dental formats • Performs provider assistance with direct data entry (DDE) submission of claims, 270/276 transactions, retrieval of electronic remittance advices and related reports on the MMIS Web portal	communication skills • Strong organizational skills, attention to detail and problem solving • Ability to perform tasks with a high degree of accuracy
Enrollment Analyst	• Performs provider enrollment and re-enrollment functions • Performs provider re-validation • Ensures all State and Federal guidelines for enrollment and re-enrollment are met (including PPACA rules and regulations) • Maintains provider demographic data within the MMIS • Assigns provider enrollment/re-enrollment status • Verifies all provider enrollment/reenrollment documentation, including licenses and certifications is received; follow up with providers where additional documentation is needed • Refer evidence or reports of Provider fraud/abuse/exclusion to BMS and/or its designee on a monthly basis. • Distribute provider enrollment materials including a welcome package • Responds to provider inquiries specific to provider enrollment/re-enrollment	• Bachelor's degree or equivalent experience • Two years of experience in the health care billing or health care public relations fields • Experience with Microsoft Office • Knowledge of FileNET document classes, indices and distribution queues • Knowledge of Cincom (Letter Manager) and Call Center Toolsets (Contact Manager) • General knowledge of a personal computer • Good verbal and written communication skills
Extract, Transform, and Load Developers	• Provides guidance to site management including cost analysis. Also provides guidance to other teams • Provides guidance to other teams regarding ETL questions and issues • Provides guidance to the infrastructure team for ETL application server	• Bachelor's degree or equivalent experience • Three to five years analysis experience • Three to five years ETL design and/or development experience • Three to five years database experience in

ROLE	RESPONSIBILITIES	SKILL SET
	architecture requirements • Mentors other team members • Develops and manages packages and applications • Packages ETL packages for deployment to development, test, and production environments • Identifies, develops, and documents processes and procedures • Automates processes where appropriate • Participates in the ETL on-call rotation • Ensures that assigned tasks are completed on or ahead of schedule • Prioritizes assigned tasks appropriately • Informs the team lead and management of project issues; escalates issues in a timely manner, and ask for assistance when needed • Communicates effectively with a variety of audiences • Understands our processes and procedures, communicates to other groups, and enforces adherence to processes and procedures	SQL environment • Three to five years with ETL tools such as SSIS, Informatica, DataStage or Ab Initio • Analytical skills in a SQL environment • ETL design and development knowledge • Database knowledge utilizing tools such as SSIS, Informatica, DataStage, or Ab Initio • Excellent verbal and written communication skills
Health PAS Subject Matter Experts	• Analyzes, models, designs, develops and implements integrated solutions components for Medicaid sites • Designs, develops and implements customized functionality to accommodate business processes related to integrated solutions components • Identifies the need for and develops new integrated solutions functionality to accommodate new business processes and procedures as they are introduced to the solution • Assists and mentors peers with understanding integrated solution components, technical architecture, custom development, and operations support • Represents the integrated solutions group as a new implementation lead or existing customer support lead, managing junior integrated solutions resources	• Bachelors degree or equivalent experience • Combined eight years of health care, system engineering, and project management experience • Business analysis and modeling knowledge, applying technical solutions to business processes • Knowledge of FileNET configuration of document classes, indices and distribution queues (Storage Manager) • Knowledge of one or more of the following: Venetica (Process Manager), Cincom (Letter Manager), ASG Cypress (Report Distribution Manager), Apropos AVRS, Call Center Toolsets (Contact Manager) • Knowledge of Microsoft Structured Query Language (SQL), VB Script, Visual Basic for Applications (VBA) Java Script, HTML and extensive knowledge of Markup Language (XML), and Active Server Pages (ASP) • Knowledge of project management • Excellent verbal and written communication skills

ROLE	RESPONSIBILITIES	SKILL SET
Implementation Director	• Leads the Vendor's project management activities for the MMIS implementation • Communicates with Bureau representatives • Ensures appropriate resources are assigned to the project • Ensures all deliverables are provided including all status reports • Leads status meetings	• Bachelor's degree or equivalent experience • Four years of directly relevant experience can be substituted for a degree • Five years project management experience • PMP certification or industry recognized project management certification preferred
Infrastructure DBA	• Oversees Health PAS database administration, backups, and recoveries, verifying the security and integrity of the database • Creates and maintains database schema definition, performance tuning, and capacity planning • Collaborates with other systems and operations units to maximize the value of the data and determine the impact of changes on Health PAS • Verifies that databases and data dictionaries are updated according to specified schedules • Works with team members to resolve database questions or problems • Coordinates systems resource availability with database analysts, system and application programmers, and other users • Maintains industry-recognized policies, procedures, and standards relating to database management	• Bachelor's degree or equivalent experience • Five years hands-on relational database experience • Two years as a SQL Server database administrator in a production environment. Familiarity and comfort with ordinary maintenance tasks such as moving temporary databases, migrating databases, changing server configuration parameters, dropping/adding users and logins • Solid understanding of relational theory and how it applies to production environments • Advanced to expert level SQL Server 2005/2008 administration and tuning skills • Experience with large databases up to two terabytes in size and a solid understanding of the effects of various factors on the health and performance of large, transactional SQL Server databases • Excellent problem solving skills • Ability to lead complex database-related technical tasks, identify and resolve potential issues, and drive tasks to successful completion on or ahead of schedule
Infrastructure Engineer	• Establishes and maintains telecommunications and connectivity • Develops value added networks (VANS) and the eligibility verification system (EVS) • Investigates, evaluates, recommends and implements upgrades to hardware and software to according to state requirements • Prepares and maintains documentation for current network platform, backup, and printing procedures	• Bachelor's degree or equivalent experience • Strong knowledge of networks, security, and IT infrastructure • Skilled at communicating technical information to non technical users • Four years experience with LANS and Networks
Infrastructure Lead	• Establishes and maintains telecommunications and connectivity • Oversees network administrators,	• Bachelor's degree or equivalent experience • Strong knowledge of networks, security,

ROLE	RESPONSIBILITIES	SKILL SET
	technicians, and operators • Develops value added networks (VANS) and the eligibility verification system (EVS) • Investigates, evaluates, recommends and implements upgrades to hardware and software to according to state requirements • Prepares and maintains documentation for current network platform, backup, and printing procedures • Develops and maintains disaster recovery plan and leads testing activities	and IT infrastructure • Skilled at communicating technical information to non technical users • Six years experience with LANS and Networks • Two years supervisory and management experience
Intercom Engineer	• Establishes, maintains, and updates the SharePoint portal that houses the Health PAS-InterComm communications portal • Establishes and enforces standards and procedures for using InterComm, managing security and access rights, archiving, availability, establishing new folders, backup and recovery, and user manuals and training • Develops and maintains user manuals • Provides training in the use of the portal	• Bachelor's degree or equivalent experience • Three to five years computer experience • Strong knowledge of SharePoint web portal application • Strong knowledge of Health PAS-InterComm • Strong knowledge of networks and security • Skilled at documenting and communicating technical information to non-technical users
Interface Specialist	• Provides day-to-day direction to the interface team • Defines and validates the customer business requirements and solution requirements for interfaces • Develops the data mappings for the inbound and outbound data interfaces • Designs the integration of data between the Health PAS solutions • Supports testing for the interface processes • Tracks and reports the progress of interface tasks	• Bachelor's degree or equivalent experience • Strong knowledge of interfaces, including data mapping, requirements definition, data integration, and testing • Skilled at communicating technical information to non technical users • Six years experience with system interfaces • Two years supervisory and management experience
Mail Room Lead	• Management of mail room activities • Monitors subcontractor activities • Tracks use of postage • Ensures all deliveries are made	• High School diploma or GED • Two years experience in mail room processing
Member Payments Financial Analyst	• Performs member cleanup from member eligibility loads • Conducts member analysis and demographic updates as submitted by client or onsite staff • Performs daily and monthly Medicare clean-up • Serves as lead for multiple meetings	• Bachelor's degree or equivalent experience • Minimum of two years experience working with Health PAS, preferably knowledge of current version • Knowledge of insurance claims processing • SQL, Visual Basic MS Project, MS Office Suite

ROLE	RESPONSIBILITIES	SKILL SET
	(internal and with customer) • Develops and maintains all process documents regarding member module and key responsibilities • Trains staff members in member maintenance	• Ability to work independently, with minimal supervision • Excellent verbal and written communication skills
OPS LAN/ Desktop Analyst	• Provides the technical support of hardware, systems, sub-systems and/or applications for customers and/or employees • Reviews, analyzes, and evaluates information technology systems operations • Applies basic diagnostic techniques to identify problems, investigate causes, and recommend solutions to correct common failures and support of local PCs and applications • Provides technical support for computer room, printer room, and network/phone support • Assists infrastructure and applications teams implementing changes • Maintains all personal computers and desktops and disposes of obsolete equipment • Orders and sets up new staff equipment • Supports server Microsoft patches/printers/facility tasks • Provides upgrades of computer systems to Molina standards • Supports on-call as required on a rotating basis 24/7	• Associate's Degree or equivalent experience • Three to five years computer experience • Knowledge of Windows 2000/2003/2008 Server administration • Knowledge of 2005 R2 Virtual Server • Computer room/network/phone and printer support skills • Personal computer hardware and applications support skills
Mailroom Analyst/ Courier	• Receives, opens, sorts, and delivers incoming mail receipts • Delivers and collects mail daily to local post office • Delivers and collects documents twice daily to the state offices; may require additional trips to various state offices, as needed • Delivers and collects mail to various departments within Molina • Coordinates outbound mail • Maintains transportation log for van and ensures timely maintenance • Monitors contractor staff • Prepares, for mailing, return to provider (RTP) letters	• High school diploma or GED • Valid state drivers license • One year prior courier experience preferred • Ability to lift up to 50 pounds • Basic knowledge of Microsoft Office Outlook
Pharmacy Analyst,	• Leads POS team on technical tasks: analyzing work requests from customer for	• Bachelors degree or equivalent experience

ROLE	RESPONSIBILITIES	SKILL SET
Software Engineer	pharmacy applications changes, assessing risks, assigning tasks, assisting team in developing technical solutions, and mentoring other team members in applications and technical skills • Performs development tasks when needed • Analyzes production transactions and system data to understand system behavior and improve system operation • Promotes continuing high quality of software and documentation by reviewing software, documents, and team activities for compliance with the quality processes and practices developed by the POS team • Proposes process improvements as needed	• Five plus years in real-time transaction processing, application programming, relational database programming, and client-server programming • Ability to establish close working relationships with customers and internal staff, understanding their needs and perspectives • Knowledge of C, Unix, SQL, pharmacy applications, real-time processing, statistics, source code control, MS Office Suite • Ability to understand real-world application of process quality concepts
Pharmacy Benefit Technician	• Perform POS related duties such as but not limited to provider communication, operation, and claims reconciliation • Assists pharmacy providers with questions regarding BMS policy for pharmacy services • Provides resolution to pharmacy point of sale claims that, based on BMS policy and clinical needs, require an override • Reviews the WEST VIRGINIA preferred drug list for accuracy and completeness • Keeps the National Drug Codes current within the West Virginia MMIS	• High School Diploma or GED • Possess a current, valid West Virginia Board of Pharmacy technician license • Working knowledge of West Virginia MMIS • Knowledge of BMS pharmacy policies • Five years of Medicaid experience with three of those years specific to West Virginia Medicaid • Two years of experience in pharmacy operations
Pharmacy ETL Analyst	• Provides guidance to site management including cost analysis • Provides guidance to other teams regarding pharmacy ETL questions and issues • Provides guidance to the infrastructure team for pharmacy ETL application server architecture requirements and disk capacity/performance needs • Mentors other team members in areas of expertise • Develops and manages packages and applications • Packages ETL packages for deployment to development, test, and production environments • Identifies, develops, and documents processes and procedures • Automates processes where appropriate • Participates in the ETL on-call rotation • Ensures that assigned tasks are completed on or ahead of schedule. Prioritizes	• Bachelors degree or equivalent experience • Three to five years analysis experience • Three to five years pharmacy ETL design and/or development experience • Three to five years database experience in SQL environment • Three to five years experience with ETL tools such as SSIS, Informatica, DataStage or Ab Initio • Analytical skills in a SQL environment • ETL design and development knowledge • Database knowledge utilizing tools such as SSIS, Informatica, DataStage, or Ab Initio • Excellent verbal and written communication skills

ROLE	RESPONSIBILITIES	SKILL SET
	assigned tasks appropriately • Informs the team lead and management of project issues; escalate issues in a timely manner, and ask for assistance when needed • Communicates effectively with a variety of audiences including management, peers, and members of other MMS teams. Tailors the message to the audience • Understands our pharmacy processes and procedures, communicates processes and procedures to other groups, and enforces adherence to processes and procedures • Solves complex issues in innovative ways	
PMO Analyst	• Conducts independent analysis of the schedule for the design, development and implementation of the West Virginia MMIS replacement • Analyzes the process and methodologies used by the various technical and operational teams for the West Virginia MMIS replacement project to confirm that risks, issues and opportunities have been addressed • Reviews the deliverables associated RTMs, BSD, and other design artifacts • Possesses broad knowledge of and exposure to project management disciplines to support PMO activities	• Bachelors degree or equivalent • Five to eight years leading service delivery teams • Five years experience with automated tool suites • One to three years PMO experience • Excellent MS Office skills including Excel, PowerPoint, Access, Word • Thorough knowledge of automated tool support including Rational Tool Suite and Risk Radar • Familiarity with MS Project Server administration, and MS SQL Server queries and reporting • Understanding of MS networking technologies • Adherence to Project Management Institute best practices • Ability to handle multiple, high priority assignments concurrently
PMO Manager	• Originates the appropriate planning concepts and tools used for planning, scheduling, and tracking projects • Establishes the project management infrastructure, including development of project plans, schedules, resource requirements, and change orders • Maintains the project management plans; including issue management plan, a risk management plan, a quality management plan, and a change and configuration management plan • Monitors the work activities against with the approved work plan • Controls project requirements, scope, and	• Bachelor's degree or equivalent experience • Six to eight years project management experience • One to three years PMO experience • Five years strategic planning experience • Five years SDLC experience • Excellent MS Office skills including Excel, PowerPoint, Access, Word • Excellent MS Project client and server skills • Thorough understanding of MS networking technologies • Excellent attention to detail and follow-up

ROLE	RESPONSIBILITIES	SKILL SET
	change management issues	skills • Broad business management background including resource management, policy determination, and financial impact analysis • Analytical ability to identify issues and develop solutions • Excellent verbal and written communication skills • Certified Project Management Professional preferred
PMO QA Lead	• Conducts independent analysis of the schedule for the design, development and implementation of the West Virginia MMIS replacement • Audits the process and methodologies used by the various technical and operational teams for the West Virginia MMIS replacement project • Audits the deliverables and associated RTMs, BSD, and other design artifacts to ensure thoroughness and accuracy • Develops the process for identifying, tracking and reporting the risks, issues and opportunities associated with the West Virginia MMIS replacement project • Exhibits broad knowledge of and exposure to project management disciplines to support PMO activities • Proactively facilitates business process improvements	• Bachelors degree or equivalent experience • Five to eight years leading service delivery teams • Five years experience with automated tool suites • One to three years PMO experience • Excellent MS Office skills including Excel, PowerPoint, Access, Word • Thorough knowledge of automated tool support including Rational Tool Suite and Risk Radar • Familiarity with MS Project Server administration, and MS SQL Server queries and reporting • Understanding of MS networking technologies • Adherence to Project Management Institute best practices • Ability to handle multiple, high priority assignments concurrently
PMO/Testing Consultant	• Conducts independent analysis of the schedule for the design, development, and implementation of the West Virginia MMIS replacement • Analyzes the process and methodologies used by the various technical and operational teams for the West Virginia MMIS Replacement project to confirm that risks, issues, and opportunities have been addressed • Reviews the project's associated RTMs, BSD, and other design artifacts • Possesses broad knowledge of and exposure to project management disciplines to support PMO activities • Creates and executes test cases and documents results of test execution • Generates test data	• Bachelors degree or equivalent • Three years experience with automated tool suites • One to three years PMO experience or four plus years test experience • Excellent MS Office skills including Excel, PowerPoint, Access, Word • Thorough knowledge of automated tool support including Rational Tool Suite and Risk Radar • Familiarity with MS Project Server administration, and MS SQL Server queries and reporting • Understanding of MS networking technologies • Adherence to Project Management Institute best practices

ROLE	RESPONSIBILITIES	SKILL SET
	• Documents defects from test case execution • Tracks defects and code drops related to assigned solution component; helps ensure their completion and incorporation into all related documentation	• Thorough knowledge of Medicaid components • Excellent interpersonal and verbal and written communication skills
Portal Configuration Analyst	• Ensures all standards are applied to portal designs • Gain approval for all changes • Document changes to portal	• Bachelor's degree or equivalent experience in Web design • Three years of Web Design experience • Health care experience preferred
POS Clinical Lead	• Support clinical programs for the pharmacy POS, such as criteria development for automatic prior authorization and drug utilization review parameters	• Preference given to a registered pharmacist with two years of experience
POS Help Desk Rx Claims Clinical	• Responds to pharmacy POS questions • Assists pharmacy providers with questions regarding BMS policy for pharmacy services • Provides resolution to pharmacy point of sale claims that, based on BMS policy and clinical needs, require an override • Provides data layouts/responds to questions regarding pharmacy point of sale claims submission	• High School Diploma or GED • Working knowledge of West Virginia MMIS • Knowledge of BMS pharmacy policies • Five years of Medicaid experience with three of those years specific to West Virginia Medicaid
POS Technical Lead	• Supports technical aspects of the pharmacy POS including but not limited to the automatic prior authorization program, clinical Web portal, drug utilization review program, and others • Suggests improvements to functionality • Monitors team work assignments • Leads POS Technical Team	• BA/BS degree preferred in computer science, information systems, or related field • Five years of directly relevant experience
POS Technical Team Resources	• Support technical aspects of the Pharmacy POS including but not limited to the automatic prior authorization program, clinical Web portal, drug utilization review program, and others	• BA/BS degree preferred in computer science, information systems, or related field • Three years of directly relevant experience
Provider Enrollment Lead	• Supervises and provides direct oversight of the activities of the provider enrollment unit • Assists in the development of internal desktop processes, policies, and procedures in conjunction with the manager • Maintains appropriate call center reporting statistics and quality improvement practices • Researches, reports, and analyzes enrollment data including functions of the	• Bachelor's Degree or equivalent experience • Three to five years of leadership/ supervisory experience in a call center operations environment • Four plus years experience in claims and/or benefits interpretation and provider networking

ROLE	RESPONSIBILITIES	SKILL SET
	call center and creates reports for results, monitoring and recommendations	
Provider Field Representa-tives	• Proactively resolves problems to ensure compliance with contract terms and resolve problems due to system issues to build trust and strong business relations with all providers; analyze data to assess the scope of the problem, plan an appropriate approach and measure results • Develops implements and maintains operational content used to train providers and their office staff and/or billing vendors • Coordinates and conducts education activities involving providers, provider services and other vendors with the objective to modify inefficient claim filing behaviors • Conducts field visits to provider's offices proactively and in response to business issues including, but not limited to, claims processing, policy application and reimbursement issues • Attends and supports appropriate provider and vendor committee meetings • Participates and attends community or provider sponsored events representing the company or the customer/client • Responds to provider issues in writing, telephonic and in the provider's office. This includes issues related to all aspects of claims filing, reimbursement, and dispute resolution as defined in customer/client contract, application of payment or medical policies • Meets and retains all quality and production standards set by management and/or customer • Exhibits excellent time management when handling special projects	• Associate's Degree or equivalent experience • Minimum three years of customer service experience • Two years of experience in the health care billing or health care public relations field • Excellent verbal and written communication skills • Effective analytical skills • Experience with Microsoft Office and Internet navigation • A current driver's license with good driving record • Ability to work a flexible schedule • Excellent organizational skills • Through direct interactions with providers, builds positive and collaborative relationships • Leadership qualities • Ability to multi task in a high paced environment
Provider Payment Systems Analyst	• Assists in conducting requirements to COTS specification workgroups • Acts as a gap systems analyst, using the prescribed gap process for collecting and documenting the full set of requirements with the customer in order to develop requirements specifications artifacts to ensure that requirements are complete • Prepares prototypes, artifacts and deliverables, and demonstration of product configuration • Completes after each workshop, artifacts	• Bachelor's Degree or equivalent experience • Intermediate Health PAS product knowledge and best practices • Advanced Medicaid industry knowledge • Microsoft SQL Server knowledge • Excellent verbal and written communication skills

ROLE	RESPONSIBILITIES	SKILL SET
	and unit test tasks as well as updates to deliverable documents • Supports conversion and interface activities • Supports operations staff in researching configuration and processing issues	
Provider Services Lead	• Leads the assigned department on policy and procedures related to claims and providers • Facilitates meetings with the customer/client and the necessary management team to discuss provider; offers suggestions for improvement and/or changes; assists with the implementation of changes • Assists providers with problem solving and resolution of more complex claims and other issues; advises providers of new protocols, policies and procedures and website data • Proactively resolves problems to ensure compliance with contract terms and resolve problems due to system issues to build trust and strong business relations with all providers; analyzes data to assess the scope of the problem, and plans an appropriate approach and measure results • Researches and coordinates the resolution of provider claims • Researches and analyzes call center data and create reports for results and recommendations • Works collaboratively with the quality improvement department to review the accuracy, completeness and verification of provider/member calls in the call tracking documentation and Health PAS; ensures that provider data that is entered into the provider module is complete and accurate	• Bachelor’s Degree or equivalent experience • Five or more years of supervisory experience in a call center operations environment • Four or more years experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of health care policy and direction • Strong analytic and problem solving abilities • Through direct interactions with providers, builds positive and collaborative relationships • Leadership qualities • Ability to multi task in a high paced environment • Excellent verbal and written communication skills
Provider/ Member Representa-tives	• Handles inbound call volume with knowledge to address more complex concerns from provider community • Has responsibility for timely and professional interaction with providers including escalating recurring or critical issues to appropriate team lead or manager in a timely fashion • Navigates through the system with efficiency • Meets and retains all quality and production standards set by management	• High School diploma or GED • Two years of experience in the health care billing or health care public relations field • Excellent organizational skills • Familiarity with data input • Knowledge of Microsoft Office • Ability to work independently with little to no supervision • Excellent verbal and written communication skills • Must possess knowledge and skill to

ROLE	RESPONSIBILITIES	SKILL SET
	and/or customer • Displays excellent time management when handling special projects that include but are not limited to member mail, LTC calls, nursing home, hospice, and research	support and enable less experienced staff
Provider/ Member Inquiry Lead	• Directs the assigned department on policy and procedures related to call center/correspondence/field inquiries • Supervises the team including recruitment, development and motivation of staff • Facilitates meetings with the teams to discuss issues/suggestions for improvement and assists the manager with the implementation of changes • Resolves problems to ensure compliance and customer satisfaction • Builds trust and strong business relationships internally and externally • Researches, reports and analyzes call center/correspondence/field data and creates reports for results, monitoring and recommendations • Works collaboratively with all monitoring functions to assure accuracy and quality of information	• Bachelors degree or equivalent experience • Three to five years of leadership/ supervisory experience in a call center operations environment • Four plus years of experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of health care policy and direction • Good knowledge and understanding of Medicaid policies and procedures • Good working knowledge of the Medicaid policies, medical billing, authorization processes, and enrollment • Ability to build positive and collaborative relationships • Leadership qualities • Ability to multi-task in a high paced environment • Excellent verbal and written communication skills • Excellent customer service skills • Excellent organizational and analytical skills
Provider/ Member Inquiry Manager	• Directs the assigned department on policy and procedures related to claims/providers/ members • Manages a team of representatives that includes recruitment, development, and management of staff • Initiates and communicates a variety of personnel actions that includes employment, termination, and performance reviews • Performs salary reviews and disciplinary actions • Facilitates meetings with the customer/ client and the necessary management team to discuss provider/member issues; offers suggestions for improvement and/or changes; assists with the implementation of changes • Assists providers and members with problem solving and resolution of more	• Bachelor's Degree or equivalent experience • Five or more years of supervisory experience in a call center operations environment • Four or more years experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of health care policy and direction • Strong analytic and problem solving abilities • Through direct interactions with providers, builds positive and collaborative relationships • Leadership qualities • Ability to multi task in a high paced environment • Excellent verbal and written

ROLE	RESPONSIBILITIES	SKILL SET
	complex claims and other issues; advises providers and members of new protocols, policies and procedures and website data • Proactively resolves problems to ensure compliance with contract terms and resolve problems due to system issues to build trust and strong business relations with all providers; analyzes data to assess the scope of the problem, and plans an appropriate approach and measure results • Researches and coordinates the resolution of provider claims • Researches and analyzes call center data and create reports for results and recommendations • Works collaboratively with the quality improvement department to review the accuracy, completeness and verification of provider/member calls in the call tracking documentation and Health PAS; ensures that provider data that is entered into the provider module is complete and accurate	communication skills
QA Auditor	• Assists in creating deliverables and documentation • Assists with quality assurance reviews for each project deliverable; including internal peer reviews and project management reviews • Helps prepare the final deliverables for submission to the State • Assists in addressing comments from the State pertaining to project deliverables • Ensures that the testing processes are adhering to the procedures documented in the test plans • Reports quality review findings • Participates in the corrective action plan activities	• Bachelor's Degree or quality assurance support experience can be substituted for the Bachelor's Degree on a year-for-year basis • Two years of Medicaid or health care quality assurance support experience • Two years experience with assigned deliverables
Quality Assurance Trainer	• Assists with quality assurance reviews for each project deliverable, including internal peer reviews and project management reviews • Performs internal quality control functions • Participates in the development of training materials and curricula • Provides feedback to staff regarding errors/problems identified and correction action required • Ensures that the testing processes are adhering to the procedures documented in	• A Bachelor's Degree; can be substituted by quality assurance support experience on a year-for-year basis • Two years of Medicaid or health care quality assurance support experience • Technical writing and documentation control experience • Two years conducting training for internal and external clients • Practical knowledge of document control management systems • Excellent writing and editing skills

ROLE	RESPONSIBILITIES	SKILL SET
	the test plans • Reports quality review findings • Participates in the corrective action plan activities • Participates in training facilitation	• Experience with Word, Excel and Adobe • Detail oriented and organized • Excellent verbal and written communication skills
Registered Nurse (Sterilization/ Hysterectomy)	• Reviews forms or Physician Certification Statements sent in for sterilization and hysterectomy for accuracy, completeness and meeting federal regulations and guidelines • Enters authorizations into the system for approval or denial, or return to provider for corrections • Reviews and processes claims for edit 225 for emergency transportation. Review encompasses medical necessity and appropriate information provided • Communicates with providers regarding concerns about claims that have denied due to the sterilizations, and hysterectomy, and other medical related questions • Indexes prior authorizations and RTP letters into the PET system • Reviews multiple ER visits per day, per member for medical necessity • Provides assistance to customer service for denials and guidelines followed for medical necessity	• Bachelor of Science in nursing • Active license as a registered nurse in West Virginia • One year of Medicaid or health care experience • Knowledge of professional nursing principles and techniques, medical terminology, hospital routines and equipment • Knowledge of medications, including narcotics • Two years experience in medical knowledge related to appropriate patient care • Thorough understanding of CPT/HCPCS and ICD-9 coding procedures and guidelines • Excellent verbal and written communication skills • General PC skills and Microsoft Outlook skills
Release Manager	• Defines, documents, and follows the specific process for each of the CR categories • Maintains and follows change management plan document • Establishes and follows prioritization business rules, project scope, and implementation timeline • Monitors change request (CR) tracking in RQMS and maintain updates to tracking information • Establishes and follows criteria for scope changes, statements of work, cost estimates, and invoicing • Reports to site leadership on CR performance measurements • Develops strong customer relationships based on mutual respect and rigorous business rules • Works with site leadership and finance to ensure timely invoicing of billable CRs and	• Bachelor Degree or equivalent experience • Five years experience in project management, software implementation, or system change management • Strong client-facing and relationship skills required, including proven ability to manage and disposition conflict resolution • Demonstrated ability to work effectively in a matrix organization and to get things done without direct authority. Comfortable working in a geographically disperse environment • Demonstrated written and verbal communication skills with customer, offsite support groups, and internal department heads • Healthcare claims processing experience strongly preferred

ROLE	RESPONSIBILITIES	SKILL SET
	report profitability of these CRs monthly • Holds all resources accountable for on-time and on-budget delivery of CRs	
Release/Sprint Foreman	• Defines, documents, and follows the specific release/sprint process • Establishes and follows prioritization business rules, project scope, and implementation timeline • Reports to site leadership on release/sprint performance measurements • Develops strong customer relationships based on mutual respect and rigorous business rules • Holds all resources accountable for on-time and on-budget delivery of sprints	• Five years experience in project management, software implementation, or system change management • Strong client-facing and relationship service skills required • Demonstrated ability to work effectively in a matrix organization and to perform without direct authority. Comfortable working in a geographically disperse environment • Demonstrated written and verbal communication skills with customer, offsite support groups, and internal department heads • Healthcare claims processing experience strongly preferred
Service Delivery Manager	• Manages all aspects of very large system implementation projects of significant complexity or multiple large-scale projects • Conceptualizes project approaches and solutions that meet client needs • Develops detailed project plans, communication plans, schedules, role definitions, risk management, and assumptions; manages to plans • Estimates resource requirements based on project scope • Manages scope and client expectations to deliver projects that meet and exceed client expectations • Identifies and resolves complex project/program tasks and issues; proactively puts plans in place to prevent future issues • Leads or facilitates complex, multi-session client meetings • Forecasts risk areas and develops mitigation strategies • Participates in developing methods and tools to support improved implementation success and repeatability	• Bachelor's Degree or equivalent years of experience • Master's Degree in business preferred • Eight years large system implementation experience • Five to seven years healthcare/payer experience • Strong healthcare and public sector knowledge and experience • Direct experience implementing configurable applications that support health plan/payer processes • Strong understanding of technology trends and solutions • Ability to use and develop repeatable methods, processes, and tools that support implementation of new technologies • Excellent verbal and written communication skills
Solution Leads	• Analyzes, models, designs, develops and implements integrated solutions components for Medicaid sites • Designs, develops and implements customized functionality to accommodate business processes related to integrated	• Bachelors degree or equivalent experience • Combined eight years of health care, system engineering, and project management experience • Business analysis and modeling

ROLE	RESPONSIBILITIES	SKILL SET
	solutions components • Identifies the need for and develops new integrated solutions functionality to accommodate new business processes and procedures as they are introduced to the solution • Assists and mentors peers with understanding integrated solution components, technical architecture, custom development, and operations support • Represents the integrated solutions group as a new implementation lead or existing customer support lead, managing junior integrated solutions resources	knowledge, applying technical solutions to business processes • Knowledge of FileNET configuration of document classes, indices and distribution queues (Storage Manager) • Knowledge of one or more of the following: Venetica (Process Manager), Cincom (Letter Manager), ASG Cypress (Report Distribution Manager), Apropos AVRS, Call Center Toolsets (Contact Manager) • Knowledge of Microsoft Structured Query Language (SQL), VB Script, Visual Basic for Applications (VBA) Java Script, HTML and extensive knowledge of Markup Language (XML), and Active Server Pages (ASP) • Knowledge of project management • Excellent verbal and written communication skills
Systems Architect	• Identifies the standards and technologies for implementing Health PAS solutions and enabling performance qualities, such as availability, scalability, recoverability, etc. • Selects the appropriate architecture and technologies for solutions and interfaces • Evaluates and selects server hardware, software configuration, and ongoing job control for a specific solution area • Supports the applications architect in selecting application frameworks • Plans acceptance test criteria assisting teams conducting integration and acceptance testing • Balances quality issues for solution designs and assists in parametric cost estimations • Monitors performance benchmarks for solutions provided by customer SLAs • In conjunction with the project architect, sizes the applications and selects the hardware, software, and configuration • Participates in the drafting of service level agreements • Establishes processes to monitor existing systems for performance problems • Participates in tuning and troubleshooting software applications and solutions • Assists technical support teams in defect management	• Bachelor's Degree or equivalent experience • Five to eight years solution architecture design • Three to five years of software modeling experience (e.g. RUP, Agile, UML) • Three to five years of leading development teams • Ability to architect high-volume transaction processing systems and understands the effects of various factors on the health and performance of applications making up larger solutions; ability to conduct design reviews • Software modeling and visual representation skills • Ability to survey emerging technologies and evangelize new technologies, standards and methodologies that will have a positive impact on cost and performance • Solid understanding of Health PAS architecture and processing and of how software architecture and design relates to larger project objectives • Self-motivated, takes initiative to identify, communicate, and resolve potential issues • Excellent problem solving skills and excellent verbal and written communication skills

ROLE	RESPONSIBILITIES	SKILL SET
	• Assists in strategic sales efforts from a technical perspective • Provides technical leadership and guidance to the product development team • Trains fellow architects and engineers in new or unfamiliar software designs and programming techniques • Works with the enterprise architect to roll out solutions to the sites Assists delivery teams with solving issues • Establishes, documents, and rolls out software architecture processes and procedures • Provides recommendations, alternatives, and guidance to product development teams regarding software product issues • Communicates effectively with a variety of audiences • Communicates software architecture policies and procedures	
Technical Architecture Lead	• Facilitates the analysis and documentation of the to-be business process workflow, identifying where efficiencies can be gained through business process reengineering • Oversees the entire Health PAS architecture team • Completes the system and data architecture of the Health PAS environments to support the integration of the components • Ensures the integrity of the system through the development phases • Establishes the development, test, and production environments in support of the implementation • Makes certain that the technical requirements and design meets the customer requirements consistent with the Health PAS software architecture and underlying technologies • Establishes and enforces development methodologies, processes and procedures	• Bachelor's Degree or equivalent experience • Three to five years experience with leading or managing technical resources systems • Thorough knowledge of Health PAS • Excellent written and oral communication skills
Telecom Flow Analyst	• Establishes and maintains telecommunications and connectivity • Develops value added networks (VANS) and the eligibility verification system (EVS) • Investigates, evaluates, recommends and implements upgrades to telecommunications networks	• Bachelor's degree or equivalent experience • Strong knowledge of networks, security, and IT infrastructure • Skilled at determining telecommunication needs based on use • Four years experience with LANS and

ROLE	RESPONSIBILITIES	SKILL SET
	• Communicates with telecommunication companies • Creates back up scenarios for telecommunication needs	Networks
Test Analyst	• Creates and executes test cases and documents results of test execution • Generates test data • Documents defects from test case execution • Tracks defects and code drops related to assigned solution component; helps ensure their completion and incorporation into all related documentation	• Bachelors Degree and/or equivalent experience • Four plus years test experience • Thorough knowledge of Medicaid components • Excellent interpersonal and verbal and written communication skills
Test Manager	• Defines and documents testing process modifications • Manages and coordinates testing Environments and tools for all phases of testing • Coordinates the testing of requirements for small to large projects • Interfaces with QA, program management stakeholders, client management, client test teams and other client defined points of contact to ensure ongoing satisfaction with delivery of test center services • Acts as onsite liaison to client for all things related to project testing • Identifies requirements for training of test center staff • Oversees/manages specific DDI sub-initiatives as required • Communicates project initiatives, status, tasks and responsibilities to test team to ensure their understanding	• Bachelor's degree or equivalent experience • Seven to ten years in testing environment • Two to three years supervisory/management experience • Strong Health PAS application knowledge • Proficiency with majority of MS Office product set • Strong follow through and active listening skills • Strong project and task scoping and management skills • Understanding of overall architecture of Health PAS solution • Good ability to identify issues with direction, executing plans
Trainer	• Develops training curricula, training materials, and facilitates training sessions Trains staff on document control policies and procedures • Reviews policies, procedures, work instructions, forms, etc. for format consistency • Creates training classes on topics relevant to Health PAS users and providers	• Bachelor Degree or four years relevant experience in training multiple classes • Excellent MS Word and PowerPoint • Detail oriented and organized • Excellent verbal and written communication skills • Prefer Medicaid fiscal agent operations experience • Excellent presentation and facilitation skills
Transformation Rules Analyst	• Manages configuration activities for modifications and enhancements • Interprets client policies for analysts • Uses rules engine to establish system edits	• Bachelor's degree or four years demonstrated experience in a state or fiscal agent Medicaid environment • Five years of Medicaid MMIS experience

ROLE	RESPONSIBILITIES	SKILL SET
	• Monitors changes required to remain compliant with federal regulations and standards • Manages rules initiated by the Bureau to achieve strategic objectives, implement new programs, and mature business capabilities • Suggest efficiencies to Bureau using rules	• Highly knowledgeable in quality assurance/control procedures • Strong documentation and reporting background • Proactive problem management skills • Experience with rules engine configuration • Candidates with implementation experience in Health PAS preferred
Turnover Manager	• Plans, coordinates, and manages all tasks related to the turnover of this contract to the State or a new vendor	• Bachelor’s Degree or equivalent experience • Excellent planning and coordination skills • Excellent written and verbal communication skills

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14.5 Key Staff Resumes

RFP Requirement 4.1.8, bullet #2

Resumes for the Molina proposed key staff, continuously dedicated staff, support staff, mandatory staff, and other named staff are contained within this section.

- 14.5.1 Key Personnel
- 14.5.2 Continuously Dedicated Staff
- 14.5.3 Support Staff
- 14.5.4 Other Named Staff

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14.6 Timeline or Gantt Chart

RFP Requirement 4.1.9 Project Approach and Solution. A timeline or Gantt chart for the activities required and planned milestones.

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14.7 Project Management Plan Subsidiary Documents

RFP Requirement from 3.2.2.1: The Vendor should also include in their proposal a comprehensive initial draft deliverable Project Management Plan that describes how they intend to complete each phase of the project. The Project Management Plan will be updated and submitted after project initiation, according to a schedule approved by BMS.

The Project Management Plan should include (but not be limited to) the following:

1. Work Breakdown Structure (showing all project deliverables) and Deliverables Dictionary

2. Project Schedule

> **It is recommended that the Vendor propose interim and draft deliverable due dates to facilitate BMS's review of project deliverables. The Vendor may propose additional deliverables to the deliverables specified by this RFP; however, those new deliverables do not have payments associated with them.**

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14.8 Requirements Checklist

RFP Requirement 3.1, 4.1.14, Attachment II

The following table provides a cross-reference between the RFP Attachment II's requirements (A) and the proposal section (B) and page number (C) in which each requirement is addressed.

A		B	C
MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
3.1	**MANDATORY REQUIREMENTS**		
3.1.1	Establish a Charleston, West Virginia-based facility within 5 miles of the BMS for DDI and Fiscal Agent operations, where all Key Staff Members designated in Section 3.2.3 will be located. The site will provide space for project team meetings and work sessions, and office space for one BMS staff member.	6.0 Location	6-1
3.1.2	Ensure the BMS staff member's office space in the Vendor's Charleston facility can be individually locked. This office space must be fully equipped with furniture; telephone service; a personal computer with access to the MMIS, Microsoft Office™ Suite, and the Internet; and access to a printer and copier. The following reserved or paid parking spaces must be provided to accommodate designated BMS staff: one (1) BMS parking space and six (6) general visitor parking spaces.	6.0 Location	6-1
3.1.3	Provide one named Vendor staff member/position, to be approved by the Bureau, who will be located at the BMS to facilitate communication and coordination between the Bureau and the Vendor. This position requires system, technical/operational and program experience with the ability to facilitate and communicate Bureau needs effectively back to the Fiscal Agent. This position is envisioned to be located onsite at the Bureau 100% through the DDI phase. After DDI, the percentage of time will be determined by the Bureau and the Vendor. The position is not a member of the Key Staff.	8.00 Staff Capacity, Qualifications, and Experience	8-1
3.1.4	Provide the Bureau access to conference space at the Vendor's site that is adequately sized, for ten or more participants, furnished, and equipped to support the DDI review, planning, testing and training sessions required of the Vendor. The conference space must have a computer and projector for displaying Internet-based and Windows PowerPoint™ presentations, and a high-quality speakerphone for multiple remote staff to attend meetings by telephone. Conference space must also accommodate video conferencing and web-based application sharing for attendees.	6.0 Location	6-1
3.1.5	Provide facilities for the recovery of operations in the event of a disaster that disrupts operations as described in the Fiscal Agent's Disaster Recovery and Business Continuity Plan to be developed by the Vendor and approved by the Bureau. The Vendor will provide resources necessary to: recover critical services in accordance with the Recovery Time Objective and Recovery Point Objectives approved by the Bureau and documented in the Disaster Recovery and Business Continuity Plan; and meet the approved Service Level Agreements listed in Appendix G of this RFP.	10.1.2.1.1.7 Initial Disaster and Business Continuity Plan	10-64
3.1.6	Assume all costs related to securing and maintaining the facility for the duration of the contract, including but not limited to hardware and	6.0 Location	6-1

A		B	C
MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
	software acquisition necessary to maintain approved performance requirements throughout the life of the contract, maintenance, lease hold improvements, utilities, office equipment, supplies, janitorial services, security, storage, transportation and insurance.		
3.1.7	Agree to incur all costs associated with accessing and acquiring Provider licensure and certification data.	9.2.3 Phase 2 Fiscal Agent Operations	9-25
3.1.8	Comply with all current and future security policies and procedures of DHHR, BMS and the WV Office of Technology which can be found at the following: DHHR: http://www.wvdhhr.org/mis/IT/index.htm. BMS: Procurement Library: This will be provided on a password protected CD at the vendor pre-bid conference. WV Office of Technology: http://www.technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx	10.1.1.1.9 General and Technical Requirements	10-24
3.1.9	Perform all work associated with this contract within the continental United States or U.S. Territories.	6.0 Location	6-1
3.1.10	Host the MMIS and maintain a secure site and secure back-up site within the continental United States.	6.0 Location	6 -2
3.1.11	Warrant that the proposed and implemented MMIS will meet CMS certification requirements and that certification will be available retroactive to the first day of operations of the new West Virginia MMIS to ensure full Federal Financial Participation (FFP).	9.2.3.2 Phase 2b: CMS Certification	9-63
3.1.12	The Vendor will be responsible for lost enhanced Federal Medical Assistance Percentages (FMAP) for delayed certification due to system deficiencies or deficiencies noted during the certification process that extend beyond the claiming window. The Vendor will be responsible for only the portion of FMAP lost that is determined by BMS to be the fault of the Vendor. The MMIS Vendor will not be responsible for system certification of components that are not included in the scope of this RFP.	9.2.3.2 Phase 2b: CMS Certification	9-63
3.1.13	Warrant that the proposed and implemented Pharmacy Point-of-Sale (POS) system will be certified with Surescripts to support all available ePrescriptions transaction types, including controlled substances.	10.1.1.1.2 Pharmacy Point-of-Sale (POS)	10-18
3.1.14	Ensure the Point-of-Sale drug file will be independent and not a shared file with other clients.	10.1.1.1.2 Pharmacy Point-of-Sale (POS)	10-18
3.1.15	Provide a system that will support multiple programs, e.g., Medicaid, Tiger Morton, BMS State Programs, Children with Special Health Care Needs (CSHCN), Behavioral Health and Health Families (BHHF)) and multiple Medicaid eligibility categories, including but not limited to the addition of any other State Agency, United States Territory or political subdivision. All programs, eligibility categories and benefit plans are to be supported according to the service level	10.1.1.1.1.1 Member Management	10-9

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MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
	agreements set forth in this RFP.		
3.1.16	Ensure all hardware, software and communications components installed for use by Bureau staff are compatible with the most current West Virginia Office of Technology (WVOT) supported versions of the Microsoft™ Operating System, Microsoft Office™ Suite and Internet Explorer™, and current technologies for data interchange which are listed on the below provided link. (http://www.technology.wv.gov/support/Pages/default.aspx).	10.1.1.2.1.1.2 Proposed Technical Architecture Design	10-29
3.1.17	Ensure the entire system is installed on the Vendor's hardware and supported through staff at both the Vendor's data center and the Charleston, West Virginia, location.	6.0 Location	6-2
3.1.18	Align the proposed MMIS with MITA principles and employ service-oriented architecture.	10.1.1.2.1.1.4 Approach to Meeting MITA Requirements	10-36
3.1.19	Develop any bridges and integration code necessary for the replacement MMIS to interface with other State software and systems, e.g., DW/DSS, HIE, HIX, and Enterprise Resource Planning (ERP) – none of which are currently interfaced.	4.0 Executive Summary	4-2
3.1.20	Agree to incorporate all requirements mandated through federal and state regulations, including , current and future coding standards, to ensure that the MMIS is current in its ability to accept and appropriately employ new standards and requirements as they occur, such as, but not limited to, ICD-10, HIPAA v5010, National Council for Prescription Drug Programs (NCPDP) Claims Processing Standards D.0, the Patient Protection and Affordable Care Act (PPACA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Formalized change control will be used for all such changes, during all phases of the project. This provision extends to all court ordered services requiring system modifications.	10.1.1.1.1 Designated Components of an MMIS	10-9
3.1.21	Adhere to the current NCPDP version standards, or the most current HIPAA required version for single drug claims and compound prescriptions.	10.1.1.1.2 Pharmacy Point-of-Sale (POS)	10-18
3.1.22	Provide right of access to systems and facilities to the Bureau or its designee to conduct audits and inspections. Provide access to data, systems, and documentation required by auditors.	9.2.3.1.1.1.1.1 General	9-30
3.1.23	Update deliverables at the request of BMS to align with major changes in approach or methodology, or to include new or updated information that was not available at the time the deliverable was submitted and approved.	10.1.2.4.1.4 Finalization of Previously-Initiated Deliverables	10-134
3.1.24	Meet all CMS Certification Requirements as described in Appendix D.	9.2.3.2 Phase 2b: CMS Certification	9-63
3.1.25	Agree to operate the MMIS and perform all functions described in the RFP and continue all operations from the date of implementation of each component until each function is turned over to a successor	9.2.3 Phase 2: Fiscal Agent Operations	9-25

A		B	C
MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
	Fiscal Agent (FA) at the end of the contract, including any optional additional periods or extensions.		
3.1.26	Agree to perform according to approved Service Level Agreements listed in Appendix G of this RFP.	9.2.3.1.1.1.6.1 Quality Control and Verification	9-59
3.1.27	Forfeit agreed-upon retainage as described in Section 4 of this RFP if approved service levels are not achieved.	9.2.3.1.1.1.6.1 Quality Control and Verification	9-59
3.1.28	Ensure the new system functions without interruptions or non-scheduled downtimes. The response time from the new system must be within acceptable limits as defined in Appendix G (Service Level Agreements) of this RFP.	10.1.1.1.1.4 Program Management	10-14
3.1.29	Provide project status information to the MMIS Re-procurement Project Manager in the timeframes and in the agreed-upon format.	4.0 Executive Summary	4-3
3.1.30	Actively use industry-standard professional project management standards, methodologies and processes to ensure the project is delivered on time, within scope, within budget, and in accordance with the Bureau's quality expectations.	9.2.1.1 Industry Standard Project Management Methodology	9-7
3.1.31	Provide a software and hardware solution that is upgradeable and expandable to meet current and future needs.	10.1.1.1 Meeting or Exceeding Contractual Requirements and Supporting Components and Capabilities in Appendix E	10-9
3.1.32	Employ a Relational Database Management System (RDBMS) or Object Oriented Database Management System (OODMS), to create a data infrastructure that is easily configurable, role-based with 24 X 7 access to data, and use best in class analysis tools.	10.1.1.2.1.1.4.3 Relational or Object-Oriented Database	10-41
3.1.33	Ensure that the Pharmacy prior authorization system is available 24 hours per day, seven (7) days per week, except for scheduled maintenance.	10.1.1.1.2 Pharmacy Point-of-Sale (POS)	10-18
3.1.34	Agree that BMS retains ownership of all data, procedures, programs and all materials developed during DDI and Operations, as well as the initial licensing for installed COTS. Manufacturers' support and maintenance for the proprietary COTS software licensing subsequent to the initial install must be provided only for the life of the contract.	10.1.1.1.1 Designated Components of an MMIS	10-9
3.1.35	Provide role-based access for authorized users, ensuring confidential access to the data at the individual and group security levels.	10.1.1.1 Meeting or Exceeding Contractual Requirements and Supporting Components and Capabilities in Appendix E	10-9
3.1.36	Ensure that adjudicated claims cannot be changed outside an approved adjustment process. Once a claim is adjudicated and in a final status,	10.1.1.1.1.3 Operations	10-12

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MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
	the information must remain static while it is displayed, e.g., users may not cut claim information from claim lines/data.	Management	
3.1.37	Place the source code in a third-party escrow arrangement with a designated escrow agent who is acceptable to the Bureau, and who shall be directed to release the deposited source code in accordance with a standard escrow agreement approved by the Bureau. That agreement must, at minimum, provide for release of the source code to the Bureau a) when the owner of the software notifies the Bureau that support or maintenance of the Product will no longer be available; b) if the Vendor fails to provide services pursuant to this contract for a continuous period; or c) appropriate individual(s) from the Bureau have directed the escrow agent to release the deposited source code in accordance with the terms of escrow. Source code, as well as any corrections or enhancements to such source code, shall be updated for each new release of the product within sixty (60) days of being made available in the Bureau's production environment. The Escrow agent and the Vendor shall notify the Bureau in writing when new production versions have been escrowed. The Vendor shall identify the escrow agent upon commencement of the contract term and shall certify annually that the escrow remains in effect and in compliance with the contract. The Vendor shall be responsible for all costs associated with the third-party escrow arrangement. The Vendor also must place in escrow one (1) paper copy and one (1) electronic copy of all maintenance manuals and additional documentation that are required for the proper maintenance of the software used to develop, test, and implement the MMIS. Revised copies of manuals and documentation must be placed in the escrow account in the event they are changed. Such documentation must consist of logic diagrams, installation instructions, and operation and maintenance manuals, which must be the same documentation as that which the Vendor supplies to its maintenance personnel to maintain its software. All such materials must be provided to the escrow agent within sixty (60) days of its use or applicability to the use of the MMIS. When source code is provided, it must be provided in the language in which it was written and will include commentary that will allow a competent programmer proficient in the source language to readily interpret the source code and understand the purpose of all routines and subroutines contained within the source code. In the event that this contract expires and is not renewed or extended, the Bureau has the option to continue the escrow agreement until such time that the Bureau is no longer using the software or documentation covered by this escrow agreement. In the case of a COTS product, the medium necessary to reinstall that version as part of the MMIS platform must be kept. Any future versions of COTS products must also be kept and provided upon demand.	10.1.1.2 COTS with Modifications	10-27
3.1.38	Provide increased staffing levels if requirements, timelines, quality or other standards are not being met, based solely on the discretion of	8.00 Staff Capacity,	8-2

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MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
	and without additional cost to the Bureau. In making this determination, the Bureau will evaluate whether the Vendor is meeting deliverable dates, producing quality materials, consistently maintaining high quality and production rates, and meeting RFP standards without significant rework or revision.	Qualifications, and Experience	
3.1.39	Develop, submit to BMS for approval, and maintain a comprehensive West Virginia MMIS Security, Privacy, and Confidentiality Plan (as described in Section 3.2.6.1.1) that meets or exceeds the current industry standards for such documents, and is compliant with any and all state and Federal mandated security requirements. The Security, Privacy and Confidentiality Plan must be reviewed and updated annually during the operating period.	10.1.2.1.1.4 Initial Security, Privacy, and Confidentiality Plan	10-66
3.1.40	Deliver systems and services that are compliant with Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, titled “Administrative Simplification” and the rules and regulations promulgated there under.	10.1.1 Proposed West Virginia MMIS	10-5
3.1.41	Ensure that all applications inclusive of internet, intranet and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 U.S.C. §794d, and 36 CFR 1194.21 and 36 CFR 1194.22.	10.1.1.1 Meeting or Exceeding Contractual Requirements and Supporting Components and Capabilities in Appendix E	10-9
3.1.42	Ensure that data entered, maintained, or generated to meet the requirements of this RFP be retained and accessible according to Federal requirement 42 CFR 431.17 and applicable BMS and State requirements.	10.1.1.1 Meeting or Exceeding Contractual Requirements and Supporting Components and Capabilities in Appendix E	10-9
3.1.43	Comply with prompt pay regulations in accordance with Federal requirement 42CFR 447.45(d).	10.1.1.1.1.4 Program Management	10-15
3.1.44	Follow formalized change control procedures (as described in Section 1.21.13 Changes and the approved Change Management Plan named in Section 3.2.2.1) for all changes to project scope, including (but not limited to) changes arising during the DDI and operations phases of the project, and changes necessitated as a result of new and amended Federal and State regulations and requirements.	14.10.14 Change Management Plan	14.10.14-1
3.1.45	Acknowledge that upon award the Bureau reserves the right to reject any staff proposed or later assigned to the project, and will require the successful Vendor to remove them from the project. In all circumstances, Key Staff shall be replaced only with persons of equal ability and qualifications.	8.00 Staff Capacity, Qualifications, and Experience	8-2
3.1.46	Designate one named individual as the Vendor organization’s HIPAA compliance officer.	8.00 Staff Capacity,	8-1

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MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
		Qualifications, and Experience	
3.2	NA – OMITTED FROM THIS TABLE	NA	NA
3.3	NA – OMITTED FROM THIS TABLE	NA	NA
4.	**PROPOSAL FORMAT AND RESPONSE REQUIREMENTS**		
4.1	Technical Proposal Format	Molina's proposal is formatted following RFP requirements, and Proposal Section 14.0 includes all sections not applicable to the 300-page limitation	NA
4.1.1	Title Page	1.0 Title Page	1-1
4.1.2	Transmittal Letter	2.0 Transmittal Letter	2-1
4.1.3	Table of Contents	3.0 Table of Contents	3-1
4.1.4	Executive Summary	4.0 Executive Summary	4-1
4.1.5	Vendor's Organization	5.0 Vendor's Organization	5-1
4.1.6	Location	6.0 Location	6-1
4.1.7	Vendor Capacity, Qualification, References and Experience	7.0 Vendor Qualification, References, and Experience	7-1
4.1.8	Staff Capacity, Qualifications and Experience	8.0 Staff Capacity, Qualifications, and Experience	8-1
4.1.9	Project Approach and Solution	9.0 Project Approach and Solution	9-1
4.1.10	Solution Alignment with BMS' Business and Technical Needs	10.0 Solution Alignment with BMS Business and Technical Needs	10-1
4.1.11	Subcontracting	11.0 Subcontracting	11-1

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MMIS RFP REQUIREMENT		PROPOSAL SECTION	PROPOSAL PAGE NO.
4.1.12	Special Terms and Conditions	12.0 Special Terms and Conditions	12-1
4.1.13	Signed Forms	13.0 Signed Forms	13-1
4.1.14	Cost Summary	See Cost Volume	See Cost Volume
4.1.15	Invoicing and Retainage	See Cost Volume	See Cost Volume

Molina abides by the technical proposal 300-page limitation as shown in the table below. All content not applicable to the 300-page limitation has been placed in Proposal Section 14.

SECTION	TITLE	RFP RESPONSE PAGES
1.0	Title Page	NA
2.0	Transmittal Letter	NA
3.0	Table of Contents	NA
4.0	Executive Summary	3
5.0	Vendor's Organization	NA
6.0	Location	4
7.0	Vendor Capacity, Qualification, References and Experience	15
8.0	Staff Capacity, Qualifications and Experience	24
9.0	Project Approach and Solution	105
10.0	Solution Alignment with BMS' Business and Technical Needs	143
11.0	Subcontracting	1
12.0	Special Terms and Conditions	1
13.0	Signed Forms	1
	TOTAL	**297**

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14.9 Staff Matrix

RFP Requirement 3.2.3.5 #4. Attachment III

This section contains confidential and proprietary information and has been redacted.

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This page contains proprietary or confidential trade secret information. Use or disclosure of this information is subject to the restriction on the title page of this proposal.

Project Management Plans

Initial Draft

Molina Medicaid Solutions

INITIAL DRAFT

Some of the information furnished in this proposal in response to RFP MED13006 is submitted in confidence and contain trade secrets and/or privileged or confidential information and such information shall only be disclosed for evaluation purposes. Provided that if a contract is awarded to this proposer as a result of or in connection with the submission of this proposal, the State of West Virginia shall have the right to use or disclose the information therein to the extent provided in the contract. This restriction does not limit the State of West Virginia's right to use or disclose information obtained from any source, including the proposer, without restrictions.

This information is proprietary or confidential and contains trade secret information that is privileged and is therefore exempt from disclosure under the provisions of West Virginia Code 29B-1-4.

Pages containing such proprietary or confidential trade secret information are appropriately marked.

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INITIAL DRAFT

OVERVIEW

RFP Requirement 3.2.2.1 The Vendor should also include in their proposal a comprehensive initial draft deliverable Project Management Plan that describes how they intend to complete each phase of the project.

Our project management methodology (PMM) is based on sound and rigorous Project Management Institute (PMI) Project Management Body of Knowledge (PMBOK) principles, an internationally recognized standard for the project management profession. The PMBOK is the standard describing project management processes, tools, techniques, and plans used to manage projects toward successful outcomes. Each initial draft project management plan, requested in the Request for Proposal (RFP), includes a table of contents as well as draft specific content to demonstrate Molina's ability to produce the required deliverable. Each initial draft consists of:

- A cover page indicating the initial deliverable's title
- An introduction which describes how the initial deliverable is assembled
- Table of contents
- Initial deliverable contents.

Table 14.10-1 contains a list of the initial draft project management plans with the proposal section number and project management plan name.

Table 14.10-1: Initial Draft Project Management Plans

PROPOSAL SECTION	INITIAL DRAFT PROJECT MANAGEMENT PLAN NAME
14.10.1	Staffing Plan
14.10.2	Facility Plan
14.10.3	Documentation Management Plan
14.10.4	Training Plan
14.10.5	Testing Plan
14.10.6	Scope Management Plan
14.10.7	Schedule Management Plan
14.10.8	Cost Management Plan
14.10.9	Quality Management Plan
14.10.10	Human Resources Management Plan
14.10.11	Communication Management Plan
14.10.12	Risk Management Plan
14.10.13	Issue Management Plan
14.10.14	Change Management Plan
14.10.15	Integration Management Plan
14.10.16	Workflow Management Plan
14.10.17	Problem Management Plan
14.10.18	Transition Plan
14.10.19	Weekly Project Status Report Template
14.10.20	Monthly Project Status Report Template
14.10.21	Integrated Test Environment Plan

INITIAL DRAFT

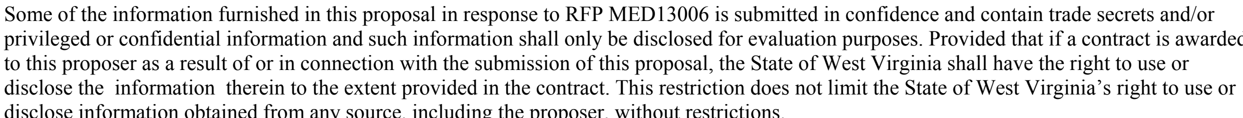
All project management plans contain confidential and proprietary information and have been redacted.

INITIAL DRAFT

Other Initial Draft Plans

INITIAL DRAFT

Molina Medicaid Solutions



Some of the information furnished in this proposal in response to RFP MED13006 is submitted in confidence and contain trade secrets and/or privileged or confidential information and such information shall only be disclosed for evaluation purposes. Provided that if a contract is awarded to this proposer as a result of or in connection with the submission of this proposal, the State of West Virginia shall have the right to use or disclose the information therein to the extent provided in the contract. This restriction does not limit the State of West Virginia's right to use or disclose information obtained from any source, including the proposer, without restrictions.

This information is proprietary or confidential and contains trade secret information that is privileged and is therefore exempt from disclosure under the provisions of West Virginia Code 29B-1-4.

Pages containing such proprietary or confidential trade secret information are appropriately marked.

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INITIAL DRAFT

OVERVIEW

RFP Requirement 3.2.6.1.1: The Vendor should also include in their proposal initial drafts of the following plans and their components (all of which are to be submitted in updated form following project initiation, according to a schedule approved by BMS).

Molina has extensive, recent experience creating and delivering quality project deliverables. Each initial draft deliverable provided includes a table of contents as well as a sufficient number of pages to demonstrate Molina's ability to produce the required deliverable. Each initial deliverable consists of:

- A cover page indicating the initial deliverable's title
- An introduction which describes how the initial deliverable is assembled
- Initial deliverable title page
- Table of contents
- Initial deliverable contents.

Table 14.11-1 contains a list of initial deliverables provided:

Table 14.11-1: Other Initial Draft Deliverables

NUMBER	INITIAL DELIVERABLE TITLE
14.11.1	Security, Privacy and Confidentiality Plan
14.11.2	Configuration Management Plan
14.11.3	Data Conversion Plan
14.11.4	Disaster Recovery and Business Continuity Plan
14.11.5	Data Retention and Records Plan

In addition as instructed in the RFP Section 3.2.2.1, Table 14.11-2 provides a list of the initial draft project management plans in included in Proposal Section 14.10.

Table 14.11-2: Initial Draft Project Management Plans

PROPOSAL SECTION	INITIAL DRAFT PROJECT MANAGEMENT PLAN NAME
14.10.1	Staffing Plan
14.10.2	Facility Plan
14.10.3	Documentation Management Plan
14.10.4	Training Plan
14.10.5	Testing Plan
14.10.6	Scope Management Plan
14.10.7	Schedule Management Plan
14.10.8	Cost Management Plan
14.10.9	Quality Management Plan
14.10.10	Human Resources Management Plan
14.10.11	Communication Management Plan
14.10.12	Risk Management Plan
14.10.13	Issue Management Plan
14.10.14	Change Management Plan
14.10.15	Integration Management Plan

INITIAL DRAFT

PROPOSAL SECTION	INITIAL DRAFT PROJECT MANAGEMENT PLAN NAME
14.10.16	Workflow Management Plan
14.10.17	Problem Management Plan
14.10.18	Transition Plan
14.10.19	Weekly Project Status Report Template
14.10.20	Monthly Project Status Report Template
14.10.21	Integrated Test Environment Plan

All initial draft deliverables contain confidential and proprietary information and have been redacted.

INITIAL DRAFT

14.12 Signed Forms, Addenda, and Transmittal Letters

RFP Requirement 4.1.13 Signed Forms. Complete and sign all necessary forms, such as the MED-96 and Purchasing Affidavit forms. The successful vendor shall be required to comply with the HIPAA Business Associate Addendum (BAA). If applicable, sign and submit a Resident Vendor Preference Certificate with the proposal.

In this section, Molina provides the RFP-required signed forms, addenda, and transmittal letters.

14.12.1 Signed Forms

Molina provides all necessary complete and signed forms as shown in the following table:

RFP REFERENCE	FORM NAME	PROPOSAL SECTION	SIGNATURE REQUIREMENTS
Appendix J	Med Purchasing Affidavit	14.12.1.1	Signed and provided with proposal.
Appendix I	MED 96 Agreement Addendum	14.12.1.2	Signed and provided with proposal.
Appendix K	HIPAA Business Associate Addendum (BAA)	14.12.1.3	No signature required. Provided with proposal.
Appendix M	Resident Vendor Preference	14.12.1.4	Signed and provided with proposal.
RFP Section 1.6	Vendor Registration and Disclosure Statement	14.12.1.5	No signature required. Registration proof provided
Appendix L	Disclosure by Fiscal Agents: Information on Ownership and Control	14.12.1.6	No signature required. Information provided with proposal.
RFP Section 4.1	Addendum Acknowledgement(s)	14.12.2	Signed and provided with proposal.
RFP Section 4.1	Transmittal Letter	14.12.3	Please refer to transmittal letter that immediately follows the proposal title page.

14.12.1.1 MED Purchasing Affidavit

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax, or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company, or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company, or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing (West Virginia Code §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: Molina Medicaid Solutions

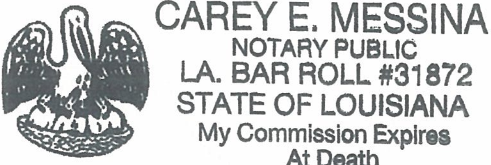
Authorized Signature: [signature] Date: 6/13/2012

State of LOUISIANA, to-wit:

Taken subscribed and sworn to before me this 13 day of JUNE, 2012.

My Commission expires AT DEATH, 20__.

AFFIX SEAL HERE **NOTORY PUBLIC** [signature]



14.12.1.2 MED 96 Agreement Addendum

In the event of conflict between this addendum and the agreement, this addendum shall control:

1. **DISPUTES** – Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.
2. **HOLD HARMLESS** – Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.
3. **GOVERNING LAW** – The agreement shall be governed by the laws of the State of West Virginia. The provision replaces any references to any other State's governing law.
4. **TAXES** – Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, now will the Agency file any tax returns or reports on behalf of Vendor or any other party.
5. **PAYMENT** – Any references to prepayment are deleted. Payment will be in arrears.
6. **INTEREST** – Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.
7. **RECOUPMENT** – Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.
8. **FISCAL YEAR FUNDING** – Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.
9. **STATUTE OF LIMITATION** – Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.
10. **SIMILAR SERVICES** – Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.
11. **ATTORNEY FEES** – The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.
12. **ASSIGNMENT** – Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board, or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of the Agency prior to assigning the agreement.
13. **LIMITATION OF LIABILITY** – The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.

14. **RIGHT TO TERMINATE** – Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay vendor for services rendered or goods received prior to the effective date of termination.

15. **TERMINATION CHARGES** – Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or income sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.

16. **RENEWAL** – Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.

17. **INSURANCE** – Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.

18. **RIGHT TO NOTICE** – Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right to repossession with notice.

19. **ACCELERATION** – Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.

20. **CONFIDENTIALITY** – Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.

21. **AMENDMENTS** – All amendments, modifications, alterations, or changes to the agreement shall be in writing and signed by both parties. No amendments, modifications, alterations, or changes may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

ACCEPTED BY DHHR OFFICE OF PURCHASING:	**VENDOR:**
Spending Unit: ______	Company Name: Molina Medicaid Solutions
Signed: ______	Signed: [signature]
Title: ______	Title: President
Date: ______	Date: 06-13-12

14.12.1.3 HIPAA Business Associate Addendum

Molina will comply with the Appendix K – HIPAA Business Associate Addendum (BAA) requirements and provide a new signed form as required by the Bureau.

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective on the date of execution of a binding agreement with the Agency.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE; the parties agree that in consideration of the mutual promises herein, in the Agreement; and of the exchange of PHI hereunder that:

1. **Definitions.**
    a. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy and Security Rules.
    b. **Privacy Rule.** Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and Part 164, Subparts A and E, as amended.
    c. **Security Rule.** Security Rule means the Standards for the security of electronic protected health information found at 45 CFR Part 164, Subpart C, as amended.
    d. Security Incident. Any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.
2. **PHI Disclosed; Permitted Uses.**
    a. **PHI Described.** PHI disclosed by the Agency to the Associate, PHI created by the Associate on behalf of the Agency, and PHI received by the Associate from a third party on behalf of the Agency are disclosable under this Addendum. The disclosable PHI is limited to the minimum necessary to complete the tasks, or to provide the services, associated with the terms of the original agreement.
    b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks. Or provide the services, associated with, and required by the terms of the original agreement, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or violate the minimum necessary policies and procedures of the Agency.
3. **Obligations of Associate.**
    a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than stated in this Addendum or as required or permitted by law.
    b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the associate other than as stated in this Addendum or as required or permitted by law.

c. **Safeguards.** The Associate will use appropriate safeguards to prevent use or disclosure of the PHI except as provided for in this Addendum. This shall include, but not be limited to:
   i. Limitation of the groups of its employees or agents to whom the PHI is disclosed 10 those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary;
   ii. Appropriate notification and training of its employees or agents to whom the PHI will be disclosed in order to protect the PHI from unauthorized disclosure;
   iii. Maintenance of a comprehensive written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum.

f. **Documentation.** Associate agrees to document disclosures of the PHI and information related 10 such disclosures as would be required for Agency to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §§ 164.528 and 164.316. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:
   i. the date of disclosure;
   ii. the name 01 the entity or person who received the PHI, and if known, the address of the entity or person;
   iii. a brief description of the PHI disclosed; and
   iv. a brief statement of purposes of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure.

g. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45CFR §164.528.

h. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524.

i. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

j. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.1 of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

k. **Agents, Subcontractors Compliance.** The Associate will ensure that any of its agents, including any subcontractors, to whom it provides any of the PHI it receives hereunder,

or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder.

l. **Amendments.** The Associate shall make available to the specific Individual to whom it applies any PHI; make such PHI available for amendment; and make available the PHI required to provide an accounting of disclosures, all to the extent required by 45 CFR §§164.524,164.526, and 164.528 respectively.

m. **Federal Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504.

n. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI, and provide data security procedures for the use of the Agency at the end of the contract period. These steps shall include at a minimum, the requirements contained in the West Virginia Office of Technology Policy No. WVOT-P01001 (1-18-07) which may be found at: http://www.state.wv.us/oVPDF/Document center/SecurityPol0107.pdf.

o. **Notification of Breach.** During the term of this Agreement:

   i. The Associate shall notify the Agency immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI, where the use or disclosure is not provided for by this addendum of which it becomes aware, if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency contract manager (see www.state.wv.us/admin/purchase/vrc/agencyli.htm) and the Office of Technology Help Desk at (304) 558.9966; (877) 558.9966 (Toll Free); or servicedesk@wv.gov.

   ii. The Associate shall immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency contract manager, and the Office of Technology Help Desk of: (a) What data elements were involved and the extent of the data involved in the breach; (b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (e) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (d) A description of the probable causes of the improper use or disclosure; and (e) Whether any federal or stale taws requiring individual notifications of breaches are triggered.

   iii. All associated costs shall be borne by the Associate. This may include, but not be limited to costs' associated with notifying affected individuals.

p. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement. Available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Associate, except where Associate or its subcontractor, employee or agent is a named adverse party.

4. Termination.

a. **Duties at Termination.** Upon any termination of the underlying agreement, if feasible, the Associate shall return or destroy all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying agreement.

b. **Termination For Cause.** Agency may terminate the underlying agreement if at any time it determines that the Associate has violated a material term of the agreement or this Addendum. Agency may, at its sale discretion, allow Associate a reasonable period of lime to cure the material breach before termination.

c. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined.

d. **Survival.** The respective rights and obligations of Associate under Section 3.j. and 3.0 of this Addendum shall survive the termination of the underlying agreement.

5. General Provisions/Ownership of PHI.

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an Individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an Individual must not be transmitted to another party by electronic or other means for additional uses not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected Individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

14.12.1.4 Residence Vendor Preference Certificate

RFP Requirement 10.4.7 and Appendix M: Resident Vendor Preference

Molina's provides our completed vendor preference certificate.

Rev. 09/08

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**

✓ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**

____ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

____ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: Molina Medicaid Solutions **Signed:** [signature]

Date: June 11, 2012 **Title:** President

**Check any combination of preference consideration(s) indicated above, which you are entitled to receive.*

14.12.1.5 Vendor Registration and Disclosure Statement

RFP Requirement 1.6: Vendor Registration: Vendors participating in this process should complete and file a Vendor Registration and Disclosure Statement (Form WV-1) with the West Virginia Department of Administration (DOA) Purchasing Division and remit the registration fee. Vendor is not required to be a registered vendor in order to submit a proposal, but the successful bidder must register and pay the fee prior to the award of an actual purchase order or contract.

Molina is a registered vendor with the West Virginia Department of Administration (DOA) Purchasing Division. The required Vendor Registration Disclosure Statement (Form WV-1) has been filed with the DOA Purchasing Division, and the registration fee has been paid. A copy of our filing is provided for verification. This filing was made in 2010 and was renewed in 2011.

VIA UPS NEXT DAY AIR

April 15, 2010

State of West Virginia
Purchasing Division/Vendor Registration
2019 Washington Street East
Charleston, WV 25311-2214

RE: Vendor Registration and Disclosure Statement

Dear Purchasing Director:

Enclosed for immediate filing is the Vendor Registration and Disclosure Statement (Form WV-1) for Molina Information Services, LLC (Molina). Also enclosed is Molina Healthcare, Inc. check number 052363 in the amount of $125.00, payable to the State of West Virginia for the annual filing fee.

If everything is in order, please register Molina as soon as possible. If you require additional information to complete the registration process, please contact me immediately. I can be reached via email at *Greg.Pappas@MolinaHealthcare.com*, or telephone at (916) 646-9193 extension 114668.

Thank you very much.

Sincerely,

Gregory A. Pappas
Paralegal

Enclosures

Molina Healthcare, Inc. • 300 University Avenue - Suite 100, Sacramento, CA 95825
916-646-9193 • www.MolinaHealthcare.com • Fax: 916-646-4572

WV-1
REV. 04/01/09

STATE OF WEST VIRGINIA
PURCHASING DIVISION

VENDOR REGISTRATION AND DISCLOSURE STATEMENT

Dear Vendor:

Before a vendor is eligible to sell goods and/or services to the State of West Virginia, the ***West Virginia Code*** (§5A-3-12) requires all vendors to have on file with the West Virginia Purchasing Division a completed Vendor Registration and Disclosure Statement.

All vendors wishing to participate in the competitive bid process and receive purchase orders from the State of West Virginia exceeding one thousand dollars ($1,000) are required to complete the Vendor Registration and Disclosure Statement (WV-1 form) and pay a **$125.00** annual fee. Payment of the annual fee includes access to the ***West Virginia Purchasing Bulletin***, in which purchases expected to exceed twenty-five thousand dollars ($25,000) are advertised.

Please complete this form in its **ENTIRETY** and return it with a check or money order made payable to the **STATE OF WEST VIRGINIA** in the amount of **$125.00**. Incomplete forms will not be processed and will be returned to the vendor. Please send completed form and payment to:

Purchasing Division
Vendor Registration
2019 Washington Street East
P.O. Box 50130
Charleston, WV 25305-0130

Pages 1 and 2 which consist of information related to vendor organizational structure must be completed. Whenever a change occurs in the information submitted as required, such change shall be reported immediately in the same manner as required in the original disclosure affidavit **(WV Code §5A-3-12)**. If you have any questions concerning the Vendor Registration and Disclosure Statement, please call the Purchasing Division at (304) 558-2311.

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION
To Be Completed by the Vendor and Returned to the West Virginia Purchasing Division

1. Legal Name of Company/Individual: Molina Information Systems, LLC

   Bidding Address: 200 Oceangate, Suite 100

   City/State/Zip: Long Beach, California 90802

   Contact Person: Gene Berk

   Telephone Number: (916) 646-9193 FAX Number: (916) 646-4572

2. Vendor Classified As:

   ___ Individual/ Sole Proprietor
   ___ Non-Profit Organization
   ___ Corporation
   ___ Governmental Entity
   ___ Estate/Trust
   ___ Partnership
   X Limited Liability Company (LLC) *[Enter tax classification: D=Disregarded Entity; C=Corporation; P=Partnership]* D
   ___ Other (Explain) ________

3. If you have a Federal Employer's Identification Number enter it. All partnerships, corporations, or companies with employees must have an FEIN.

2	7	1	5	1	0	1	7	7

   For individuals with no FEIN, enter Social Security Number.

4. By providing the following information, I represent that this enterprise is a small business as defined by the ***Code of Federal Regulations***, Title 13, Part 121, as appended - which contains detailed industry definitions and related procedures - and/or the characteristics of the enterprise's control, operation and/or ownership are accurately reflected in the information provided. *Check all that apply.*

   ___ Disabled Small Business Ownership [1]
   ___ Minority Small Business Ownership [2]
   ___ Small Business Ownership [3]
   ___ Veteran Small Business Ownership [4]
   ___ Woman Small Business Ownership [5]

   The information gathered in question 4 is for data collection efforts only.

VENDOR REGISTRATION AND DISCLOSURE STATEMENT

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION

5. Are you registering as a new vendor with the Purchasing Division? ____ No __X__ Yes

6. Are you updating the information previously submitted? __X__ No ____ Yes

7. Are you completing this form to register a branch/division/subsidiary? __X__ No ____ Yes
   If yes, please list the parent company's name, address, and FEIN.

   Company Name: ____________________

   Address: ____________________

   FEIN: ____________________

8. Has the vendor done business under another name? If so, list the name and address under which the business was conducted.

Name	Street Address, City and State
Molina Medicaid Solutions	200 Oceangate, Suite 100, Long Beach, California 90802

9. List the name, title, city and state of residence for all officers. Attach an additional sheet if space is needed.

Name	Position	City and State of Residence
J. Mario Molina, M.D.	President	Pasadena, California
John Molina	Chief Financial Officer	Long Beach, California
Mark L. Andrews	Secretary	Sacramento, California
Joseph White	Vice President	Altadena, California

If the vendor is classified as a Limited Liability Company (LLC) with only one officer, list officer above and initial here: ____

10. List the name and telephone number of one or more banking institutions to serve as reference for the vendor.

JPMorgan Chase Bank, Lucy Nixon SVP, (310) 860-7257; East West Bank, Kathleen Kwan SVP, (626) 768-6228

11. What is the latest Dun & Bradstreet number and rating on the vendor *(if available)*?

n/a

12. Is the vendor acting as an agent for some other individual, firm or corporation? If yes, attach statement of the principal authorizing such representation. __X__ No ____ Yes

13. List the three digit commodity code number(s) from the list on pages 3 and 4 which best describe the product(s)/service(s) furnished by your company. *(Attach additional page, if necessary)*

920

As authorized agent of the vendor named herein, I do solemnly swear that the above information is true and complete.

[signature]
Vendor Signature

Assistant Secretary
Title

April 14, 2010
Date

PURCHASING DIVISION USE ONLY

Vendor ID: *
Check No.: ____
Memo No.: ____
Date: ____
Entered by: ____

2

14.12.1.6 Disclosure by Fiscal Agents: Information on Ownership and Control

Any person with an ownership or control interest in the disclosing entity or fiscal agent or subcontractor in which the disclosing entity has a 5% or more interest must be listed. This includes owners and managing employee(s) of the disclosing entity. The address for corporate entities must include primary business address, every business location and P.O. Box Address. If you are required to provide this information for multiple persons (individuals and corporations) you may attach a separate page. For the attached page label it at the top of the page with Supplement, Ownership Disclosures.

Name _____Please see attached, Supplement: Ownership Disclosures_

Address: ______________________________

Address: ______________________________

Address: ______________________________

Date of Birth: ______________________________

Social Security Number: ______________________________

Federal Employer Id Number: ______________________________

Relationship and Subcontractor Disclosures

For each ownership or control interest listed, disclose any relationship to another person (parent, spouse, child or sibling) including control interest in subcontractors who has an ownership or control interest in the disclosing entity. If additional space is needed, you may attach a separate page. For the attached page, label it at the top of the page with **Supplement, Owner Relationships**

Owner Name	Relationship	Owner Name
n/a		

SUPPLEMENT: OWNERSHIP DISCLOSURES

This page contains confidential and proprietary information and has been redacted.

14.12.2 Addendum Acknowledgement(s)

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED13006	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR:
MOLINA MEDICAID SOLUTIONS
200 Oceangate, Suite 100
Long Beach, CA 90802

LOCAL ADDRESS:
1600 Pennsylvania Ave
Charleston, West Virginia 25302

SHIP TO:
BUREAU FOR MEDICAL SERVICES
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 6/21/2012 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

1. TO ANSWER VENDOR QUESTIONS (SEE ATTACHED).

2. TO PROVIDE A REVISED ATTACHMENT 1: COST SUMMARY BID SHEET (SEE ATTACHED).

3. TO MODIFY VARIOUS SECTIONS OF THE RFP PER THE ATTACHED.

4. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED13006

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 ✓
NO. 2 ____
NO. 3 ____
NO. 4 ____
NO. 5 ____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE [signature] TELEPHONE 225-216-6010 DATE 06-13-12

TITLE President FEIN 27-1510177 ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED13006	2

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR:
MOLINA MEDICAID SOLUTIONS
200 Oceangate, Suite 100
Long Beach, CA 90802

LOCAL ADDRESS:
1600 Pennsylvania Ave
Charleston, West Virginia 25302

SHIP TO:
BUREAU FOR MEDICAL SERVICES
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 06/21/12 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

SIGNATURE

Molina Medicaid Solutions
COMPANY

DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE [signature]		TELEPHONE 225-216-6010	DATE 06-13-12
TITLE President	FEIN 27-1510177		ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED13006	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR
MOLINA MEDICAID SOLUTIONS
200 Oceangate, Suite 100
Long Beach, CA 90802

LOCAL ADDRESS:
1600 Pennsylvania Ave
Charleston, West Virginia 25302

SHIP TO
BUREAU FOR MEDICAL SERVICES
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 6/21/2012 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 2

1. TO CLARIFY RESPONSES TO QUESTIONS #16 AND #17 IN ADDENDUM #1.

2. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED13006

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 ____
NO. 2 ✓
NO. 3 ____
NO. 4 ____
NO. 5 ____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE [signature]	TELEPHONE 225-216-6010	DATE 06-13-12
TITLE President	FEIN 27-1510177	ADDRESS CHANGES TO BE NOTED ABOVE

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SIGNATURE

Molina Medicaid Solutions
COMPANY

DATE

END OF ADDENDUM NO. 2

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE [signature]	TELEPHONE 225-216-6010	DATE 06-13-12
TITLE President	FEIN 27-1510177	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

14.12.3 Transmittal Letter

Per RFP Requirement 4.1.2, the transmittal letter can be found immediately after the proposal title page.

14.13 Other Optional Services

RFP Requirement 3.2.10 BMS Optional Services

As a healthcare organization, Molina brings to West Virginia a wealth of clinical and technical experience in a variety of innovative approaches. These business applications and approaches increase efficiency and flexibility while maximizing federal match rates. The Health PAS integrated COTS software provides support for ARRA, PPACA, HITECH Act, MITA alignment, and CMS Seven Conditions and Standards for Enhanced Funding. This technology allows Molina to rapidly implement these optional services so savings can be realized sooner.

BMS seeks to use Phase 2c: MMIS Modifications and Enhancements to makes changes to the system concurrent with Routing Operations. In addition, BMS seeks to initiate changes that achieve strategic objectives, implement new programs, and mature business capabilities, all after the system is certified by the Centers for Medicare and Medicaid Services (CMS). Enhancements and modifications are funded out of a pool of 25,000 hours that the State will allocate to the successful contractor to implement changes approved by BMS, using a process described in Proposal Section 9.2.3.3 Phase 2c: MMIS Modifications and Enhancements.

Table 14.13-1 provides an overview of Molina's proposed optional services. Detailed information regarding these services, including a description of each solution, planned project tasks and deliverables associated with the solution, and current status of the solution is contained in the sections that follow.

Table 14.13-1: BMS Optional Services

PROPOSAL SECTION	TOPIC	OVERVIEW
14.13.1	Care Management	Molina's care management process combines technical solutions with best practices for disease and care management, using nationally recognized guidelines and proven clinical management techniques. Molina recommends the following services to maximize healthcare value: Care Access and Monitoring, Integrated Care Management, Care Transitions, and Nurse Advice Line. These programs are administered by Molina Pathways, a comprehensive care management QIO-like entity expressly designed for Medicaid managed fee-for-service populations.
14.13.2	Care Management Registry Management	Health PAS comprises care management capabilities, HIE connectivity tools, virtual health record display tools, and care coordination/ care management tools. These tools help facilitate connectivity and analysis of data streams with immunization and other registries to better determine patient care management needs.
14.13.3	Healthy Rewards Program Management	West Virginia Healthy Rewards, Health Homes, and Mountain Health Choices care management and care promotion programs will benefit from an approach that uses proven methods over time and are successful in other state Medicaid programs. Molina's approach includes engagement and response methods to improve the level of involvement of members with their health care in addition to offering improved benefits and services. Incentive points are expected to increase the use of preventive services, compliance with treatment care plans, and reinforce behavioral changes. Rewards to providers are based on points awarded to assigned members with the assumption

PROPOSAL SECTION	TOPIC	OVERVIEW
		that providers will encourage their patients to earn points. These reinforcements increase the likelihood of desired behavior without changing benefit or cost structure.
14.13.4	Personal Health Records (PHR)	Molina's approach to a PHR system provides an invaluable tool in Medicaid patient care for West Virginia in supporting their Health Homes, Healthy Rewards, and Mountain Health Choices initiatives and programs. The Health PAS PHR enables patients to have a view into their MMIS electronic health record (EHR) data as well as any available clinical data from the West Virginia Health Information Network (WVHIN) in a clinically appropriate, informative presentation. Patients become an active member in their care by using the technical tools to stay informed and in active communication with their providers – creating a true continuous circle of care between the payer, provider, case manager, and patient.
14.13.5	Personal Health Improvement Plans Management (PHIP)	Molina's PHIP combines proven wellness interventions with a dynamic Web-based platform, allowing members to craft their own health improvement plan with goals and milestones. Offering meaningful programs with tangible outcomes via a robust member web portal will encourage members to take a more active role in their own health care management.
14.13.6	HITECH: Electronic Health Records (EHR) Incentive Program	The Health PAS Provider Incentive Payment solution currently serves the West Virginia provider population, providing comprehensive ARRA registration, attestation, oversight, and reporting EHR capabilities that will continue to evolve as the Stage 2 and Stage 3 Meaningful Use requirements are finalized.
14.13.7	HITECH: Health Information Exchange (HIE) Models	Molina offers BMS an HIE connection and display capability as a base portion of its new Health PAS offering. This baseline portion of the solution offers a solution that can be leveraged by Medicaid to provide bi-directional data exchange with the statewide HIE. Should Medicaid wish to expand this capability, the solution can be leveraged to support a free-standing, Medicaid-centric HIE and set up the ability to bi-directionally communicate with providers, MCOs, registries hospitals, laboratories and nonstandard data sources. Users of supporting applications have access to vast amounts of clinical and administrative data on the patient, enabling a virtual health record for patient review and analysis.
14.13.8	Eligibility Determination System	Molina, with Deloitte, the State's current eligibility vendor, to provide BMS with support for an expanded Eligibility Determination System. Molina supports the integration of our partner solution or State selected eligibility solution with the MMIS. Our ability to interface with our selected partner, or any State selected partner, will allow BMS flexibility to select a solution that best suits its needs.
14.13.9	Permanent Member Cards	Molina's proposed permanent member card solution with Oberthur Technologies provides durability, security,

PROPOSAL SECTION	TOPIC	OVERVIEW
		flexibility, and a more cost effective alternative to monthly paper ID cards.
14.13.10	Real Time Member Eligibility	Molina's Member Eligibility Gateway (MEG) facilitates real-time member eligibility loads in addition to batch processing of large monthly eligibility files. This will assist in facilitating future eligibility data exchanges with Health Insurance Exchange solutions and update eligibility processing from the State and other payers and providers.
14.13.11	Enhanced Member Web Portal Functionality	Health PAS has a member web portal capable of supporting, educational, and reporting tools and inclusion of State HIE enabled integrated personal health record modules and provider care coordination messaging. Our offering is designed to improve long-term health care and reduce medical expenditures by informing the patient on their care history, care authorizations, and care needs.
14.13.12	Interfaces with External Data Stores	Molina's base HIEConnect and optional HIE support solution fully enables batch and real-time bi-directional connection to disparate data sources that are external to the MMIS, such as directly with providers, State immunization and disease registries, Statewide HIE and HIXs for MITA aligned enhanced patient history sharing and immunization and disease reporting and update.

14.13.1 Care Management

RFP Requirement 3.2.10, #1

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14.14 Additional Materials

RFP Requirement 4.1.10: The Vendor may include additional materials, in a separately labeled section at the back of the proposal, which describes company offerings that may be of value to BMS. This section will not be reviewed as a formal section of the RFP and will not be included in the Technical evaluation and scoring.

Molina provides the following additional materials for consideration:

- Proposal Section 14.14.1: Additional Company Offerings
- Proposal Section 14.14.2: Glossary and Acronym List
- Proposal Section 14.14.3: Organizational Charts
- Proposal Section 14.14.4: Letters of Recommendation

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14.14.1 Additional Company Offerings

With the continuing challenges surrounding federal and state driven healthcare regulations and reform, Medicaid is experiencing a once in a lifetime evolutionary process in the history of healthcare. These healthcare reforms will transform how Medicaid manages itself, its providers, and its members to leverage the power of new technology and newly available patient data. These capabilities will allow states to improve the way they manage their programs by becoming more patient centric with their patient analysis and program management. Healthcare organizations today are facing significant technical and business challenges related to these changes in healthcare management that are putting incredible demands on states to respond quickly and effectively with sweeping changes. Molina understands that helping West Virginia Medicaid meet these challenges and create the next generation of healthcare for West Virginia involves much more than just providing a technical solution; it will encompass holistic changes in BMS' business that will impact MMIS processing and analysis.

In our current relationship, BMS and Molina are working to meet these challenges, and Molina hopes to continue this partnership as the new MMIS vendor. The American Recovery Reinvestment Act (ARRA), the Broadband Act (for which West Virginia is seen as a national innovator and leader), the Patient Protection and Affordable Care Act (PPACA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act have caused states to look many years into the future for their planning and resource allocations. These laws have once in a lifetime funding mechanisms, whose timelines and compliance must be met in order for states to receive these funds.

To maximize these opportunities, states must be innovative, leverage best practices, evaluate the experience of other states, and exercise diligence in adhering to the path they choose over the next five to ten years. While West Virginia has long been a leader in healthcare innovation and has a large number of providers and healthcare officials who know what it takes to be in the vanguard of healthcare quality improvement, today's opportunity is for West Virginia to take all of the best practices from across the healthcare arena and expand upon them. This involves an integrated focus on operational efficiencies, and the reduction of administrative overhead.

Moreover, a clinical focus will also be necessary, which includes defining measurable clinical goals, efficiencies, and outcomes. This is necessary to maximize the positive impact of BMS' Health Home initiative.

Molina wants to reiterate that, as an enterprise, we have deliberately integrated the best of MMIS and MCO services and functionality for the Medicaid population to achieve the vision of a fully integrated healthcare delivery system.

Molina proposes the following to help BMS achieve its goals, some of which Molina offers at no additional cost and some that will require additional funds:

- Experts to help West Virginia improve program management
- Business process improvement to improve program management
- Clinical data integration technology to maximize and expand the potential of existing benefits.

14.14.1.1 Additional Experts to Help West Virginia Improve Program Management

Molina has enjoyed a strong partnership with BMS supporting grant applications, waivers, and advanced planning documents. Molina continues to be impressed at the innovative drive demonstrated by West Virginia, and Molina wants to continue to support these efforts by bringing additional expertise, resources and support than what has been offered already in this proposal. The following are a few examples of additional service support that Molina believes might be welcome by BMS:

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14.14.2 Glossary and Acronym List

The table below includes a glossary of terms and acronyms used in this proposal.

TERM	DEFINITION
A	
ACA	Affordable Care Act
Acceptance Testing	The last phase of MMIS testing prior to final acceptance of the system.
Accretion	The process of adding members to a specific file
Accumulator	A counting device configured to track visits and/or dollar limit for specified services unique to a member. These counting devices can be configured for time periods, such as calendar year, rolling days, and have associated numeric values if the time increments are plural
Action Item	A set of activities established and assigned by the project to address some project need. Action items are often established in response to a project issue
Active Financial Transaction	Any account with a financial transaction pending some activity, e.g., an open member account with a patient payment waiting to be posted
Activity	Any of the various functions that are available to users according to their assigned security or access level to a particular module
AD or ADW	Aged/Aging and Disabilities Waiver
Ad Hoc Request	A request to provide non-production reports
ADAP	AIDS Drug Assistance Program
Adjudicate	To determine whether all benefit plan requirements have been met and whether a claim should be paid or denied
Adjudicated Claim	A claim that has reached final disposition paid or denied. An adjudicated claim is ready for payment processing
Adjudicated Claim Volume	The number of claims fully adjudicated. For the purposes of counting adjudicated claims, a claim shall be defined as one claim regardless of the number of lines on the claim. System created financial transactions and Mass void and replacements initiated by DPHHS shall be included in this definition. Rejected claims, any void or replacement initiated by a provider or as a result of Fiscal Agent processing errors shall not be included in this definition
Adjudication	The processing of a transaction resulting in either a Pay or approved, Deny, or Suspend status
Adjusted Claim	Claim created after a reversed claim is processed in order to resubmit and adjudicate the revised claim data; see also reversed claim
Adjustment	A transaction that changes any payment information on a previously paid claim. (In the replacement MMIS, adjustments will be made by voiding the original claim and, if applicable, creating a replacement through submission of a paper claim, 837, or use of direct data entry on the Web portal
Advance	A payment to a provider based on an estimate of claims that have not be adjudicated to pay status at the time the advance is issued
Affiliate	A provider or organization (i.e., hospital, clinic, etc.) that has some type of professional relationship with another provider and contracts to provide healthcare services to that provider's patients
Affiliation	The process by which one provider is linked to another provider. A provider may be an individual physician, a group practice or physician's network, or a hospital or other type of facility. Types of provider affiliations used by Health PAS-

TERM	DEFINITION
	Administrator are Pay-To (direct), Coverage, Hospital Staff, Network, Group, and 1099
Agency	Any department, commission, council, board, office, bureau, committee, institution, agency, government, corporation, or other establishment of the executive branch of this state authorized to participate in any contract resulting from this solicitation.
AHA	American Hospital Association
AHIMA	American health Information Management Association
AID Category	An alpha and numeric code identifying the criteria used to determine an individual's benefit plan enrollment.
Alert	An indicator that a record has an important warning attached that is not currently visible (e.g., health plan member is being monitored for a pattern of drug-seeking behavior)
Allowable Service	A benefit authorized by the Medical Assistance Program and rendered to an eligible recipient by an eligible provider.
Alphanumeric	Data made up of any of the letters of the alphabet and any digit from 0 to 9
Anesthesia Time	The period of time that begins when an anesthesiologist starts to prepare a patient for the induction of anesthesia in the operating room or equivalent area, ending when the anesthesiologist is no longer in personal attendance and the patient is safely placed under post-operative supervision
Annual Limit	The maximum amount the plan will pay within a year for a single benefit or for all of the covered services
ANSI X12N 270/271	The HIPAA named transaction between a provider and a health plan or between two health plans to determine eligibility for health plan benefits. The 270 transaction is submitted and the 271 transaction returns the eligibility information.
ANSI X12N 278	The HIPAA required transaction to request prior authorization or referral and receive such authorization.
ANSI X12N 820	The HIPAA required transaction to make premium payments
ANSI X12N 834	The HIPAA required transaction to enroll individuals in a health plan.
ANSI X12 N 837	The HIPAA required transactions to submit Health Care claims or equivalent encounters. There are three versions of the 837, Institutional, Professional, and Dental
ANSI X12 N 276/277	The HIPAA required transaction to inquire as to the status of a previously submitted claim. The 276 makes the inquiry and the 277 is the response from the health plan
ANSI X12 N 835	The HIPAA required transaction to send healthcare claim payment and remittance advice
APC Pricer	A third-party pricing application for Ambulatory Payment Classifications (APCs) using customized rules and payment rates
APD	Advanced Planning Document
Appeals	The administrative process through which the recipients or providers can appeal adverse decisions in respect to eligibility, coverage or payment.
Approved Authorization	Authorizations that have been approved and which will allow the Claims module to process the claim against those services on the authorization
Approved Provider Services (APS)	Specific services that a only particular provider can perform for members according to the guidelines of provider's contract

TERM	DEFINITION
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover 75% of the customary charges made for similar services in the same locality.
Artifact	A document, list, or any other type of internal or external deliverable
Assessment (Event)	A type of event in which the Case Referrer or Case Manager administers an assessment of the member
Assessments	Assessments are critical questions and responses used in the gathering of information about care for a patient. Assessments help Case Managers to determine the type of care plan required and any risks or problems that could increase the complexity of a case. Users configure questions, question categories, and response templates to be selected when building the assessment
Assigned Members	Those members assigned to a provider's affiliation for a particular program
Assigned To	The person who is responsible for an open issue created during a call. This person typically is responsible for completing the appropriate research and follows up with the caller to resolve the issue. The Assigned To assignment designates which issues are included in a call user's assigned issue list
Attribute	A field that contains unique information defined by a health plan (e.g., whether or not a member has Medicaid coverage). Attributes are attached to member, employer, and provider records and allow a health plan to record and track specific information pertinent to that health plan business rules
Atypical Provider	Individual or organization providing non-traditional services that are indirectly related to healthcare; examples include such services as non-emergency transportation and modifications to living quarters or vehicles
Authorized Service	Medical or dental assistance and/or other health related services authorized by the Department.
Auto Approve	Resolution does not require a workflow
Auto Assign Tier Level	Automatic assignment to a provider of the tier level that will be used in the process of assigning a PCP to a member; see also Provider Tier Level
Automatic Coverage	A function that allows membership coverage among PCP providers who have assigned membership as part of the same group
AVRS	Automatic Voice Response System
B	
BA	Bachelor of Arts
BAA	Business Associate Addendum
Base Dependencies	The base set of reports that must be installed and the user security setup that should be completed before running the Report Administrator module
Base Priority	Initial priority assigned to a call center interaction for a given queue
Basic Plan	A health insurance plan which covers core medical benefits but more limited coverage associated with services such as vision, dental, or prescription drugs; see also Enhanced Plan
BCF	Bureau for Children and Families
Bed Hold	This definition is for Nursing Facilities Bed Hold - Bed Hold days are days when the facility is holding a bed for a resident who is temporarily away from the facility and expected to return. The resident may be out of the facility on a Therapeutic Home Visit or while receiving medical treatment in another facility that is not a Nursing Home

TERM	DEFINITION
BENDATA	The input file to BENDEX (Beneficiary Data Exchange)
BENDEX	Beneficiary Data Exchange System – A file containing data from the Federal government regarding all persons receiving benefits from the Social Security Administration. This file is received and processed by TEAMS/CHIMES, the State's eligibility determination system, and the data is forwarded to the MMIS
Beneficiary	The Medicare term for a recipient.
Benefits	A schedule of coverage that an eligible participant in the program receives for specific health care services for the treatment of illness, injury or other condition.
Benefit Period	The period that begins when the patient enters a hospital and ends 60 days after the patient is discharged
Benefit Plan	Benefit Plan is the aggregate services that a member can receive, along with any criteria that should be used during claim adjudication, such as age, gender, place of service, service and visit limits, or other configurable parameters. The individual sets of services that make up the Benefit Plan are divided into benefits and contain benefit properties that delineate the criteria based on the health plan policy
Billing Provider	The provider who is submitting the claim. Can be a different provider from the servicing or rendering provider.
Billing Provider ID	ID of the provider under whose name a claim is submitted for services to a member
BizTalk	BizTalk is an EAI (Enterprise Application Integration) product from Microsoft, used to transform X12N transaction to XML and vice versa for communication in and out of Health PAS-Administrator
Bookmark	Editable Areas
BMS	Bureau for Medical Services
BS	Bachelor of Science
BU	Billable Units
Business Day	A day scheduled for regular state employees to work; Monday through Friday except holidays observed by regular state employees. Timeframes in the RFP requiring completion with a number of workdays shall mean by 5:00 p. m. local time on the last workday
Buy-In	Obsolete term/title, see Medicare Savings Program A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible Medicaid recipients, enrolling them in the Medicare Title XVIII Part A and Part B Program. All Buy-In activities are managed by TEAMS/CHIMES, the State's eligibility determination system
C	
Calendar Day	A 24 hour period between midnight and midnight, regardless of whether or not it occurs on a weekend or holiday
Calendar Year	A 12 month period beginning on January 1 and ending on December 31
Call	Point of contact between a member, provider, or employer affiliated with one organization's programs and the appropriate client relations department of that organization (e.g., member relations)
Call (Event)	A type of event that specifies Case Manager contacts (can be by phone)
Call Manager	The person who is ultimately responsible for an open call, ensuring that the issue is resolved. Depending upon organizational structure, the call manager may be

TERM	DEFINITION
	responsible for assigning issues to other users. The call manager typically documents each action taken to resolve an issue
Call Record	An instance of a call from a member, provider, or employer
Call User	Any person who answers the telephone or who resolves issues when members, providers, or employers call into the organization
Can	Used to express non-mandatory provisions; words denote the permissive
Candidate(s)	Members who are going through a Case Management Services review process to determine whether they are eligible for case management services. The Case Manager creates a candidate record for those candidates whose collected information supports acceptance into the Case Management program
Capability Maturity Model	An information technology system development methodology developed and promoted by Carnegie Mellon University to measure and certify the methods and controls used by a company or agency in the development of IT systems
Capitation	A system of payment, used in healthcare by managed care plans, for each patient served, rather than by service performed. Amounts are determined by assessing a payment per covered life or per member for a given time period. Providers are not reimbursed for services that exceed the allotted amount
Capitation Carve Out	Services that are excluded from a global capitation agreement
Capitation Payment	Payment to a provider for capitated services
Capitation Payment Fund	A specific payment fund reserved for capitation payments
Caps	Limits on services available to a client enrolled in a benefit plan, such as the number of dentures a recipient may receive
Captiva	Third party vendor, source for Base for reference and pricing information including diagnoses, service codes, modifiers, revenue codes, other code sets, and quarterly pricing changes
Care Management	Process that focuses on identifying client's needs, registering those clients into programs, and maintaining the plan of care or case.
Carrier	The entity/health plan that underwrites or administers programs and is ultimately responsible for claims incurred by members In Health PAS, the Carrier portal represents the highest level of organization and enables the State to manage various lines of business. It is also the highest level of summarization for reporting purposes. Health PAS supports three distinct types of carriers: Health Plan (the health insurance organization), COB Carriers (other health insurance organizations through which members have medical insurance), and TPL (third-party-liability or auto) carriers
Case Management Record	A record created when a case management services candidate has been determined to benefit from a specific case management plan and has been approved for case management services
Case Manager	The single point of contact for providers and those members who are supported with case management services; trained to know medical and non-medical resources to assist patients
Case Mix	The type or mixture of treatment provided to an enrollee by an Intermediate Care Facility (ICF) or nursing homes.
Case Number	Number assigned to a provider application in Health PAS-OnLine; used if the application is incomplete and the provider returns to complete the application at a later time; also used to access the provider enrollment data for edits or updates
Case Referrer	Individuals who search for and create candidate records for Case Management;

TERM	DEFINITION
	may do predefined case assessments as well
Case Supervisor	Supervises Case Managers and their workload; manages the Health PAS Case Management application and performs queries on the data.
Categorically Needy	All individuals receiving financial assistance under the State's approved plan.
Category of Service	A classification of medical services authorized under Medicaid (e.g., physician, inpatient hospital, ICF, etc.).
CD	Continuously Dedicated Staff
CDC	Centers for Disease Control
Centers For Medicare And Medicaid Services	The organizational unit of the U.S. Department of Health and Human services responsible for administration of the Title XIX Program under the Social Security Act
Certification	Written acknowledgment from CMS that the operational MMIS meets all legal and operational requirements necessary for 90 percent and 75 percent Federal Financial Participation (FFP)
Certified Family Home Provider	A home for one or two adults who are elderly, have a mental illness, physical or developmental disability which allows them to live in a safe setting; the home is operated by a provider with special training and proven skills in providing safe, effective services to the residents
CFR	Code of Federal Regulations
Change Control Board	A board made up of State staff and Contractor staff that will review and approve or deny all requested changes to the system.
Change Request	A perceived need for an addition, modification, or deletion to an existing project item or system; it is an essential tool in the process for controlling and managing project changes
Charge Back Risk Pool	A risk pool that applies to all defined services within a contract term. This option is primarily used whenever certain services are allocated to predefined pools. These services are part of a financial agreement between the health plan and the contracting provider. At the end of the fiscal year, the amount of monies spent on these services is calculated, and the contracted provider receives a percentage of the total remainder, if applicable.
Check Digit	A computer generated digit that becomes part of the provider ID number at enrollment time and is used for a validity check in claims processing.
Check Register	An output of the Claims Processing Subsystem which list checks approved from the current adjudication cycle.
Children's Health Insurance Plan	A fee-for-service benefit plan managed on the MMIS and through a state contract with a specific vendor
CHIP	Children's Health Insurance Program
Choose to Barge	Choice of the call center supervisor in a Web chat to communicate to both the call center customer service representative and the Health PAS-OnLine user engaged in a web chat interaction
CIB	Continuous information
CIN	Client identification number
Cine Mode	Text printed from top to bottom
Claim	A request for a benefit plan to pay for healthcare services
ClaimCheck	McKesson product that performs comprehensive coding audits of claims having CPT, HCPCS and ICD-9/ICD-10 codes

TERM	DEFINITION
Claim Detail	MMIS produced reports displaying details of adjudicated claim history for selected providers and/or recipients, or based on other selection criteria.
Claim Line	A line item of a document or electronic media claim which bills the State for a specific service(s) for a single recipient from a single provider.
Clean Claim Date/Clean Date	Represents the actual date that the claim was received or when additional information was received as a result of a telephone call or written correspondence; this data is recorded in accordance with the Prompt Pay mandate; also called a clean date
Client	A person who has been determined to be eligible for a one or more State health care programs
Clinical Indicator (Event)	A type of event in case management that requires review and/or reassessment of the clinical indicators of the patient; may include viewing a graphical display of clinical indicators
The Clinical Laboratory Improvement Amendments	Provisions of 1988 which requires all laboratory testing sites to obtain either a certificate of waiver or a certificate of registration along with an identification number in order to legally perform testing anywhere in the United States
Closed Authorization	Authorizations that are no longer valid and no longer need to be used. Since authorizations cannot be deleted, this status is used primarily to indicate authorizations created in error or which do not need to be used for any reason
CMS	Centers for Medicare and Medicaid Services
CMS 1500	Health Insurance Claim Form; CMS approved, used for billing professional services to insurance companies., formerly called a HCFA-1500
CMT File	A commit file that is required input for the commit process to burn images to the Storage Manager repository
Code Of Federal Regulations	The federal rules that direct the State in its administration of the Medicaid program and implementation and operation of an MMIS
Coordinated Care Network	The Department of Health and Hospitals is working to make Medicaid better for our residents, our providers and our state, with the ultimate goal of improving system of care for the state that includes the creation of a culture of personal responsibility for health, greater flexibility and financial incentives for Medicaid providers, and a more sustainable and budget-conscious solution for all state residents. A key component of this transformation includes a shift in the Medicaid delivery system from a traditional fee-for-service only program to Coordinated Care Network (CCN) models. Inherent in the system are numerous benefits for the Medicaid enrollee, who can expect greater coordination of his or her care and management of chronic conditions, as well as overall improved health and higher satisfaction in his or her care.
Co-payment/Co-Pay	The cost paid directly by members associated with receiving benefits or services from providers
COB Carriers	Other health insurance organizations through which any commercial or self-funded plan is primary insurance for a member
COMP	Computational, used to store a numeric data value in binary format
CommunityCARE Program	Primary Care Case Management program (PCCM). This program links Medicaid recipients to primary care physicians and operates statewide.
Component	An object that has its own versioned object base (VOB) and is usually a software deliverable; often referred to as a subsystem or module

TERM	DEFINITION
Compound Drug	A medication that is a combination of two or more pharmaceuticals
Computer Time	Time during which the Contractor's computer system is processing information ("wall" or "clock" time, not "CPU time").
Condition	A patient's diagnosis, symptomatology, and/or state of well being
Confidentiality	All reports, files, information, data, tapes and other documents provided to and prepared, developed, or assembled by the Contractor shall be kept confidential in accordance with federal and state laws, rules and regulations and shall not be made available to any individual or organization by the Contractor without prior written approval of the Department.
Continuity Of Operations Plan	A plan that incorporates disaster recovery, risk analysis and Contingency Planning to assure continued operation of Fiscal Agent responsibilities in case of a disaster, system failure, work stoppage, or other occurrence. Same as Business Continuity Plan BCP
Contract	The written, signed agreement resulting from, and inclusion of, this RFP, any subsequent amendments thereto and the Offeror's proposal
Contract Affiliation	Relationship between a provider's pay-to affiliation and contracts
Contract Amendment	Any written alteration in the specifications, delivery point, rate of delivery, Contract period, price, quantity, or other Contract provisions of any existing Contract, whether accomplished by unilateral action in accordance with a Contract provision, or by mutual action of the parties to the Contract; it shall include bilateral actions, such as administrative changes, notices of termination, and notices of the exercise of a Contract option
Contract Term	A contract is comprised of a set of contract terms, each of which describes the services that the contract term encompasses, as well as the rules and regulations that will dictate how providers will be reimbursed
Contractor	The successful Offeror (Fiscal Agent/Fiscal Intermediary) with which the State has executed a Contract that processes and adjudicates provider claims on behalf of the State
Contract Life	See Contract Term.
Contract Term	The Contract shall be effective as of the date it is duly signed and for the length of time as specified in the contract.
Contract Year	A twelve (12) month period beginning January 1 and ending December 31, during which time this Contract is in effect.
Computer-Based Training	Formal course materials delivered thorough an interactive Web-based training application
Correspondence (Event)	Correspondence events are a type of event used to initiate and track correspondence between the Case Manager and the member
Cost Avoidance	Purpose for requiring the provider to bill and collect or receive a denial from liable third parties before sending a claim to Medicaid
Cost Based Provider	Any hospital, clinic or health care agency enrolled to receive interim payments regularly as reimbursement toward costs for services rendered. At year-end, cost settlement is performed to determine actual costs incurred in providing services for Medicaid recipients.
Cost Factor	A percentage factor which indicates the percent of total charge paid to an institutional provider by Medicaid.
Cost Savings (Event)	Type of event to document information regarding negotiations that are performed as part of the case management process, such as setting rates regarding individual,

TERM	DEFINITION
	vendor or facility , primary contact information or type of service
Cost Settlements	Reimbursement based on the provider's actual costs for rendering services to state Health Care Program recipients. Some providers who are reimbursed on a cost basis include: Critical Access Hospitals and Nursing facilities
Cost Share	The amount that members contribute to their coverage. Cost share is for reporting purposes only and has typically been used for members participating in a state-provided long term care program
COTS	Commercial Off The Shelf
Coverage Period	The length of time during which an individual is covered by an insurer/third party carrier
Coverage Type	The family unit for which a member's selected coverage applies, which may include any combination of self, spouse, and dependents
Covered Service	Mandatory medical services required by CMS and optional medical services approved by the State for which enrolled providers will be reimbursed for services provided to eligible state Health Care Programs recipients
CPC	Certified Professional Coder
CPC-H	Certified Professional Coder – Hospital
CPC-P	Certified Professional Coder – Payer
CPM	Certified Project Manager
CPT Code	Current Procedural Terminology codes: a list of medical services and procedures performed by physicians and other providers identified by a unique five-digit code; CPT has become the HIPAA standard for reporting physician procedures and services
CPU Time	One hour of CPU clock time on an IBM model with 40 to 50 MIP or equivalent. Conversion of a IBM model with 40 to 50 MIP CPU hour to the equivalent will be based on industry accepted performance ratings of CPU processing through put as measured by millions of instructions per second (MIPS). Industry accepted performance ratings are published by sources such as Computer World.
Credentialing	For the purposes of this RFP, credentialing is validation by the Fiscal Agent that providers or applicants meet the state Health Care Program requirements for enrollment either through data exchange or document review
Credit	A claim transaction which has the effect of reversing a previously processed claim transaction.
Crossover Claim	A claim submitted by a Medicare/Medicaid provider to a Medicare carrier or intermediary on behalf of a dual Medicare/Medicaid eligible or Qualified Medicare Beneficiary that has been paid by Medicare and crossed over to Medicaid for payment of the Medicare deductible and/or coinsurance
Crossover Only Provider	Providers who work with patients who are dually eligible for Medicare and Medicaid coverage; they will be paid deductible and co-insurance amounts only
CTI Data Manager	Component that manages the processing of data requests initiated by the IVR
Current Procedure Terminology	Unique coding structure scheme for all medical procedures approved by the American Medical Association—Fourth Edition
Custom Fee	Payment pricing based on a custom-defined fee schedule
Customer Relationship Management	A term applied to processes implemented by a company to handle their contact with their customers. CRM software is used to support these processes, storing information on customers and prospective customers. Information in the system can be accessed and entered by employees in different departments, such as sales,

TERM	DEFINITION
	marketing, customer service, training, professional development, performance management, human resource development, and compensation
Customer Service Request	An official work request notification to the Fiscal Agent to initiate an update, research discrepancy modify or complete maintenance work in the MMIS/PBM/DSS
Cutover	The date on which the successful bidder begins full and complete operation of the LMMIS.
D	
DAF	Deliverable Acceptance Form
Data Element	A specific unit of information having a unique meaning.
Data Element Numbering	Set of numbers (e.g., 1000-1999, 2000-2999) allocated to each subsystem for assignment to data elements that originate in that subsystem.
Data Entry	The process of entering claims data into the MMIS.
Data Integration	Ability to produce and/or consume the same data from multiple systems, physical locations, and diverse vendors
Data Object	A data structure used in object linking and embedding that enables a user to export a document from an application, edit it in another application, and then re-import it into the original application
Data Source	The storage location for the data used in a report (e.g., a Microsoft Excel spreadsheet)
Day	Calendar day, unless specified as a business day
DDI	Design, Development and Implementation
Decision Support System	Component of a data warehouse that provides analytical-level queries and reporting
DED	Data Element Dictionary
Deductible and Coinsurance Portions of Health Care Benefits Paid under Title XVIII of the Social Security Act	Claims of this type will represent a request for payment by Medicaid of the deductible and coinsurance portions of claims submitted Medicare to which Medicare has made a payment determination.
Deemed	Deemed Cash Assistance Member with Medicaid
Delegated Services	Administrative services that are contracted out to a third party
Delegation	The assignment of member activity to another entity by transferring financial risk for a group of services to that entity
Deliverable	All software, documentation, reports, manuals, and any other item that the Vendor is required to produce and/or tender to the State under terms and conditions of this Contract
Denied Authorization	Authorizations that have been reviewed and denied, and which will prevent the Claim Manager module from processing the claims against the services on the authorization
Denied Claim	A claim for which no payment is made to the provider because the claim is for non-covered services, is for an ineligible provider or recipient, is a duplicate of another similar or identical transaction, or does not otherwise meet State standards for payment
Department of Labor and Industry	The agency that is responsible for licensure of most healthcare professionals

TERM	DEFINITION
DHHR	Department of Health and Human Resources
Diagnosis	The classification of a disease or condition
Diagnosis Code	An alphanumeric code used to identify the diagnosis of a patient's illness, disorder, or symptoms; also referred to as an ICD-9 code
Diagnosis Related Group	A prospective inpatient hospital reimbursement methodology used in Medicare. Under DRG, a single flat amount is paid per discharge.
Disable	Deactivate a business rule in claims adjudication
Disaster Recovery And Back-Up Plan	A plan to ensure continued claims processing through adequate alternative facilities, equipment, back-up files, documentation and procedures in the event that the primary processing site is lost to the Contractor
Disallow	To determine that a billed service(s) is not covered by Medicaid and will not be paid.
Discount FFS	Payment pricing based on a percentage of billed charges
Discount UCR	Payment pricing based on a predefined health plan or state-defined reduced UCR fee schedule
Discussions	For the purposes of the SFP presentations, a formal, structured means of conducting written or oral communications/presentations with responsible Proposers who submit proposals in response to this SFP.
Disease Management	A program that coordinates education, communication, and health care intervention for a population with a chronic condition, such as diabetes or hypertension, which self-care efforts can significantly improve the quality of life and reduce healthcare cost by reducing or preventing the effects of the condition.
Dispensing Fee	The dollar amount paid to a dispenser of drugs as compensation for his professional services.
Disproportionate Share Hospital	Payments made by the Medicaid program to hospitals designated as serving a disproportionate share of low-income or uninsured patients. DSH payments are in addition to regular Medicaid payments for providing care to Medicaid beneficiaries. The maximum amount of federal matching funds available annually to individual states for DSH payments is specified in the federal Medicaid statute.
DLP	Desk Level Procedures
DMERC	Durable Medical Equipment Regional Carrier
DOA	Department of Administration
Document Class	Part of the meta data with a document to direct it to the appropriate document library, or High level organization of documents within EDMS that corresponds with the major functional areas of Health PAS (e.g., claims, member, provider, utilization management); document types fall under document classes
Double-blind Keying	A method of ensuring data is correctly entered for important indexes. For example, a data entry clerk will enter a SSN, hit enter and the value will clear, then the data entry clerk will enter the same value a second time. The values must match for the data entry clerk to move on to the next data field
DRG	Diagnosis-related Group
Drug Rebate	Program authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) in which legend drug manufacturers or labelers enter into an agreement with the Secretary, DHHS, to provide financial rebates to States based on dollar amount of their drugs reimbursed by the state Health Care Programs

TERM	DEFINITION
Drug Utilization Review	Drug Utilization review is a process whereby the pharmacist reviews the prescription and the patient record for therapeutic appropriateness
DSD	Detailed Systems Design
DTS	Data Transformation Services
Dual Eligible	Individuals who are entitled to Medicare and are eligible for full or partial Medicaid benefits. Medicaid pays for all or a portion of Medicare Part A and B premiums, co-payments, and deductibles for dual eligibles. There are two types of eligibility, full dual eligibles, and partial dual eligibles.
Duplex	Double sided document
Duplex Scanning	Scanning both sides of a two-sided document
Duplicate Claim	A claim that is either totally or partially an exact or near duplicate of services previously paid. It is detected by comparison of a new claim to processed claims history files.
DUR Committee	Administrative control mechanism that is a crucial element in the management of the pharmaceutical component of the Medicaid Program. The committee is composed of physicians and pharmacists.
DW/DSS	Data Warehouse/Decision Support System
E	
E-Code	A supplemental code to the ICD-9 diagnosis code; captures cause(s) (how an injury/poisoning happened), intent (accidental or intentional) and place where the event occurred
Early and Periodic Screening, Diagnosis, and Training (EPSDT)	The EPSDT program is federally mandated under Medicaid and is administered by each state
EDB	Enrollment Data Base
EDI	Electronic Data Interchange
EDMS	Electronic Document Management System
Edifecs	Company providing SpecBuilder, XEngine, XEngine Server, and Ramp Management products, used for EDI validation and Provider Testing (Ramp Management)
Edit	Validation of data
EHR	Electronic Health Records Incentives Program
Electronic Data Interchange	The electronic exchange of standardized business information between computer systems. In the healthcare industry EDI is used for the exchange of member eligibility, provider, claims and referral/authorization data and other health related information between eligibility organizations, health plans, and healthcare providers and facilities. When data is exchanged electronically it is necessary to use uniform structure, format, and content to ensure transmissions will be successful
Electronic Medical Record	A record of diagnoses, treatments and laboratory results stored in an electronic record for retrieval and use by authorized treatment professionals
Eligible Provider	A provider of health care services entitled to payment under the state's Medical Assistance Program for rendered authorized services to an eligible recipient as established and certified by the Department to the Contractor.
Eligible Recipient	An individual entitled to health care services under the Medicaid Program as established and certified by the Department to the Contractor.

TERM	DEFINITION
Eligibility File	A file that maintains pertinent data for each state Health Care Program eligible recipient
Eligibility Segment	A specific date range (effective to termination date) during which a covered person is/was eligible for benefits under a health plan
Eligibility Verification	Refers to the process of validating whether an individual is determined to be eligible for health care coverage through the state Health Care Program Eligibility for the Client is determined by the State
EMC Snap	Product from EMC which creates economical, pointer-based, space-saving snapshot copies of EMC Symmetrix DMX storage volumes
Enable	Activate a business rule in claims adjudication
Enable Rebill Carrier Processing	Health Plans can designate a carrier as a Rebill Carrier to process claims transactions through a rebilling process. The rebilling process involves the calculation of fees based on services, the production of a billing invoice, the tracking of the payments, and the management of the claim payments. During claim adjudication, services identified as requiring rebilling determine the rebill rate from the rebill carrier fee schedule associated with the program. In order for this functionality to work, the Enable Rebill Carrier Processing must be enabled
Encounter	Standard transaction used by providers to identify services rendered to a member for reporting purposes only; no fee for service reimbursement is associated with encounter
Encounter Claims	Medical service claims submitted with the intent to provide statistical information only
Encounter Codes	Special billing codes used by Essential Care Providers in the place of local codes
Encounter Data	Detailed data about individual health care related services provided by a capitated managed care organization (MCO) or other State designated managed care providers. Encounter data is equivalent to a standard state Health Care Program claim except that it is submitted to provide service delivery data to the Agency and is not eligible for reimbursement
Enhanced Plan	A health insurance plan which includes all the benefits covered under a basic plan as well as additional coverage for such services as vision, dental, prescription drugs, health maintenance, or disease prevention; see also Basic Plan
Enhancements	MMIS/PBM/DSS system changes to update payment methodologies, program changes per State or Federal mandates, etc
Enrollee	A person who is qualified for Medicaid and whose application has been approved, but he or she may or may not be receiving services. Enrollee is used interchangeably with “member” and “recipient.”
EOBM	Explanation of Member Benefits
EPLS	Excluded Parties List System
EPMO	Enterprise Project Management
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review
ERD	Entity Relationship Diagrams
ERP	Enterprise Resource Planning
Essential Care Providers	Physicians for Rural Health Clinics and Indian Health Specialties who provide medical services for their respective populations and manage mid-level service providers in those clinics

TERM	DEFINITION
Event	An event is a user-defined activity that Case Managers must perform either on a scheduled or unscheduled basis. Event types can be configured. Once events are defined, Case Supervisors can assign the events to protocols. Protocols, in turn, are then assigned to case records
Evaluation	The in-depth review and analysis of Contractor's proposals
Exceptional Utilization	A pattern of health care delivery which is outside the range of normal utilization for a particular service or group of services.
Expenditure	Expenditure refers to fiscal information derived from the financial system of the Integrated State Information System (ISIS). ISIS reports the program expenditures after all claims and financial adjustments are taken into account.
Explanation of Benefits	An explanation of denial or reduced payment included on the provider's remittance advice
Explanation of Medical Benefits	The result of Medicare claims processing reported to a provider
Extended Care Facility	A long-stay institution which provides care for a recipient who is usually bed-ridden, at a lower cost than inpatient hospital care.
Extensible Markup Language	Designed to improve the functionality of the Web by providing more flexible and adaptable information identification. XML is actually a meta language-a language for describing other languages-which allows users to design their own customized markup languages for limitless different types of documents
Extension Point	The framework for the addition of custom code that cannot be accommodated through configurable components
External Document	A document, paper or electronic, significant to the project but that the project does not have content control over.
External Enrollment	Any external entity where a member is covered
External Provider Portal User Groups	The five classes of authenticated external provider portal user groups are provider, billing agency, clearinghouse, health plan, and authenticated (logged on) public.
F	
FA	Fiscal Agent
FACTS	Families and Children Tracking System
Fair Hearing	A legal proceeding in which the applicant/enrollee and BHSF agency representative presents the case being appealed in front of an impartial hearing officer.
Family Annual Limit	The total dollar amount that the health plan will pay for services rendered under this benefit during a one-year period for all members of the family combined. Limits may be calculated on calendar year, benefit year, or enrollment year
Family Deductible	The total dollar amount of eligible expenses a covered family must pay each twelve-month period from their own pocket before the plan will make payments for eligible services
Family Lifetime Maximum	The total dollar amount that the health plan will pay for services under this benefit for any and all family members regardless of any stated annual limits. Once the family lifetime maximum is met, the health plan will never pay for services under the benefit for any member of the family. Family lifetime maximums are not dependent upon benefit period and continue to accrue year-by-year until the family lifetime maximum limit is met
Family Maximum Out of Pocket Expenses	Family maximum out of pocket expense is the total dollar amount that a family is responsible to pay in a given benefit period. The maximum out of pocket limit is

TERM	DEFINITION
	calculated as the sum of all co-payments and deductibles paid by all members of the family. Family maximum out of pocket limits may be calculated on calendar year, benefit year, or enrollment year
Family Planning Services	Any medically approved diagnosis, treatment counseling, drugs, supplies or devices which are prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
FEA	Fiscal Employer Agent
Federal Financial Participation	The percentage amount contributed by the Federal government towards administrative costs in the Medicaid costs or the State Children's Health Insurance Program
Federal Medical Assistance Percentage	The percentage amount contributed by the Federal government towards the costs of most benefits in the Medicaid program
FFP	Federal Financial Participation
FFS Payment	Fee for Service payment, a traditional healthcare payment system, under which physicians and other providers receive payment that does not exceed their billed charge for each unit of service billed
Final RAP	The last RAP submitted at the end of a home healthcare episode. The final RAP is denoted by a 329 or 339 bill type
Financial Transaction	A system generated non-claim transaction used to make to related payments or recovery funds from clients, providers and other entities such as insurance carriers
Fiscal Agent	Refers to the Vendor operating the MMIS. A Contractor who processes Health Care Program provider claims for payments and performs certain other related functions as an agent for the State
Fiscal Intermediary	An organization under contract to perform functions such as claim processing for the Medicaid Program.
Fiscal Month	The Monthly time interval in a fiscal year.
Fiscal Year	The twelve month period beginning July 1 and ending June 30. Federal: the 12 month period beginning October 1 and ending September 30
FlexiFinancials	FlexiInternational's FelxiFinancials is a suite of commercial off-the-shelf (COTS) software products at the core of our Health PAS Financials solution; it includes modules for managing accounts payable, accounts receivable, and the general ledger
FMAP	Federal Medical Assistance Percentages
FOIA	Freedom of Information Act
FTE	Full-Time Equivalent
Full Risk Services	A provider who assumes responsibility and is financially liable for the member's care. If a provider is deemed at full risk for a set of services, any other practitioner who provides the same service must meet predefined criteria. (Formerly states as "at risk.")
Full Risk Term	All services defined within their term are deemed "at risk." All billed services will be defined as part of the provider's risk agreement
Fund	A source of cash for the payment of claims
G	
GAAP	Generally Accepted Accounting Principles
GAAS	Generally Accepted Auditing Standards

TERM	DEFINITION
General System Design	Defines the major feature and functions of an automated system to include major system logic, reports, screens, and input forms and files required for a certifiable MMIS
Geographical Information Systems	Software program that allow data to be displayed spatially
Geographic Price Cost Indices	An index of cost comparisons used to pay claims adjusted by geographic location during the adjudication process
Group Practice	A medical practice in which several providers render and bill for services under a single provider number.
GSA	General Services Administration
Guardian ID	This field will house the Case Number from IBIS
H	
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
Healthcare Common Procedure Coding System	A coding system designed by CMS that describes the physician and non-physician patient services covered by Medicaid and Medicare Programs and used primarily to report reimbursable services provided to patients
Health Plan	The health insurance organization
Health Plan ID	For internal use (as in Medicaid claims processing) the Health Plan ID is the field that holds the Medicaid ID. In external situations (such as TPL/TPR) the Health Plan ID is the group subscriber ID or the external organization's identifier for the insured. On the Member Summary screen this will be the Medicaid ID. On the Eligibility screen it will be the Medicare ID for the Medicare segment, subscriber ID for whatever other external health plan segments are shown
Healthy Connections	A primary care case management (PCCM) model of managed care
Health Insurance Prospective Payment System	Specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under prospective payment systems; at least one HIPPS code is defined to represent each case-mix group and may need to be included on the UB-04 claim form
The Health Insurance Portability And Accountability Act Of 1996	A Federal law that includes requirements to protect patient privacy, to protect security of electronic health information, to prescribe methods and formats for exchange of electronic administrative transactions, and to uniformly identify providers
HHS	Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPP	Health Insurance Premium Payment
Historical Financial Transaction	An open financial transaction from a legacy accounting system; it may be converted from the legacy system to a new accounting system to become an active financial transaction on the new system
History File	A file containing extracts of all past paid claims (or past recipient activity or past provider activity) that can be used for surveillance and trend development.
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act

TERM	DEFINITION
HIX	Health Insurance Exchange
HMO	Health Maintenance Organization
Hold	A financial delay represented by a claim being in a 'wait' status ('waitpay', 'waitrev', 'waitdeny') for a period of time
Home Health Care	Any of the services, therapy, or equipment charges covered by Medicaid when the provider performs these services at the residence of the recipient.
Hospital Based Physician	A physician having an agreement with a hospital whereby he receives fees for services performed for that hospital.
Hours of Operation	The specific hours of operation required for specific business operations, (for example, Enrollee and Provider Call Center hours of operations are 7:00 AM to 6:00 PM Central Time).
Hypertext Markup Language	A standardized computer language for displaying information in Web browser screens across various operating systems and platforms
I	
IAC	Inter-Agency Advisory Committee
ICD	International Classification of Diseases
ICN	Internal Control Number
I/DD	Intellectually Developmentally Disabled
In-Process Authorization	Authorizations that are approved but will cause the Claim Manager module to evaluate each service line on the claim depending on the status of each line. In-process authorizations allow the authorization department to keep working on additional services in addition to the services already approved
Individual Annual Limit	Individual annual limit is the total dollar amount that the health plan will pay for services rendered under a given benefit during a one-year period. Limits may be calculated on calendar year, benefit year, or enrollment year
Individual Cost Plan	Benefits limited by a cost plan established for an individual
Individual Deductible	The total dollar amount of eligible expenses a covered person must pay each twelve-month period from his or her own pocket before the plan will make payment for eligible services
Initial Enrollment Period	First period during which an individual can apply for a Medicare benefit
Initial RAP	The initial claim submitted at the beginning of care for a home health episode. An Initial RAP is denoted by a 322 or 332 bill type, contains the 0023 revenue code, and lists one HIPPS code. See also LUPA and RAP in the Acronyms Section and No RAP LUPA in the Terms Section
Inpatient Care	All services and procedures covered by Medicaid when the recipient requires an acute hospital stay.
Institution	An organization which provides medical services for persons confined within its structure (e.g., hospital, nursing home, etc.).
Insurance Carrier	Establishment primarily engaged in initially underwriting (i.e., assuming the risk and assigning premiums) relating to…health and medical insurance policies. (US Census Bureau definition)
Insured	The person who is responsible for paying health plan premiums, or whose employment or group membership is the basis for eligibility for coverage under a health plan. For example, if a married couple has health insurance through the employment of the wife, the wife would be the insured. The insured may also be called the subscriber

TERM	DEFINITION
Interaction Type	Type of call center interaction accepted by the Contact Manager solution; the following interaction types will be accepted: inbound voice, outbound voice, voicemail, Web chat, E-mail, task, and Web request
Interface	A file that enables the exchange of information between one or more entities via a specified format and media type
Integration Testing	Software testing in which individual software modules are combined and tested as a group. It occurs after unit testing and before system testing. Integration testing takes as its input modules that have been unit tested, groups them in larger aggregates, applies tests defined in an integration test plan to those aggregates, and delivers as its output the integrated system ready for system testing.
Intermediary	Private insurance organization under Contract with the Federal government handling Part A Medicare claims
Intermediate Care Facility (ICF)	A long-stay institution which provides care for a recipient, who is usually not bed-ridden, at a lower cost than inpatient hospital care.
Internal Control Number	A unique serial number applied to each imaged document stored in MMIS/DSS. Several ICNs may be associated with a single Transaction Control Number and non-claim documents may have an ICN as their sole control number
Internal Plan Managed	These enrollments are associated with a carrier or program that is actively managed through Health PAS
International Classification Of Disease, Ninth Edition, Clinical Modification	A classification and coding structure of diseases used by the State and health care community to describe patients' conditions and illnesses and to facilitate the collection of statistical and historical data
Interqual	Scientifically derived proprietary medical review criteria used for determining hospital admissions, continued stays and discharges.
IPA	A Molina product which uses a rule based engine to establish the prior authorization criteria for numerous drug classes; it adjudicates prior authorization requests online in real time
ISA	Interchange Control Header segment in an X12 transaction, relates to the BizTalk Configuration
IRG	Innovative Resource Group
ISP	Internet Service Provider
Issue	A question, problem, or condition related to the project that requires a decision and resolution.
ITE	Integrated Test Environment
IV&V	Independent Verification and Validation
J	
J2EE - JAVA 2 Platform, Enterprise Edition or J2EE	A standard for developing distributed Multi-tier architecture applications, based on modular components running on an application server. It uses several technologies, including JDBC and CORBA, and extends their functionality with Enterprise Java Beans, Java Servlets, Java Server Pages and XML technologies
J-Code	Permanent HCPCS codes used to report injectable drugs that ordinarily cannot be self administered; chemotherapy, immunosuppressive drugs and inhalation solutions: and some orally administered drugs
K	
Key Personnel	Contractor staff that shall be considered the key management team.
KIDMED	The screening component of the EPSDT Program including vision, hearing and

TERM	DEFINITION
	dental screening services.
KPI	Key Performance Indicator
L	
LAN	Local Area Network
LEIE	List of Excluded Individuals/Entities
Lifetime Maximum	Limits on the total dollar amount of eligible services a member may receive during their lifetime
Lifetime Reserve Days	Each Medicare patient is entitled to a lifetime reserve of 60 additional hospital days that can be used after the standard 90-day inpatient stay within a benefit period
Limits Effective Date	The starting date of the accrual and deductible
Limits Termination Date	The date the accrual of deductibles and accumulators is scheduled to end. If a claim is processed with a date of service after the member's limits termination date, deductible and accumulator amounts will not be calculated in plan limits for the specified time period
Line Status	Status of a claim detail line
LLC	Limited Liability Corporation
Lock In	An MMIS/DSS function that a Medicaid recipient receives certain benefits from a single, identified source. Lock-In is most used in Pharmacy Benefits Management to require a potentially abusive recipient to pick up prescriptions at a certain pharmacy only. Lock-In is used in managed care to require a recipient to receive care through a certain HMO or service network for a set period of time
M	
MAF	Milestone Acceptance Form
Managed Care	A term denoting management of recipient care by a provider or case manager to encourage maximum therapeutic efficacy and efficiency through service planning and coordination. Also used in reference to prepaid, capitated health systems.
Manual Pricing	Pricing a claim “by hand”. Usually performed due to the special nature of the service, e.g., no code exists; no allowed amount exists for a covered benefit, etc.
Man Day	Eight (8) man hours.
Man Hour	Sixty (60) minutes during which an employee of either the Contractor or the Department is actively performing an assigned task.
Man Month	Twenty-one and a half (21-1/2) man days.
Man Week	Five (5) man days.
Man Year	Twelve (12) man months.
MAPP	Medicare Automated Premium Payment
MAR	Management and Adminsitrative Reports
MAS	Minimum Acceptable Score
Maximum Out Of Pocket	The total dollar limit a health plan member is required to pay under his/her benefit plan in the form of co-payments, deductibles, and coinsurance during a specified time period. A health plan may or may not include co-payments in maximum out of pocket calculations
MCO	Managed Care OrganizationMDM
MDM	Master Data Management

TERM	DEFINITION
MDS	Minimum Data Set
MECT	Medicaid Enterprise Certification Toolkit
Medicaid	The Federal health care program as described in Title XVIII of the Social Security Act. Part A covers hospitalization and Part B covers medical insurance
Medicaid ID	Medicaid ID is the Client ID from the IBIS system. It is stored on the Enrollkeys table as CarrierMemID in Health PAS
Medicaid Fraud Control Unit	A section under the Attorney General that investigates potential Medicaid fraud and abuse
Medicaid Information Technology Architecture	An initiative by the Federal Centers for Medicare and Medicaid Services to modernize Medicaid Management Information Systems operated by the States by promoting greater interoperability with other systems, use of Commercial-Off-The-Shelf software, reusable programs and systems, and system analysis that allows business needs to drive system development.
Medicaid Reform Section	This section is a newly formed section that ultimately will have responsibility for the Coordinated Care Network (CCN) waiver when approved by CMS. Families deserve better health. Building on years of analysis, input, and recommendations from health care providers and advocacy groups statewide, and under the direction of the Legislature, the Bureau is working to transform Medicaid. The ultimate goal is a sustainable system that will provide better health coverage to residents. Coverage that allows residents to seek treatment in coordinated systems of care will offer better management of chronic conditions, overall improved health and higher patient satisfaction.
Medical Review	Pre-payment review conducted by the contractor to assure accurate payment for procedures and/or diagnosis that require review by medical professionals.
Medically Needy	Those individuals whose income and resources equal or exceed those levels of assistance established under a State or Federal Plan but are insufficient to meet their costs of health and medical services.
Medicare Action Code	A three-digit code indicating the final outcome of the claim. If the claim is paid, "PAID" will display. A list of applicable codes is provided in the remittance advice explanation of codes section
Medicare Advantage	Medicare Part C health plan options
Medicare Part A	Medicare hospital insurance, covers inpatient hospital care, hospital, home health benefits and limited skilled nursing facility care
Medicare Part B	Medicare supplemental medical insurance, covers physician services, outpatient hospital care, and other specified services
Medicare Part C	Medicare coverage under a managed care model
Medicare Part D	Medicare prescription drug insurance
Medicare Savings Program (MSP)	A procedure in which the State pays the monthly Medicare premium to CMS on behalf of eligible Medicaid members, enrolling them in the Part A and/or Medicare Savings Program, formerly called Medicare Buy-In
MEDREVIEW Authorization	Authorizations in a working, undecided, or pended status that will cause the Claim Manager module to prevent payment for any services on the authorization. Medreview is an alert that authorizations that have started the review process but have not had a final decision made towards their eventual status
Member	A person who is qualified for Medicaid and whose application has been approved, but he or she may or may not be receiving services. Member is used interchangeably with "enrollee" and "recipient."

TERM	DEFINITION
Member Share of Cost	A cost sharing payment, can be a member contribution or a patient liability
Member's Eligibility Organization	The system of record for member demographic and eligibility information in Health PAS. All changes to member information, with a few exceptions, will come to Health PAS via the daily interface. Whenever a member changes eligibility organizations, health plans, rate codes, or coverage types, the existing enrollment segment must be terminated and a new enrollment segment must be added
Memo	An indicator that a record has additional information attached that is not currently visible (e.g., comments about a discussion with a health plan member about a pending authorization)
Milestone	The measuring point used to review and approve progress, to authorize continuation of work, and, depending on the terms of the Contract, to pay for work completed
Minimum Data Sets	The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay. These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop quality measures that give consumers another source of information that shows how well nursing homes are caring for their resident's physical and clinical needs.
Misutilization	Any usage of the Medicaid Program by a provider or a recipient not in conformance with State and Federal regulation (fraud, defects in level or quality of care, etc.).
MITA	Medicaid Information Technology Architecture
MITA SS-A	MITA State Self Assessment (SS-A)
MMIS	Medicaid Management Information System
Modality	A therapeutic method or agent, such as surgery, chemotherapy, or electrotherapy, that involves the physical treatment of a disorder
Modification	Routine MMIS system changes that are identified throughout the life of the Contract, documented on the Customer Service Request form, and submitted to the Contractor for design, programming, and implementation
Modified Authorization	Authorizations that are approved but will cause the Claim Manager module to evaluate each service line on the claim depending on the status of each line
Modifier	A special code providers use to adjust a CPT code on a CMS-1500 claim form. Modifiers establish different payment amounts or record descriptive information that does not affect payment levels. Only modifiers for which the Centers for Medicare & Medicaid Services (CMS) has established a national payment policy will affect payment levels; carrier-unique local modifiers may be used but such modifiers have no affect on payment under Medicare
Modifier Discount	The percentage of the contract amount on a claim line that is eligible for processing based on a specific modifier
Module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MTS Component	MTS is a Microsoft Transaction Server which will calculate accumulator values/ balances from Com+. Microsoft COM (Component Object Model) technology enables software components to communicate. COM+ brings together COM components with the application host of MTS to handle difficult programming tasks

TERM	DEFINITION
M-WIN	Medicaid-Work Incentive Network
N	
National Payer Identification	The National Payer Identification is a project in which a unique identifier, called a Payer ID, will be assigned to every payer of health care claims, eliminating the need for multiple numbering schemes.
National Drug Code	The national standard formulary 11 digit code used by most states to uniquely identify drugs. Codes are assigned by the FDA.
National Provider Identifier	A universally recognized, unique identifier assigned permanently to every provider of health care services or supplies by CMS.
NCID	National Crime Information Database
NCPDP	National Council on Prescription Drug Programs
NDC	National Drug Code
New Assignments	Primary Care Provider (PCP) assignments made for health plan members who do not have a PCP assignment or whose previous PCP assignment was with a provider no longer eligible to provide services to health plan members
NIST	National Institute of Standards and Technology
No-RAP LUPA	A LUPA billed without a preceding RAP. See also LUPA and RAP in the Acronyms Section and Initial RAP in the Terms Section
Numeric	Fixed precision and scale numeric data from -1038 -1 through 1038 -1; synonymous with decimal in MSSQL
O	
Object	A data structure defined according to the template for data of the specified class with each object having a unique value among the variables in its class. For example, within the class of employer objects, each employer would have its own independent data structure which stored both information about how the employer record was to be used that was common to all employer records, and unique information about that specific employer (i.e., name, address, etc.)
Offeror	A vendor who returns a properly completed response to a request for proposal from an authorized State or agency-purchasing agent
OIG	Office of Inspector General
On-Line	Interaction between a user operating a cathode ray tube (CRT), personal computer, or point of sale(POS) device to send and receive information on a video display via a telecommunications network to a central computer processing unit (CPU)
OODMS	Object Oriented Database Management System
OQPI	Office of Quality and Program Integrity
On-Line Survey Certification & Reporting	The Federal file which contains CLIA certified providers and their classifications. The interface loads and verifies the CLIA provider number, status and specialties for which a provider is approved and can deny claims based upon CLIA specialties and subspecialties found on the OSCAR file
Organization	An administrative and functional structure where people collectively manage one or more projects, and the projects share a senior manager and operate under the same policies
OrgPolicy	A component of sponsor, the linking mechanism from policy to sponsor in Health PAS. Configurable options make a generic policy template specific for an organization

TERM	DEFINITION
ORT	Operational Readinerss Testing
OSCAR	On-line Support Collections and Reporting
OT	BMS Operations Team
OT or WVOT	Office of Technology
Overpayment	Payment made to a provider in excess of the amount allowed under the reimbursement rules of the benefit plan
P	
PA	Prior authorization
PAAS	Physician Assured Access System
Packed decimal	A storage mode that places two decimal digits into one byte, each digit occupying four bits. The sign occupies four bits in the least significant byte
Paid Claim	A claim that has resulted in the provider being reimbursed for some dollar amount or a zero paid amount
Panel Sizes	The number of members assigned to a provider
Parallel Testing	Testing based upon comparison of old and new system results. Requires a period of parallel operation where both systems operate and used the same data.
Part A Premium Payment Program (MSP)	Premium paid by the State for Part A Medicare coverage for members with less than 40 quarters of work credit
Part A Reduced Premium Payment (MSP)	Premium paid by the State for Part A Medicare coverage for those members having at least 30 through 39 quarters of work credit
Part B Premium Payment Program (MSP)	Medicare Part B monthly premiums
Part D Clawback	Refers to payments that Medicaid makes to cover the costs of outpatient prescription drugs for members who are eligible for Medicaid and who are enrolled in Medicare Part D
Pat. Control No.	Data field on the UB-04 used by the provider to identify the unique patient service visit /period covered by that claim, used by the provider in patient/service identification; may also be called the patient account number or patient’s account number (as on the CMS 1500)
Patch Sheet	Patch Sheets are used to separate multi-page documents within a batch set up for scanning. They use a rudimentary barcode (patch code) that tells the scanner when a new document is beginning
Pay and Chase	A term which denotes the practice of paying a claim on behalf of a recipient with third party resources and then recovering from the responsible parties. This is done when the third party resources are not known at the time of payment. Pay and Chase is most common with recovery claims involving casualty cases.
Pay For Performance	A mechanism to pay providers additional reimbursement for participation in specific treatment protocols
Pay-To Affiliation	An affiliation designation that allows for professional contractual relationships between providers
Payment Discount Term	The amount of time a provider has from the date of service to submit a claim in order for the claim to be considered for payment; also known as timely filing
Payment Fund	A source of cash or checking account used for claim payment
PCCM	Primary Care Case Management
PCP	Primary Care Provider

TERM	DEFINITION
PCP Affiliation	An affiliation designation permitting membership assignment to the PCP. The contract a Primary Care Provider has with a health plan covering fees and services provided to the plan members
PDL	Preferred Drug List
PDR	Physician's Desk Reference
Peer Review	An activity performed by group or groups of practitioners or other providers by which the practices of their peers are reviewed for conformance to generally accepted standards.
Pend	A processing delay for utilization documents or claims which require additional documentation, patient information, or other special manual intervention
Pended Claim	A claim that is put in suspense by the Claims Processing Subsystem for some reason(s) requiring manual review and resolution by clerical or professional staff before further processing can take place.
Per Diem	Payment pricing based on tier levels (also referred to as levels of care), which are used primarily for hospital facility charges. Tier levels are defined by current accommodation revenue codes
Per Unit	Payment pricing based on a per-unit factor
Performance Bond	A bond to be procured and maintained during the term of the Contract to secure the Contractor's performance.
Personal Representative	Individual elected in a will to handle the estate of a deceased person, also called an executor/executrix or an administrator/administratrix of the estate
Pharmacy Benefit Management	Composed of a functionality to support point-of-sale, drug utilization review and drug rebate
PIN	Personal Identification Number
Plan	A detailed formulation of a program of action; the plan details the activities to be performed to follow the process including how to, when to, and who will perform the activities
Plan Relationship	The link between a provider and a particular program in which the provider participates. Only providers with a relationship to a health plan will be assigned members from the plan and may act as a PCP for the plan members
PM	Project Manager
PMBOK	Project Management Body of Knowledge
PMI	Project Management Institute
PMO	Project Management Office
PMP	Project Management Professional
PMPM	Per Member Per Month
Policy	Policies are a compilation of settings related to enrollment, deductibles, and copayments. Each policy inherits settings from a program, which includes settings related to business rules, payment funds, networks, preexisting conditions as well as the associated benefit plans and benefits for the program, which are associated with the policy as policy plans. Rate codes are defined under the policy plan to associate members with specific aid categories or eligibility categories as defined by policy
Portal	A gateway in QNXT to a type or set of related information (e.g., provider records with contract dates outside of affiliation dates) or

TERM	DEFINITION
	A site serving as a guide or point of entry to the Web, may give access to a search engine and/or a collection of links to other related sites
POS	Point of Sale
Post-SQL Command	The SQL command defining any processes that will be applied to records after running the SQL query. For example, after the specified SQL query a post-SQL command would use the data to generate some type of report suitable unique business needs
PPACA	Patient Protectiona and Affordable Care Act
PPS	Prospective Payment System
PQAS	Prior Quarter Adjustment Statement
PRC	Provider Relations Consultant
Pre-SQL Command	The SQL command defining any processes that must be applied to Health PAS-Administrator records before running the SQL query
Premium Assistance	Maximizing cost avoidance for medical services through the accurate documentation of other health coverage of a member and by paying health insurance premiums on behalf of eligible members when it is cost effective. An individual's enrollment in a group health plan is considered cost effective if the expenditures in Medicaid payments are likely to be greater than the cost of paying the premiums and cost sharing obligations under an employer group health plan for those services
Premium Billing	Health PAS module with the capability to generate invoices and process cash receipts for specific Title XIX and Title XXI Member-related programs which contain cost-share components
Premium Rate Detail	Stores the premium rate table settings
Prepayment Review	Administrative sanction requiring review of a provider’s claims prior to payment imposed against a medical service provider whose billing practice has been found in non-compliance with the Department’s policies and procedures, and/or statues and regulations. This review shall be conducted by the Contractor.
Prescription Drug Card System	Claims processing system used by the incumbent Fiscal Agent to process all pharmacy claims with nightly data passed to MMIS (Same as POS)
Present on Admission	Used to indicate diagnoses that were documented when a patient was admitted to a facility. The implication is that additional diagnoses that occurred as a result of the admission would not generate additional payment
Presumptive Eligibility	Anticipated understanding that the member will be eligible for one of the State’s programs before that eligibility has been confirmed
Priceractive	Medicare Reimbursement Component
Primary Care Provider (PCP)	A provider whose practice is devoted to Internal Medicine, Family Practice, OB/GYN, or Pediatrics. Under HMO health plans, each member has a PCP who must be the member's first point of contact for non-emergency healthcare services. A health plan member's PCP will perform most general services for the member and/or will refer the member to other specialists or facilities for services the PCP does not provide. Some health plans allow a member to chose a PCP, while other health plans assign members to a PCP
Primary Enrollment	The first payer responsible for claims payment. This can be an external or internal source
Primary Key	The attribute selected from a table or database as being the most important identifier of the body of information

TERM	DEFINITION
Prior Authorization (PA)	Approval given in advanced by the State's Medical Assistance program to a provider for a service to a recipient.
Prior Carrier	A member's health insurance carrier prior to enrollment in one of the organization's health plans, see also prior coverage
Prior Coverage	A member's carrier prior to enrollment on another plan, see also prior carrier
Procedure	A series of tasks to be followed to perform an activity within a specific plan. Procedures are created for complex or critical plan activities that require detailed descriptions
Procedure Code	A code that represents a specific procedure, such as a service provided by a provider; also referred to as CPT codes
Procurement Library	The collection of MMIS documentation, provider policy manuals, and general information related to the Health Care Programs and the MMIS
Process	A defined set of functions and related tools that apply to a specific topic and are performed to achieve the State's objectives
Prospective-DUR	Prospective drug utilization review. A review of a patient's drug regimen before a prescription is filled.
Profile	An outline of the most outstanding characteristics of a provider practice in rendering health care services or of recipient usage in receiving health care services.
Program	A line of business created in the Carrier module (i.e. Medicare HMO)
Program Identification	An alpha-numeric numbering scheme (e.g., XYZNNNN) used to identify individual MMIS computer programs.
Program of All-inclusive Care for the Elderly	A model of managed care service delivery for the frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid benefits, and all of whom are assessed as being eligible for nursing home level of care
Project (Software Project)	The set of work activities, both technical and managerial, required to satisfy the terms and conditions of a contract. A software project should have specific starting and ending dates, well-defined objectives and constraints, established responsibilities, and a budget and schedule. A software project may be self contained or may be part of a larger project
Project Agreement	A document or set of documents baselined by the acquirer and the supplier that specifies the conditions under which the project will be conducted. A project agreement includes items such as the scope, objectives, assumptions, management interfaces, risks, staffing plan, resource requirements, price, schedule, resource and budget allocations, project deliverables, and acceptance criteria for the project deliverables. Documents in a project agreement may include a contract, a statement of work, user requirements, system engineering specifications, software requirements specifications, a software project management plan, supporting process plans, a business plan, a project charter, or a memo of understanding
Project Management Institute	A body that certifies Project Management Professionals
Project Lead	For larger projects, there may be more teams than a Project Manager can manage directly. For those projects, the Project Manager will appoint one or more project leaders to manage logical groups of teams. The team leader of each team reports to a designated project leader and the project leader reports to the Project Manager
Project Management Body Of Knowledge	A library of project management skills, tools and standards used by the Project Management Institute to measure and certify Project Management Professionals

TERM	DEFINITION
Prospective Enrollments	An individual eligible for enrolling in one of the health plans for the organization but who will not become an active plan member until eligibility confirmation is received from a forwarding agency (i.e., Medicare). Although a prospective enrollment may be assigned a PCP, any claims submitted for services received cannot be paid until after the date the enrollment is made active on one of the internal enrollment segments for the organization
Prospective Plan Managed	Claim and capitation payments will not be paid for prospective plan enrollments, but all other functions may be performed for prospective enrollments. Since this type of plan requires an additional activation step, Unisys will not be using this functionality for Healthy Connections eligibility segments
Protocol	Care plans created in the Case Management Configuration module maintained in the Protocols tab. These protocols are available for selection and are created for the management of a patient's disease or health condition. A protocol consists of various activities or events designed to promote long term goals for individual cases. Before configuring protocols, the appropriate events must be configured for use with the protocol. Protocols can be customized to fit an individual case once it is assigned to a member by adding additional protocol events. Multiple protocols may be added to a member's case record, with one being designated as the primary protocol
Provider	A person, organization or institution that provides health care related services and is enrolled in the Health Care Programs
Provider Affiliation	The relationship between providers; provider affiliation types include direct, group, network, service location, coverage, 1099, hospital subsidiary, and hospital staff
Provider Audit	An audit, financial or conformance in nature, which reviews the books and records of a provider in accordance with AICPA standards.
Provider Handbook	Provider manuals that contain the State's program specific coverage, limitation, and reimbursement policies
Provider Master File	A file of each person, organization, or institution certified to provide health or medical care services authorized under Medicaid.
Provider Relations	The activities performed by the Contractor regarding relationships with Medicaid providers.
Provider Review	An activity performed by the Department or its designated contractor whereby a provider's facilities, procedures, records and books are reviewed for conformance to Medicaid regulations. A field review may be conducted on a regular routine basis, or on a special basis to investigate suspected misutilization.
Provider Specialty	The professional medical specialty designation(s) for a provider (e.g., Family Practice, Cardiology)
Provider Tier Level	A priority number assigned to a provider for designating the relative order in which, in relation to other providers, a provider should be chosen for automatic assignment during the PCP automatic assignment process
Provider Type	General classification of the types of services a provider will render to a Medicaid member (e.g., hospital, home health, physician, laboratory)
Q	
QA	Quality Assurance
QC	Quality Control
QIO	Quality Improvement Organization

TERM	DEFINITION
Queue Groups	A logical grouping of call center queues
Queue Permissions	Permission which a call center customer service representative has been assigned for a given queue
Queries	A request for information from a database. A query must be in the format specified by the system being used (i.e., SQL)
R	
RAPIDS	Recipient Automated Payment and Information Data System
RBRVS	Resource-Based Relative Value Scale
Rate Code/Rate Group	Aid categories for members. A list of aid categories that will be used for Health PAS-Administrator and their corresponding benefit plans is included in the Policy OrgPolicy Sponsor of the Program Management folder in the Configuration Library. Also called a Rate Group.
RCS Workshop	Requirements to COTS Specification Workshop. A workshop to review and clarify Replacement MMIS requirements relative to the Health PAS COTS solution. Replaces the traditional Joint Application Design (JAD) workshops.
RDBMS	Relational Database Management System
RDTP	Rational Drug Therapy Program
Reasonable Cost	All costs found allowable in accordance with State and Federal regulations in the efficient delivery of needed health services.
Reassignment	Assignment of a health plan's members to previously-used PCPs whenever possible. During the PCP automatic assignment process for a new eligibility segment Health PAS-Administrator attempts to re-assign members to maintain continuity of care in the provider/patient relationship
Recipient	A person who is qualified for Medicaid and whose application has been approved, but he or she may or may not be receiving services. Recipient is used interchangeably with "enrollee" and "member."
Recipient Eligibility File	Maintains the current enrollment of all persons determined by the BHSF to be eligible for Medicaid benefits.
Recipient Explanation of Medical Benefits	A notice issued to Medicaid recipients that explains the payment of services made on their behalf and requests verification that the service was actually received.
Reconciliation	An automatic PCP assignment process that searches prior member PCP records for previous assignments or To make consistent or congruent, in accounting to check two elements/lists/totals /or the like against each other for accuracy
Recoupment	A payment returned by a Medicaid provider or a full or partial recovery of such payment due to an overpayment.
Redetermination	An annual repeat of the process for determining eligibility in case management
Referral	Indication that a member has approval from their primary care provider (PCP) to visit a specialist or obtain services that require a referral
Reimbursement Handbook	Provider manuals that contain billing instruction for reimbursement by Health Care Programs
Reject	To return a claim to a provider for a correction or change that will allow it to be processed properly.
Rejected Claim	A claim containing errors found during front-end screening such as missing provider ID or other key data elements, or has some conflicting information that

TERM	DEFINITION
	will impede the proper adjudication through the automated system. Such claim is returned to the responsible provider without entering it into the MMIS
Relationship	Describes how various family members are related to a primary subscriber (i.e. spouse, child). Relationships are used in the following modules: Member Administration, Employer, and Policy Administrator. Restrictions, holds, or limits on an enrollment can be defined in terms of relationship. For example, the maximum age for a dependent student covered under a subscriber's health plan is a relationship-based restriction
Relative Value Scale	Payment pricing based on the Relative Value Scale method. Health PAS supports several RVS methods, including CRVS, McGraw-Hill RVS, and RBRVS. Each scale consists of a specified unit amount; a discount can be applied to this pricing method
Remit	A report that details the explanation of a member’s benefits to a provider for each claim (and claim line) included in a payment
Remittance Advice	A summary of claim payments and denials produced by MMIS. An RA can mailed or posted to the Web portal
Rendering Provider ID	Identification number of the provider who actually saw the patient and provided medical service
Replacement Code	Code replacement occurs when a service billed by a provider is discontinued and an alternative code is priced in place of the discontinued code. This replacement code is supported under the subscriber's benefit plan and contract terms
Report Identification	An identification number of a report to identify and associate it with the program from which it was produced.
Report Item	A unit of information or data appearing on an output report.
Request for Proposal	The document that describes to prospective Offerors the requirements of the Fiscal Agent, MMIS, terms and conditions and technical information.
Required Documents	Documentation necessary for provider enrollment, claim processing and payment or the like
Requirement	A functionality specified by the state as being mandated for the Replacement MMIS.
ResHab Agency	Residential Habilitation Agency
Resource	A person or a tool available to and employed by the project to achieve project objectives
Restrictions	Hold or limits on an enrollment.
Retro-DUR	Retrospective Drug Utilization Review
Retroactive	Refers to “back dated” coverage or service date in which a person was determined to be eligible for a period prior to the month in which the application was initiated.
Retrospective Drug Utilization Review	A review of a patient’s drug regimen designed to identify patients at risk for drug induced illness and/or interactions.
Retrotermination	A termination that occurred after a payment was processed and the check was sent or when a health plan has supplied an advance to a provider during a claims backlog
Revenue Code	A numeric code that identifies a specific type of charge on a UB-04 claim form
Reversed Claim	A paid claim in which all amounts are reversed or backed out of all areas in QNXT, including the accumulator
RFP	Request for Proposal

TERM	DEFINITION
RHIA	Registered Health Information Administrator
Rider	An optional benefit that benefit plan members may attach to the standard benefit program for an additional premium (i.e. vision, dental, long-term care). Members of different rate codes within a benefit plan may have different rider options. These additional health services are available only for members of the specified benefit plan and rate code
Risk	An element in a process or a project that has the potential to jeopardize project objectives related to schedule, cost, efficiency, quality, or delivery
Risk Pool	A defined account (e.g., defined by size, geographic location, claim dollars) that exceeds a specified amount per individual, etc. to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities for a given account, as well as required funding to support claim liability.
Rollover Months	The number of months at the end of a policy period that will carry forward any deductibles assessed to the next policy year
ROSI	Reconciliation of State Invoice
RSD	Requirements Specifications Document
RTM	Requirements Traceability Matrix
Runtime	The time required by a computer to run a report or process a computation
S	
SACWIS	Statewide Automated Child Welfare Information System
SAS70	Statement on Auditing Standards Number 70
Scope of Work	A document prepared by the requestor and included in the requisition package, which delineates and fully describes the service to be performed or the required end result
SDM	System Development Methodology
Seagate Crystal Reports	A high performance reporting tool that is compatible with most applications and can create robust reports from many different types of data sources. Also referred to as SCR
Secondary Enrollment	Any subsequent payer. These enrollment segments can be ordered by responsible party. For example, a member might have Aetna as a primary segment, with Medicare and Medicaid as secondary segments in that order
Segment	An enrollment with a third party payer in QNXT
Server	A computer that provides some service to other computers or programs.
Service Authorization	The approval required from a designate authority for reimbursement for certain Health Care Program services
Service Category Group	A predefined service category that is delineated using local CPT, HCPCS, or revenue codes
Service Group	Predefined category of services based on CPT, HCPCS, and/or revenue codes. Service groups are maintained in the Claim Finance Codes module
Service Level Percentage	Percentage of call center interactions that must be answered within the time specified before a service level violation occurs
Service Level Violation	Amount of time that a call center interaction may remain in the queue before being considered to have violated a goal
Service Limitation	A maximum amount of services allowable for a recipient for a given time period, such as 12 physician visits per fiscal year.

TERM	DEFINITION
Shall	The term “shall” denotes mandatory requirements.
Should	The term “should” denotes desirable.
SIC	Standard Industry Codes classify businesses in terms of the industry in which they provide products. Primarily used in underwriting when pricing for groups, the codes are for reference purposes only
Simple Object Access Protocol	A light-weight protocol for exchanging messages between computer software, typically in the form of software components. It is an XML based protocol that consists of three parts: an envelope that defines a framework for describing what is in a message and how to process it, a set of encoding rules for expressing instances of application-defined datatypes, and a convention for representing remote procedure calls and responses. SOAP can potentially be used in combination with a variety of other protocols; however, the only bindings defined in this document describe how to use SOAP in combination with HTTP and HTTP Extension Framework
Simplex	Single sided document
Skilled Nursing Home Facility	A long-stay institution which provides care for a recipient who is usually bed-ridden.
SLA	Service Level Agreement
Smalldatetime	Date and time data from January 1, 1900, through June 6, 2079, with an accuracy of one minute. Note that Firebird’s dates have greater range and accuracy
Smallmoney	Monetary data values from -214,748.3648 through +214,748.3647, with accuracy to a ten-thousandth of a monetary unit. Note that Firebird’s range is greater with this declaration
Snap	See EMC Snap
Source Code	Instructions to a computer written by or programmer/developer in a language understood by the computer and the programmer; causes the computer to take certain actions or make certain decisions
Specialty	Branch of medicine in which a provider is Board Certified, e.g. cardiology, dermatology
Specialty Certification	Certification or approval by a National Professional Academy, Association, or Society which designates that this provider has demonstrated a given level of training or competence and is a “fellow” or specialist.
Spend Down	The Medically Needy program requires that an individual incur medical expenses equal to his/her share of cost amount, a.k.a. spend down amount, in order to become eligible for Medicaid. Medicaid is Federally prohibited from reimbursing providers any portion of a recipient’s spend down amount, however share of the cost information and medical expenses are currently tracked on the State’s welfare eligibility system. The Client reports medical expenses to the OLA and those expenses are recorded in the TEAM/CHIMES. Once the Client has met the spend down amount, TEAM/CHIMES sends an eligibility authorization to the MMIS
Sponsor	The eligibility organization through which a member is eligible to receive services
Sponsor Summary	A component of sponsor, contains demographic information including name, primary contact, physical, and mailing addresses, and ID’s
SQL	Structured Query Language
SQL Command	The SQL query required to run the specified query also called a SQL statement
SS-A	State Self-Assessment (see MITA)
SSAE16	Standard for Attestation Engagements No. 16

TERM	DEFINITION
SSI	Supplemental Security Income
SME	Subject Matter Expert
SMM	State Medicaid Manual
SNAP	Supplemental Nutrition Assistance Program (formerly Food Stamps)
SRM	Software Release Manager
State	The State of West Virginia.
State Paid Claims Tape	The magnetic tape produced by the Contractor that identifies all Medical Assistance paid claims. The tape is submitted weekly to the Department.
State Plan	The document by which the State outlines to CMS the amount, duration, and scope of Medicaid services to be provided and the reimbursement mechanism utilized in servicing specified groups of eligible.
Statues	Laws passed by Congress or a State legislature and signed by the President or the Governor of a State, respectively, that are codified in volumes called “codes” according to subject matter
Stakeholders	An individual or group with an interest in the success of an organization in delivering intended results and maintaining the viability of the organization's products and services. Stakeholders influence programs, products, and services. Members and staff of relevant appropriations, authorizing, and oversight committees; representatives of central management and oversight entities and representatives of key interest groups, including those groups that represent the organization's customers and interested members of the public
String	A sequence of data values that stand for characters
Stub Files	Data files or programs that stands in for the original, e.g., the PBM claims stub file is a file that does not contain all of the claims information, but includes what is needed for viewing the medical and drug claims of a member
Subcontractor	Any entity Contracting with the Prime Contractor to perform services or to fulfill any of the requirements requested in this RFP or any entity that is a subsidiary of the Prime Contractor that performs the services or fulfills the requirements requested in this RFP
Submission Days	The number of days from the date of service to the date of receipt that a provider has to submit a claim before payment penalties are applied
Subscriber	The person who is responsible for paying health plan premiums, or whose employment or group membership is the basis for eligibility for coverage under a health plan. For example, if a married couple has health insurance through the wife's employment, the wife would be the subscriber. The subscriber may also be called the insured
Subscriber ID	Designates the Head of Household ID (primary applicant)
Substantive Written Response	A response which provides sufficient information to the State, Department, or provider so that the receiver of the response can determine that the Contractor is making a good faith best effort to respond to the inquiry in a timely manner.
Subsystem	A component of a larger system that performs a specific function within that larger system. The component has within itself characteristics of a system but has functional as well as structural relationships to other components of the core system. Examples would include the following parts (or subsystems) of an MMIS: Recipient, Reference, Provider, Claims, MARS, SURS, Third Party Liability, and Managed Care.
Summary Accounting	Paper billing containing the Medicare premium amounts due for a billing month

TERM	DEFINITION
Statement	
Supplier	Any organization that supplies services or goods to the customer, also known as a contractor, seller, subcontractor, or vendor
Supporting Process	A collection of work activities that span the entire duration of a software project. Examples of supporting processes include software documentation, quality assurance, configuration management, software reviews, audit processes, and problem resolution activities
SUR	Surveillance and Utilization Reivew
Surveillance	Activities designed to monitor the expenditure of Medicaid funds and services.
Suspended Claim	A claim that has been suspended for manual review during the adjudication
Suspense File	A computer file where various transactions which cannot be processed completely because of errors or other reasons are placed.
Symptomatology	Branch of medical science concerned with symptoms of diseases
System	A set of computer and human oriented procedures which operate as a regularly interacting or inter-dependent group of activities forming a unified whole.
System Documentation	Documents that contain the technical description of the configuration, components and operation of the MMIS or DSS
System Integrator	An individual or company that specializes in building complete computer systems by putting together components from different vendors
System Sets	Profile that can be used to customize a set of variables used in a specific report or group of reports
System Performance Review (SPR)	A review conducted by CMS to determine if LMMIS will continue to be certified for Federal Financial Participation.
System Testing	The process integrates testing of all components of the system.
T	
Takeover	The act of a new Fiscal Intermediary assuming the system and operational responsibilities of the previous contractor.
TANF	Temporary Assistance to Needy Families
Target Date	The date used in the PCP Assignment module to identify members who do/will not have current Primary Care Physician assignments as of a specified date
Thera Class	Term for a classification of pharmacy drugs
The Economic Assistance & Management System	This eligibility determination system is being replaced by CHIMES
Term	Contracts are configured with individual terms covering various areas. These terms define the specific services, procedures, diagnoses, payment terms, as well as required documentation, and approved locations where services are performed
Third Party	The federal definition of third parties is “Health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service”
Third Party Diagnosis	For example, a diagnosis that could be related to an accident or Diagnosis provided by an independent third party

TERM	DEFINITION
Third Party Liability	A situation in which a claim submitted as a result of an accident or injury and for which another entity may be responsible for payment or situation in which a client has health insurance resources, including Medicare, which are responsible for at least partial payment of a claim
Tier	The lines in the claim to which a modifier discount is to be applied
Tier End	The last claim line to which a specific modifier discount is to be applied
Tier Start	The first claim line to which a specific modifier discount is to be applied
Timely Filing	Submitting a claim for healthcare services to the health plan within the time set in the provider's contract or set separately by the carrier
Timestamp	A database-wide unique number that records the time of an event
Title II	Regular Social Security
Title XIX	Medicaid (Title XIX of the Social Security Act)
Title XXI	State Children's Health Insurance Program (as part of Title XXI of the Social Security Act)
TPA	Third Party Administrator
TPL	Third Party Liability
TPL Carrier	This type of carrier is designed for reporting and calculations. Examples are Allstate or Geico, where an accident is potentially involved and liability for claims payment shifts from the insured's health plan to the TPL carrier
Trading Partner	Any entity with which Unisys exchanges electronic data
Trading Partner Agreement	Users must agree to the terms of the Trading Partner Agreement after registering to be a TP
Trading Partner Categories	Categories of Trading Partners include Provider, Billing Agency, Clearinghouse, Health Plan, Public, or Member
Transaction Control Number	An internal control number assigned to each claim as the current Fiscal Agent for processing receives it. The TCN is used in both current MMIS and current POS.
Transition	The system conversion from the Contractor to the State or successor Contractor.
Trend	A measure of the rate at which the magnitude of data is changing.
Tricare	The US Government program that provides insurance to military dependents and retirees (Previously known as CHAMPUS)
Turnover	The transfer of the LMMIS to the State and/or a successor Contractor.
Type of Business Tax Entity	Nature of business structure as defined on the W-9 tax form, e.g. corporation, LLC
U	
UAT	User Acceptance Testing
UB-04	Uniform Billing form for institutional providers; has been revised to accommodate HIPPA/NPI requirements; formerly called UB-92
UDDI Version 3.0.2 Specification	Describes the Web services, data structures and behaviors of all instances of a UDDI registry. UDDI uses the XML Schema Language (See http://www.w3.org/TR/xmlschema-0/, http://www.w3.org/TR/xmlschema-1/ and http://www.w3.org/TR/xmlschema-2/) and its terminology, such as "sequence" and "choice" to formally describe its data structures
UM	Utilization Management
UM Documents	A type of event that is related to creating referrals, authorizations, and certification

TERM	DEFINITION
	for a member
UNC Name	Universal Naming Convention
Unduplicated (Eligible/Recipient)	An unduplicated eligible/recipient is a uniquely counted eligible/recipient who is counted only once during a given period for any particular category of interest.
Universal Claim Form	The NCPDP standard paper claim form for pharmacy claims
USC	United States Code
User	Any individual or a group identified by the State as the persons authorized to use all or parts of MMIS/PBM/DSS functions.
User Acceptance Testing	This is the last phase of testing in the MMIS and will be conducted with a cross section of end users testing the applications. The end users will use real world scenarios and perceptions relevant to their daily work.
Usual and Customary Fee Schedule	The file containing the reasonable charges of a given procedure to be reimbursed to a practitioner. The reasonable charge can vary according to different regions in the State.
Utilization Review	The process of monitoring and controlling the quantity and quality of health care services delivered under Medicaid Program.
V	
Validate	Support or corroborate on a sound or authoritative basis
Variable Per Diem	Allows reimbursement in different amounts, based on the length of stay for inpatient services. The start day, end day, and amount of each variable per diem are specified
Vendor	Any responsible source that provides a supply or service
Vendor Buy Loc	Vendor Buying Location, defines source of an AP invoice including the pay-to provider's associated 1099 information
Violation Time	Goal set for the amount of time a call center interaction remains in the queue; interactions remaining longer than the goal are considered in
Void	A transaction which has the effect of zeroing out the payment amount of a previously paid claim.
W	
Waiver	An exception requested of or granted by CMS in response to a request from a state, usually regarding some required aspect of Medicaid regulations in order to implement a new program or system.
WAN	Wide Area Network
Warrant	A record of an actual payment mechanism, such as a paper check or electronic funds transfer; e.g., the warrant number of paper check is the number printed on the check
Whisper	Option of the call center customer service representative to communicate with the call center supervisor without the Health PAS-OnLine user being aware of the communication
Withhold	Percentage of the capitation or fee for service payment from each service that is retained by the health plan to finance potential deficits if health plan premiums from enrollees are less than health plan payments to physicians
Work Breakdown Structure	A detailed plan used to complete and track a project. The WBS identifies every task in the project, estimates time and resource requirements, identifies predecessor and successor tasks, identifies the critical path, and is used to compare to actual project performance

TERM	DEFINITION
Workman's Compensation	A type of third-party coverage for medical services rendered as the result of an on-the-job accident or injury to a recipient for which his employer's insurance company may be obligated under the Workmen's Compensation Act.
WV	West Virginia
WVDHHR	West Virginia Department of Health and Human Resources
X	
XSL/XSLT	A language for transforming XML documents into other XML documents. XSLT is designed for use as part of XSL, which is a stylesheet language for XML. In addition to XSLT, XSL includes an XML vocabulary for specifying formatting. XSL specifies the styling of an XML document by using XSLT to describe how the document is transformed into another XML document that uses the formatting vocabulary
Y	
Z	

This section contains confidential and proprietary information and has been redacted.

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14.14.4 Letters of Recommendation

As West Virginia's current fiscal agent, Molina provides letters of recommendation from the West Virginia Medicaid community as a testament of our quality service.

- Greenbrier Valley Medical Center
- Highland Hospital
- North Spring Behavioral Health
- Office Managers Associates of Healthcare Providers, Inc.
- Princeton Community Hospital
- United Hospital Center
- WV University Health Associates
- WVU Healthcare

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14.14.4.1 Greenbrier Valley Medical Center

P.O. Box 497
Ronceverte, West Virginia 24970
(304) 647-4411 ext 6871
PROVIDER

June 6, 2012

Dear Dr. Ruth Ann Panepinto, PhD:

We have a great working relationship with Molina Medicaid Solutions. They currently handle and process all of our West Virginia Medicaid for Greenbrier Valley Medical Center. We have many useful reports set up with several of their analysts and we get a tremendous amount of assistance from their field representative. They are very knowledgeable and they are willing to go above and beyond to assist us.

Molina Medicaid Solutions also perform onsite visits and they offer Provider Relations Seminars that cover all areas that we need.

We are very satisfied with our business partnership with Molina Medicaid Solutions. We believe any change in that relationship would be detrimental to our organization.

Thank you for your consideration.

Sincerely,

Colleen Barrett

Colleen Barrett
Medicaid Billing Specialist

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14.14.4.2 Highland Hospital

Highland hospital
HIGHLAND CAN HELP

R. Terrance Rodgers
Chairman of the Board

David M. McWatters, III
President & CEO

May 23, 2012

To whom it may concern:

It is my understanding that BMS has issued an RPF for a new fiscal agent under a new 10 year contract that would begin in 2014. I am writing this letter in support of Molina being retained as the BMS Fiscal agent.

Over the years, Molina staff has provided very good customer service. The staff appears to be well-trained, and they appear to be extremely knowledgeable of West Virginia Medicaid rules and regulations. Any time I have had an issue, the Molina Claims Manager, Provider Representative, and/or EDI support staff have responded to the issue immediately.

As I recall, the transition from ACS to Unisys in 2004 was not a smooth transition, and this is something that I would not look forward to experiencing again. Therefore, I ask that you please carefully consider how transitioning to a new fiscal agent would affect Providers if BMS should award the new contract to an agency other than Molina.

Respectfully,

Rick Rucker
Accounts Receivable Manager
Highland Hospital

300-56th Street, S.E. P.O. Box 4107 Charleston, WV 25364-4107 (304) 926-1600 FAX (304) 925-1524

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14.14.4.3 North Spring Behavioral Healthcare

42000 Victory Lane, Leesburg, VA 20176

Dr. Ruth Ann Panepinto, PhD
Executive Account Manager
Molina Medicaid
1600 Pennsylvania Avenue
Charleston, WV 25302

May 30, 2012

Dear Dr. Panepinto:

I am writing this letter to show my support and appreciation for Molina Medicaid and its staff. I have been working in the healthcare field for thirty years now and have worked with an array of payors and providers. My experience has allowed me to meet many professional individuals who possess the same goals, work ethics, and morals that I have. Our main goal and focus is quality care for our residents. Molina Medicaid allows my staff to focus on these goals because of the high quality training and assistance they provide us with.

Since becoming the CFO for North Spring Behavioral Healthcare, Inc. "NSBH" six years ago my staff has attended two separate Training events held by WV Medicaid (Unisys/Molina) and they have raved about meeting two wonderful women (Angie Richards and Renee Chalfant) who helped them in the process required to treat WV Medicaid recipients at my facilities. They were very educated in the process from authorization requests to intricate claims billing. As I am sure you are aware every payor has different claims billing processes and each is an art to comprehend the first time around. Angie was gracious enough to drive all the way to our Business Office in Leesburg, VA to provide my staff with hands on training. Her knowledge and patience allowed my staff to become comfortable with online billing and follow up on the claims status.

Angie and Renee has always been "NSBH" lifeline when we succumb to an obstacle that we cannot overcome. They are always an email or phone call away and have always been able to resolve our issues. We have been able to reduce our margin of error down to 1% and had all outstanding A/R reduced down to 31-60 days. When I was first hired the WV Medicaid A/R was over 180 days on a number of residents which is not acceptable for any organization. The training and assistance from

Angie and Renee allowed my staff to be able to bill appropriately in order to resolve the outstanding issues.

Molina Medicaid has always provided exceptional EDI, web based billing, training, and intricate claims questions to be answered. They are gracious employees who must enjoy the work that they do and who they work for because it certainly transfers over through positive attitudes to the providers like me.

I appreciate you taking the time to read this letter and hope that you will pass my gratitude onto the Molina Medicaid staff.

Thank you,

William Gitzen, MBA
Chief Financial Officer
North Spring Behavioral Healthcare
Phone 703.777.0801 Fax (703.777.7147
Cell 703.297.9123
bill.gitzen@uhsinc.com

14.14.4.4 Office Managers Association of Healthcare Providers, Inc.

Dr. Ruth Ann Panepinto, PhD
Account Manager
Molina Medicaid Solutions/WV Medicaid
1600 Pennsylvania Avenue
Charleston, WV 25302

June 5, 2012

Dear Dr. Panepinto,

As a provider I would like to see that Molina remain our claims processer. Molina has been able to bring the Medicaid system to a point where we don't dread accepting that part of our population as patients. In the past the amount of time we spent trying to get paid was very time consuming along with the mental stress of having to repeat the billing process over and over. We already agree to accept lower reimbursement for services provided because we realize this population both needs and deserves quality medical care. It is a fact that if we don't have to spend time and money chasing our payments down we are more willing to continue seeing Medicaid patients.

Once again I can't stress enough how important it is to a provider to have a seamless billing process.

Thank you

Connie Frazier
Office manager, Francke and Nunley, M.D.'s P.L.L.C.
Office Managers Association of Healthcare Providers, Inc. Charleston Chapter President
OMA State Treasurer

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14.14.4.5 Princeton Community Hospital

PRINCETON
Community Hospital

May 21, 2012

Dr. Ruth Ann Panepinto, PhD

Dear Dr. Panepinto,

Please accept this letter of recommendation for Molina Medicaid Solutions. I represent Princeton Community Hospital Association and have been working with the West Virginia Medicaid program for approximately thirty years. During that time span I have seen numerous DHHR system conversions and decisions/changes made related to claims processing vendors.

I fully support retention of Molina as I have incurred far fewer issues and found the service to be superior to past entities awarded the contract.

Should you have questions and-or need additional input, please contact me directly at 304-487-7266.

Sincerely,

G. Yost

Greg Yost

Greg S. Yost

P.O. Box 1369 • 122 Twelfth Street • Princeton, WV 24740-1369 • Phone: 304/487-7000 • Fax: 304/487-2161

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14.14.4.6 United Hospital Center

327 Medical Park Drive | Bridgeport, WV 26330

March 14, 2011

West Virginia Bureau for Medical Services:

Please accept this letter of reference in regards to Molina Medicaid Solutions retaining the contract as fiscal agent for West Virginia Medicaid.

Molina has demonstrated a commitment to excellent customer service and state of the art technology while partnering with the provider community in West Virginia to serve the state's Medicaid population.

Molina's current claims processing services are far superior to those West Virginia providers have accessed in the past. Their commitment to technology and electronic transactions allows very thorough claims tracking, up to date eligibility information, timely provider enrollment updates, more accountability in payment and denial processing and increased overall efficiency for providers.

Their commitment to service means that providers have access to well trained individuals in the call center but also access to dedicated Provider Service Representatives.

Provider Service Representatives partner with the medical community at a regional level to assist with education and resolve issues. United Hospital Center has called upon our Provider Service Representative for additional education with regards to the Provider Web Portal, to address specific provider enrollment issues for new physicians and to clarify medical policies. This support and education has been beneficial and timely.

Molina Medicaid Solutions has the resources and commitment to continue providing quality service as the fiscal agent for WV Medicaid.

Sincerely,

Danielle Heston-Raddish
Assistant Director Patient Accounts
United Hospital Center

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14.14.4.7 WV University Health Associates

May 21, 2012

Molina Medicaid Solutions
Ruth Ann Panepinto, Account Manager
1600 Pennsylvania Avenue
Charleston, WV 25302

Subject: Reference Letter

Dear Ruth Ann:

This letter is in regards to the Professional working relationship between Molina Medicaid Solutions and West Virginia University Medical Corporation DBA University Health Associates. University Health Associates is the largest multi-specialty physician group in West Virginia. WVU's Robert C Byrd Health Sciences Campus is a large, modern health sciences complex that includes Schools of Medicine, Dentistry, Nursing and Pharmacy, three hospitals, a physician office building, and state-of-the art cancer and eye centers.

Effective January 1, 2012, the physician group transitioned with WVUH and we are now one entity. Although, we still continue to bill under our individual tax Identification numbers.

West Virginia Medicaid represents approximately 12% of our Revenue which equates to $4ml in charges per month. From a Revenue Cycle perspective, we electronically file the claims and electronically post the majority of the payments and denials. We have a staff of 6 employees and one Coordinator that are dedicated to working the denials and follow-up for WV Medicaid. We work closely with our Provider Field Representative, Maribeth Roach. Beth is very responsive in assisting us with questions and issues that may arise. She quickly researches and identifies the problem and then works with us on a solution.

Some of the most recent issues were related to the following:

- Payments were issued to WVUH in error for Provider Shawn Long. Beth researched and determined what the problem was and reprocessed all claims to pay UHA.
- WVU Physicians of Charleston, reversal replacements were rejecting back from WVM in error. Beth identified the problem and sent the claims back through to be reprocessed.
- UHA has on-going issues with providers not being affiliated with our group and or terminated. She always researches and rectifies the problem.

We are very pleased with Maribeth and the staff at Molina. All issues are always treated with the highest priority and professionalism.

We look forward to continuing our relationship with Molina in the future.

Please don't hesitate to contact me for further discussion.

Sincerely,

Mary Ellen Wildasin

Mary Ellen Wildasin, CPC
Manager, Revenue Cycle Operations

Revenue Cycle Operations • (304) 293-7401 (800) 541-4009

West Virginia University Medical Corporation • 255 Scott Avenue • P.O. Box 897 • Morgantown, WV 26507-0897 • FAX (304) 293-6963

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14.14.4.8 WVU Healthcare

5/25/12

Letter of Reference

WVU Hospital has been very satisfied with the service provided by Molina regarding the processing of WV Medicaid Medical claims. The Staff is very knowledgeable in assisting with problems. Claims are processed and payment made in a timely manner. The provider representatives are well trained to help out when an issue does arise.

WVU looks forward to working with Molina in the future.

Dollie Barker

Insurance claims Specialist

WVU Hospitals, Inc.

1 Medical Center Drive

Morgantown, WV. 26506

Phone: 304-598-4032
Fax: 304-598-4143
www.wvuhealthcare.com

Patient Financial Services | West Virginia University Hospitals

PO Box 8031
Morgantown, WV 26506-8031

Equal Opportunity Affirmative Action Institution

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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 ☐ (Do not check if a smaller reporting company)	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 outstanding.

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.

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Form 10-K

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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.

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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

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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."

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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

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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.

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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%

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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.

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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

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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.

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- *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.

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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,

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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

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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.

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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

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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.

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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

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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

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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.

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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.

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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.

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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

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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	$ —

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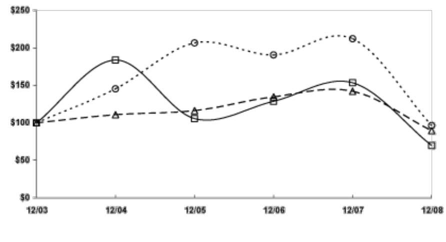
STOCK PERFORMANCE GRAPH

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.

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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

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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

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	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.

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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.

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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

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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

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(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

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	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 $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.

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- 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.

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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%.

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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;

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- 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%

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- 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

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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

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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;

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- 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

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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***

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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

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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.

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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

	2008	2007	2006
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.

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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, 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.

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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

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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.

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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.

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MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

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

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(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,

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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

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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)

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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.

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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	December 31, 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

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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	December 31, 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	December 31, 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

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	Year Ended December 31, 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

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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.

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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

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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

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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

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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.

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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%.

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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.

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	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

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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

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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

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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

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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.

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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	Filed herewith.

adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

EX-12.1 2 a51362exv12w1.htm EX-12.1

Exhibit 12.1

Molina Healthcare, Inc.
Computation of Ratio of Earnings to Fixed Charges
(Dollars in thousands)

	Year Ended December 31,				
	2008	**2007**	**2006**	**2005**	**2004**
Earnings:					
Income before income taxes	$103,891	$ 93,696	$ 73,458	$ 43,851	$ 87,685
Add fixed charges:					
Interest expense, including amortization of debt discount and exp	8,714	4,631	2,353	1,529	1,049
Estimated interest portion of rental expense	4,370	3,988	2,682	2,852	2,225
Total fixed charges	13,084	8,619	5,035	4,381	3,274
Total earnings available for fixed charges	$116,975	$102,315	$ 78,493	$ 48,232	$ 90,959
Fixed Charges from above	$ 13,084	$ 8,619	$ 5,035	$ 4,381	$ 3,274
Ratio of Earnings to Fixed Charges	8.9	11.9	15.6	11.0	27.8
Total rent expense	$ 17,481	$ 18,127	$ 12,193	$ 9,505	$ 7,416
Interest factor	25%	22%	22%	30%	30%
Interest component of rental expense	$ 4,370	$ 3,988	$ 2,682	$ 2,852	$ 2,225

EX-21.1 3 a51362exv21w1.htm EX-21.1

Exhibit 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
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
HCLB, Inc.	Michigan

EX-23.1 4 a51362exv23w1.htm EX-23.1

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the Registration Statements (Forms S-8, No. 333-108317 and No. 333-138552) 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, 2009, 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, 2008, filed with the Securities and Exchange Commission.

/S/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2009

EX-31.1 5 a51362exv31w1.htm EX-31.1

EXHIBIT 31.1

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, 2008 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, 2009

EX-31.2 6 a51362exv31w2.htm EX-31.2

EXHIBIT 31.2

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, 2008, 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, 2009

EX-32.1 7 a51362exv32w1.htm EX-32.1

EXHIBIT 32.1

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, 2008 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, 2009

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.

EX-32.2 8 a51362exv32w2.htm EX-32.2

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, 2008 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, 2009

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.

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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 ☑	Non-accelerated filer ☐ (Do not check if a smaller reporting company)	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.

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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

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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

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(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.

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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

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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.

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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

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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.

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- *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.

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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.

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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.

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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.

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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

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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***

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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.

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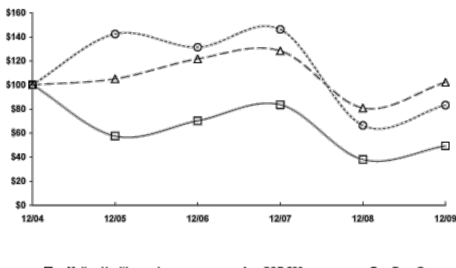
STOCK PERFORMANCE GRAPH

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.

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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

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	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.

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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

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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

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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.

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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.

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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

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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.

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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 Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
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

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	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

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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.

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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.

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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 $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.

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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.

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	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.

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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.

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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.

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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;

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- 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

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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

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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.

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- 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.

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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.

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	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.

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MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

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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

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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.

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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.

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MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

Additional	Accumulated Other

	Common Stock		Paid-in	Comprehensive	Retained	Treasury	
	Outstanding	Amount	Capital	Income (Loss)	Earnings	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.

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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

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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

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	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.

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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)	

	2009	2008	2007
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.

- *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

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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.”

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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.

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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.

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.

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.

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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.

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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

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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

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.

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

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7. Receivables

Accounts receivable by health plan operating subsidiary were as follows:

	December 31, 2009	December 31, 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.

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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	December 31, 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.

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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

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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

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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.

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- 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.

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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

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	December 31, 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.

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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%.

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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, 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.

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	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

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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

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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.

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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)

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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.

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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.

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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

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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.

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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.

EX-10.22 2 a55407exv10w22.htm EX-10.22

Exhibit 10.22

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: ______________________________

BANK OF AMERICA, N.A., as Administrative Agent

By: ______________________________

Name: ______________________________

Title: ______________________________

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: ______________________________

JEFFERIES FINANCE LLC, as Lender

By: ______________________

Name: ______________________

Title: ______________________

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

2. 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:

EX-10.24 3 a55407exv10w24.htm EX-10.24

Exhibit 10.24

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.

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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").

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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

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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.

e. **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.

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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.

2.15 **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.

4.4 **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.

5.8 **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.

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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)

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) 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
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.
NPI (or UPIN if NPI not yet designated) NPI:
UPIN:
DEA No.

Street
City
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.

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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.

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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,	$1,200 Per Diem

	152, 157, 159, 160, 164, 169,	
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 inability to maintain Health Plan's access standards. (Rule 1300.67(f))

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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 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))
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

The 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

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

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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**

http://sec.gov/Archives/edgar/data/1179929/000095012310025132/a55407exv10w24.htm[1/6/2012 11:13:06 AM]

Treasurer	**G. William Hammer**
Secretary	**Michael J. Tichon**

ATTACHMENT J

CERTIFICATE OF OWNERSHIP

I, Mr. 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

EX-10.25 4 a55407exv10w25.htm EX-10.25

Exhibit 10.25

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.

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.

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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 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

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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.

2.8 **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. 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:

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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

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.

<u>All capitated managed care activities are administered by:</u>
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)

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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.

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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:

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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 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 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))

Initials of authorized
representative of Provider:

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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:

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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:

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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(e)(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
representative of Provider:

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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)).

Initials of authorized
representative of Provider:

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. <u>DEFINITIONS</u>

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.

(c) 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.

Initials of authorized
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.

Initials of authorized
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).

Initials of authorized
representative of Provider:

(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 <u>Annual Financial Survey</u>. 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:

Initials of authorized
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.

Initials of authorized
representative of Provider:

(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.

Initials of authorized
representative of Provider:

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;

Initials of authorized
representative of Provider:

(i) An approximation of the number of enrollees served by Provider through Risk Arrangements, pursuant to a list of ranges developed by the DMHC;

(j) The name of any Management Services Organization ("MSO") that Provider contracts with for administrative services;

(k) 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.

Initials of authorized
representative of Provider:

(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;

Initials of authorized
representative of Provider:

EX-12.1 5 a55407exv12w1.htm EX-12.1

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).

EX-21.1 6 a55407exv21w1.htm EX-21.1

Exhibit 21.1

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

EX-23.1 7 a55407exv23w1.htm EX-23.1

EXHIBIT 23.1

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

EX-31.1 8 a55407exv31w1.htm EX-31.1

EXHIBIT 31.1

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

EX-31.2 9 a55407exv31w2.htm EX-31.2

EXHIBIT 31.2

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

EX-32.1 10 a55407exv32w1.htm EX-32.1

EXHIBIT 32.1

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.

EX-32.2 11 a55407exv32w2.htm EX-32.2

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.

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 ☐ (Do not check if a smaller reporting company)	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.

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Form 10-K

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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

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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

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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.

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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

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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.

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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

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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,

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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.

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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

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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

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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.

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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.

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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.

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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

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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.

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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***

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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)

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(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.

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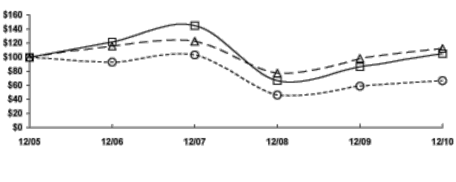
STOCK PERFORMANCE GRAPH

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.

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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

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	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.

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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.

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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

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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,

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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.

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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.

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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	Premium Revenue		Medical Care Costs		Medical	Premium Tax
	Months(1)	Total	PMPM	Total	PMPM	Care Ratio	Expense
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	Premium Revenue		Medical Care Costs		Medical	Premium Tax
	Months(1)	Total	PMPM	Total	PMPM	Care Ratio	Expense
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

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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

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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.

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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

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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.

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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 Total	Premium Revenue PMPM	Medical Care Costs Total	Medical Care Costs PMPM	Medical Care Ratio	Premium Tax Expense
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 Total	Premium Revenue PMPM	Medical Care Costs Total	Medical Care Costs PMPM	Medical Care Ratio	Premium Tax Expense
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."

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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.

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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

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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.

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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.

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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

	Total				
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.

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MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

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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

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MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2010	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.

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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.

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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.

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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

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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.

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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.

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- *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

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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 (In thousands)	Weighted Average Useful Life (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.

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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

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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)

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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.

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	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

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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	December 31, 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

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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

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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	December 31, 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.

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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

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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

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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.

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	December 31, 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

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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.

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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

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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

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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

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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.

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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	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

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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

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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

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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.

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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.

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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.

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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.

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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.

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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

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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.

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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.

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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.

EX-10.27 2 a58840exv10w27.htm EX-10.27

Exhibit 10.27

200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA

PURCHASE AGREEMENT

BETWEEN

200 OCEANGATE, LLC, A DELAWARE LIMITED LIABILITY COMPANY

AND

MOLINA CENTER LLC, A DELAWARE LIMITED LIABILITY COMPANY

NOVEMBER 30, 2010

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LIST OF EXHIBITS

Exhibit A	Description of the Land
Exhibit B	Documents Delivered to Buyer
Exhibit C	Rent Roll
Exhibit D	Form of Tenant Estoppel Certificate
Exhibit E	Service Contracts
Exhibit F	Grant Deed
Exhibit G	Bill of Sale and General Assignment
Exhibit H	FIRPTA Affidavit
Exhibit I	Form of Tenant Notice Letter
Exhibit J	Form of Owner's Affidavit
Exhibit K	Buyer's Insurance
Exhibit L	Seller's Insurance

PURCHASE AGREEMENT

200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA

THIS AGREEMENT is entered into as of the 30th day of November, 2010 ("**Contract Date**"), by and between 200 OCEANGATE, LLC, a Delaware limited liability company ("**Seller**"), and MOLINA CENTER LLC, a Delaware limited liability company ("**Buyer**").

RECITALS

Seller owns and is offering for sale the land and improvements commonly known as 200 & 300 Oceangate, Long Beach, California, and more completely described below. Buyer has offered to buy the property, and the parties are entering into this Agreement to set forth the terms and conditions of the sale to Buyer.

NOW, THEREFORE, in consideration of the foregoing and the agreements set forth below, the parties hereto agree as follows:

1. Agreement of Sale.

1.1 Seller hereby agrees to sell to Buyer and Buyer hereby agrees to purchase from Seller that certain real property (the "**Land**") with street address of 200 & 300 Oceangate, Long Beach, California, and more particularly described in attached Exhibit A, together with Seller's right, title and interest in the following, which together with the Land, shall be termed the "**Property**" herein:

(a) the approximately 461,263 square foot office project located at 200 & 300 Oceangate, Long Beach, California and all fixtures and other improvements located upon the Land (collectively, the "**Improvements**");

(b) all easements, rights of way, privileges, licenses, appurtenances and other rights and benefits of Seller belonging to or in any way related to the Land, and the Improvements, including water rights, mineral rights, air rights and development rights, if any (together with the Land and Improvements, the "**Real Property**");

(c) all fixtures, furnishings, equipment and other tangible personal property owned by Seller that are used for the operation of the Property and that are located on the Property or that are used exclusively for the operation of the Property (the "**Personal Property**");

(d) the Leases and Service Contracts (as such terms are hereinafter defined) and all security deposits held by Seller with respect to the Leases;

(e) to the extent assignable, all certificate(s) of occupancy, building or equipment permits, consents, authorizations, variances, waivers, licenses, permits, certificates

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and approvals from any governmental or quasi-governmental authority necessary for the use of the Land or the Improvements (collectively, the "**Approvals**");

(f) all transferable or assignable warranties (the "**Warranties**") relating to the ownership, development, use and operation of the Land and Improvements;

(g) to the extent assignable, all of Seller's interest in all structural, soil, seismic, geologic, engineering and other reports and studies, all operating manuals for all systems, equipment and operating components of the Property, all marketing materials that are distributed or shown to potential tenants in the marketing of the Property for lease, photos and depictions, all architectural drawings, plans and specifications relating to all or any portion of the Real Property, and all intellectual property rights to the Property, including, without limitation, trade names, trademarks, service marks, logos or other source and business identifiers, trademark registrations and applications for registration used at or relating to the Real Property and any written agreement granting to Seller any right to use any trademark or trademark registration at or in connection with the Real Property (the "**Intangible Property**").

2. Purchase Price. The purchase price for the Property is Eighty-Three Million Dollars ($83,000,000.00) ("**Purchase Price**") and shall be paid in cash by Buyer at the Closing (as defined in Section 10.1 below).

3. Non-Refundable Payment and Deposit

3.1 Non-Refundable Payment. On the Contract Date, as consideration for Seller's agreement to enter into this Agreement and grant Buyer the right to conduct due diligence and terminate this Agreement on and subject to the terms of Section 7, and as a condition precedent to the effectiveness of this Agreement, Buyer shall deliver directly to Seller, by personal check, cash or wire transfer funds in the amount of One Hundred and No/100ths Dollars ($100) (the "**Non-Refundable Payment**"). The Non-Refundable Payment shall be fully earned and retained by Seller immediately upon receipt and, notwithstanding any provisions of this Agreement to the contrary, the Non-Refundable Payment shall not be returned to Buyer in any circumstance.

3.2 Deposit; Liquidated Damages.

(a) Initial Deposit. Within one (1) business day after the Contract Date, Buyer shall deposit in an escrow (the "**Escrow**") established for the within contemplated transaction with First American Title Insurance Company, National Commercial Services, 1850 Mt. Diablo Blvd., Suite 300, Walnut Creek, California, 94596, Attention: Kitty Schlesinger, Order No. NCS-453433-CC (the "**Title Company**"), the sum of Five Hundred Thousand Dollars ($500,000) (the "**Initial Deposit**"), with instructions to the Title Company to hold the Initial Deposit in the Escrow in an interest-bearing account, with interest accruing for the benefit of Buyer. In the event the sale of the Property is consummated, the Initial Deposit and all interest earned thereon shall be applied towards the Purchase Price. If Buyer elects to terminate this Agreement pursuant to its terms or fails to notify Seller in writing that the Property is acceptable, as provided in Section 7, prior to the end of the Due Diligence Period (as defined in Section 7), the Initial Deposit and all interest thereon shall be returned to Buyer, and the parties shall be

released from all further obligations and liability under this Agreement, except for those obligations that survive the termination of this Agreement.

(b) Additional Deposit. Concurrently with, and subject to, the delivery of the Approval Notice to Buyer as provided in Section 7, Buyer shall deposit in the Escrow the additional sum of Two Million and No/100ths Dollars ($2,000,000) (the **"Additional Deposit"** and together with the Initial Deposit, the "**Deposit**"), with instructions to the Title Company to hold such Additional Deposit in the Escrow, in an interest bearing account, with interest accruing for the benefit of Buyer. In the event the sale of the Property to Buyer is consummated, the Deposit and all interest earned thereon shall be applied towards the Purchase Price.

(c) Non-Refundable Deposit. Upon the delivery by Buyer to Seller of the Approval Notice, the Deposit shall be non-refundable to Buyer except in the following events, upon the occurrence of which the Deposit and all interest thereon shall be returned to Buyer: (i) the Closing fails to occur due to a material default by Seller under this Agreement; (ii) the Closing fails to occur as a result of a failure of a condition to Closing in favor of Buyer, but only if such failure occurs other than as a result of a material default by Buyer under this Agreement; or (iii) the terms of this Agreement expressly provide for the return of the Deposit to Buyer. On the Closing Date, the Deposit and all interest earned thereon shall be applied to the Purchase Price.

(d) **Liquidated Damages. If this Agreement does not terminate pursuant to Section 7, but Buyer fails to consummate this transaction on the scheduled Closing Date (as defined in Section 10.1) due to default by Buyer and any such default continues for five (5) business days after written notice from Seller to Buyer, which written notice shall detail such default, Seller shall be entitled to the Deposit, and all interest thereon, as liquidated damages. The parties have acknowledged and agreed that Seller's damages, in the event of a default by Buyer, would be extremely difficult or impracticable to determine. Therefore, by placing their initials below, the parties acknowledge that the Deposit, and all interest thereon, has been agreed upon, after negotiation, as the parties' reasonable estimate of Seller's damages. Notwithstanding the foregoing, in no event shall Seller's ability to recover from Buyer any loss, cost, damage or expense pursuant to any indemnification or other provision of this Agreement that survives the Closing be deemed limited in any respect by this provision or by Seller's receipt of the Deposit.** The parties agree that the Deposit is not intended as a forfeiture or penalty within the meaning of California Civil Code Sections 3275 or 3369 but shall be treated as liquidated damages pursuant to California Civil Code Sections 1671, 1676 and 1677.

Seller Buyer

This Section 3.2 is not intended to limit Seller's remedies under Sections 6, 18.6 or 18.7.

4. Documents to be Delivered to Buyer.

4.1 Due Diligence Deliveries. Seller has provided Buyer with, and Buyer acknowledges receipt of, copies of the materials and documents identified in Exhibit B attached hereto.

4.2 Title Report. Seller has also provided to Buyer, and Buyer acknowledges receipt of that certain preliminary title report for the Property prepared under Order No. NCS-453433-CC, together with a copy of each document referred to therein (collectively, the "**Preliminary Title Report**").

4.3 Property Documents. Buyer shall have the right, at Buyer's sole cost and expense and with at least one (1) business day prior notice, to review Seller's real property transaction files (excluding any privileged or confidential information and excluding any valuation and appraisal information), lease files, plans and specification files, and other files relating to the Property and its ownership, operation, management and maintenance during regular business hours, which files are located in the management office at the Property.

4.4 Leases. Seller shall deliver to Buyer copies of the existing leases, license agreements and rental agreements covering any portion of the Property, any guarantees thereof, and all amendments, modifications and supplements thereto as listed on Exhibit C hereto (each a "**Lease**" and collectively, the "**Leases**").

4.5 Tenant Estoppels.

(a) Seller shall deliver to Buyer an estoppel certificate (a "**Tenant Estoppel**"), in the form of attached Exhibit D or, if the applicable Lease provides for a different form of estoppel in the form specified in the applicable Lease, dated no earlier than thirty (30) days prior to Closing, from as many of the tenants of the Property (the "**Tenants**") from whom Seller is able to obtain such Tenant Estoppels through the exercise of Seller's diligent, good faith efforts. Seller shall, at least ten (10) days prior to the expiration of the Due Diligence Period and prior to delivery to the Tenants for execution, deliver completed forms of Tenant Estoppels to Buyer for Buyer's review and approval, provided that Seller shall not be obligated to deliver the form of Tenant Estoppel for any of the following Tenants (collectively, the "**Government Tenants**"): (A) the State of California acting by and through the Director of the Department of General Services; and (B) the United States of America, Department of Veterans Affairs. Buyer may disapprove a Tenant Estoppel only if (i) it is not in the form of Exhibit D or, if the applicable Lease provides for a different form or content of estoppel in the form or content specified in the applicable Lease, the form or content provided by the applicable Lease, or (ii) if the information set forth in the Tenant Estoppel is not consistent with the terms set forth in the applicable Lease. If Buyer has not responded as to such approval within three (3) business days of receipt of a Tenant Estoppel, Buyer shall be deemed to have approved the Tenant Estoppel in question for delivery to Tenant. Seller shall deliver completed Tenant Estoppels to Buyer as they are received by Seller. Notwithstanding the foregoing, Seller shall not be obligated to prepare or seek Tenant Estoppels with respect to the following Leases, as amended and assigned to date: (1) License Agreement, dated November 30, 2000, by and between Pacific Towers Associates and Captivate Network, Inc.; (2) Antenna Site License Agreement, dated as of November 30, 2006, by and between Seller and Direct America Satellite Services; (3) Telecommunications

License Agreement, dated July 13, 2005, by and between Seller and Rocket Internetworking, Inc.; (4) Telecommunications Access and License Agreement, dated December 21, 2009, by and between Seller and TCG Los Angeles, Inc.; (5) License Agreement, dated December 21, 2000, by and between XO Communications, Inc., and Pacific Towers Associates; and (6) UPS Drop Box Agreement, dated February 2, 2010, by and between United Parcel Service, Inc., and Seller.

(b) Estoppel Thresholds. Buyer shall have a right to terminate this Agreement upon written notice prior to the Closing Date and receive a refund of the Deposit and all interest thereon as its sole remedy if Seller fails to deliver to Buyer at least three (3) days prior to the Closing Date, Tenant Estoppels from (i) the State of California acting by and through the Director of the Department of General Services, which is the contracting party under five (5) separate Leases – State Lands Commission (two Leases), California Coastal Commission, and Department of Industrial Relations (two Leases), confirming that such Leases are in effect, that the Tenant has no default claims against Seller, that the term of the Lease is consistent with the term reflected in the Lease, and that the base monthly rent payable is consistent with the base monthly rent shown in the Lease, (ii) the United States of America, Department of Veterans Affairs confirming that the Lease is in full force and effect, the date to which the rent

and other charges have been paid in advance, if any; and whether any notice of default has been issued, (iii) each of (1) AECOM Technology Corp., (2) Pacific Maritime Association, (3) Long Beach Publishing Company, Inc., and Medianews Group, Inc., and (4) J. Perez Associates, Inc. (collectively, the "**Major Non-Government Tenants in Occupancy**") in the form approved or deemed approved by Buyer pursuant to Section 4.5(a) above, and (iv) an estoppel from Crowell Weedon & Co. certifying that its Lease has not been modified or amended in writing or orally or by course of conduct, and contains the entire understanding and agreement with Seller concerning the premises under the Lease. Buyer acknowledges and agrees that if the Major Non-Government Tenants in Occupancy delete or modify one or both of sections 20 and 21 of the form Tenant Estoppel attached as Exhibit D, such deletion(s) or modification(s) shall not constitute a change in the form approved or deemed approved by Buyer. As used in this Agreement, the term "**Major Non-Government Tenants**" shall mean the Major Non-Governmental Tenants in Occupancy and Crowelll Weedon & Co.

4.6 Service Contracts. Seller has delivered to Buyer, and Buyer acknowledges receipt of, copies of the service, maintenance, management and other contracts and agreements related to the operation and management of the Property, excluding the property management agreement which will not be assigned at Closing, all of which are listed on the attached Exhibit E (the "**Service Contracts**"). If Buyer delivers the Approval Notice, Buyer shall be deemed to have agreed to assume at Closing all of the Service Contracts.

4.7 Survey. Seller shall deliver a copy of Seller's existing survey to Buyer (the "**Survey**"). Buyer may, at its sole cost and expense, cause the Survey to be updated and recertified as deemed necessary and appropriate by Buyer.

5. Title.

5.1 Title Commitment. Buyer shall be responsible for obtaining, no later than the end of the Due Diligence Period, a commitment from the Title Company to issue at Closing a policy

of title insurance in a form acceptable to Buyer, which is not conditioned on the performance by any party or third party of any actions other than the express obligations of the parties under this Agreement (the "**Commitment**"). Seller will provide, at Closing, an affidavit to the Title Company in the form attached hereto as Exhibit J. Buyer shall deliver the Commitment to Seller together with a letter from Buyer to Seller stating that the exceptions to title reflected in the Commitment are approved by Buyer. If Buyer does not provide Seller with the Commitment and such letter prior to the expiration of the Due Diligence Period, the title reflected in the Preliminary Title Report (or any updated title report) shall be deemed unacceptable and disapproved, this Agreement shall terminate and the Deposit, together with all interest thereon, shall be returned to Buyer. Seller shall have no duty to cure, and Buyer shall not be entitled to any offset or credit against the Purchase Price due to, any defect in the title to the Property or any condition or aspect of the Property, to which Buyer may object, except as may be agreed by Seller in writing, in its sole and absolute discretion; provided, however, that Seller shall remove, bond over, or obtain a title endorsement for any liens ("**Seller Liens**") that affect the Property and that are not liens for taxes or assessments accruing on or after the Closing and that are not created by, or the result of actions of, Buyer, Molina or any of their respective affiliates, agents, employees or contractors. Any cure that Seller has so agreed to perform or is obligated to perform shall become a condition precedent to Closing in favor of Buyer and shall be cured by the Closing Date. For purposes of this Section 5.1, a "cure" of a title exception means the elimination of such exception from title and shall not include the bonding of, or endorsement over unless such bonding is in an amount and on terms required by the Title Company for elimination of such exception from the Title Policy (as defined in Section 5.3) as reasonably determined by Buyer. If such cure is not accomplished by the Closing Date, Buyer, as its sole and exclusive remedy, may either terminate this Agreement, in which case the Deposit shall be returned to Buyer, or waive such objection and complete the Closing subject to such exception, provided that if Seller refuses to remove a Seller Lien at Closing, Buyer shall have the right to instruct the Title Company, as escrow agent, to apply a portion of the Purchase Price sufficient to discharge such Seller Lien at Closing.

5.2 Permitted Exceptions. The following shall constitute the "**Permitted Exceptions**": (a) the Title Company's standard exceptions; (b) all exceptions that are shown on the Commitment; (c) all of the Leases; and (d) all exceptions that arise after the expiration of the Due Diligence Period and prior to the Closing that are not Seller Liens and that are approved by Buyer, in writing, in its sole and absolute discretion, or are caused by Buyer or Molina, their agents, employees, contractors or representatives or result from any new survey of the Real Property or any update of any existing survey.

5.3 Title Policy. Evidence of title shall be the issuance by the Title Company at Closing of a policy of title insurance in the form of the Commitment, subject only to the Permitted Exceptions ("**Title Policy**"). Seller shall be responsible for the cost of a CLTA standard coverage policy of title insurance in the amount of the Purchase Price; Buyer shall be responsible for the incremental cost of an ALTA extended coverage policy of title insurance, the cost of any endorsements to the Title Policy and for providing any necessary surveys (other than the Survey) to the Title Company.

5.4 No Recording. Neither this Agreement nor any memorandum of this Agreement shall be recorded by, or on behalf of, Buyer in the Official Records of the County of Los Angeles. If Buyer violates the terms of this Section 5.4 by recording or attempting to record this Agreement or a memorandum thereof, such act shall not operate to bind or cloud the title to the Property, shall constitute a material breach and default by Buyer under this Agreement, and shall entitle Seller to terminate this Agreement by written notice to Buyer, which termination notice may be recorded against the Property.

6. Access.

6.1 Provided that Buyer has complied with the insurance requirements in Section 6.3 and gives Seller at least one (1) business day's prior notice (oral or written), Seller shall allow Buyer and authorized representatives of Buyer reasonable access, at reasonable times, to the Property for the purposes of satisfying Buyer with respect to the Property. In performing its examinations and inspections of the Property, Buyer shall use reasonable efforts to minimize any interference with Seller's and the Tenants' use and occupancy of the Property. Seller shall have the right at all times to have a representative of Seller accompany any of Buyer or Buyer's employees, agents, contractors, consultants, officers, directors, representatives, managers or members (collectively, **"Buyer's Agents"**) while such persons are on the Property. Buyer may conduct interviews with the Tenants, provided Buyer has given Seller no less than two (2) business days notice prior to any such interview, and provided further that Seller shall have the right to be present at all such interviews. Buyer's breach of this Section 6.1 (and all subsections) shall constitute a material breach and default by Buyer of this Agreement. All investigations and inspections shall be performed in compliance with this Section 6 and all local, state and federal laws, rules and regulations, including, without limitation, any and all permits required thereunder, which permits shall be obtained by and at the sole cost of Buyer.

(a) Buyer shall not conduct or allow any physically intrusive or destructive testing of, on or under the Property, without Seller's prior written consent, which consent may be withheld at Seller's sole and absolute discretion; provided, however, Buyer may, subject to its damage and repair obligations in this Section 6.1 and 6.2, inspect the Property for asbestos-related materials. Buyer shall provide Seller with two (2) days written notice prior to the commencement of any physically intrusive or destructive testing, accompanied by a detailed work plan describing the nature, scope, location and purpose of the proposed work. Buyer acknowledges and agrees that Seller's review of Buyer's work plan is solely for the purpose of protecting Seller's interests, and shall not be deemed to create any liability of any kind on the part of Seller in connection with such review that, for example, the work plan is adequate or appropriate for any purpose or complies with applicable legal requirements. All work and investigations shall be performed in compliance with all local, state and federal laws, rules and regulations, including, without limitation, any and all permits required thereunder, all of which shall be at the sole cost and expense of Buyer.

(b) During the performance of Buyer's investigations, Buyer shall promptly remove and properly dispose of all samples, substances and materials extracted from or generated by Buyer at the Property and, upon the completion of its investigations, shall return the Property to its original condition, including the removal of all equipment and materials used or

generated during its investigations. Buyer shall name itself as the generator on any waste manifests required to dispose of said materials and shall obtain its own waste generator identification number with respect thereto. If Buyer fails to perform or cause such restoration, and such failure shall continue for two (2) days after Buyer receives written notice from Seller demanding the cure thereof, Seller may perform or cause to be performed such restoration work, and Buyer shall reimburse Seller for all the costs and expenses thereof within two (2) days after receipt of bills therefor from Seller.

6.2 Notwithstanding anything in this Agreement to the contrary, any entry upon, inspection, or investigation of the Property by Buyer or Buyer's Agents shall be performed at the sole risk and expense of Buyer, and Buyer shall be solely and absolutely responsible for the acts or omissions of any of Buyer's Agents. Furthermore, Buyer shall protect, indemnify, defend and hold Seller, and its successors, assigns, and affiliates harmless from and against any and all losses, damages (whether general, punitive or otherwise), liabilities, claims, causes of action, judgments, costs and legal or other expenses (including, but not limited to, attorneys' fees and costs) (collectively, "**Access Claims**") suffered or incurred by any or all of such indemnified parties to the extent resulting from any act or omission of Buyer or Buyer's Agents in connection with: (i) Buyer's inspection or investigations of the Property; (ii) Buyer's entry upon the Property; (iii) any activities, studies or investigations conducted at, to, or on the Property by Buyer or Buyer's Agents; or (iv) the presence by Buyer or Buyer's Agents at or on the Property. If at any time prior to Closing, Buyer or Buyer's Agents cause any damage to the Property, Buyer shall, at its sole expense, immediately restore the Property to the same condition as existed immediately prior to the occurrence of such damage as determined by Seller in Seller's reasonable discretion. Buyer's obligations under this Section 6.2 shall survive the termination of this Agreement or the Closing, as the case may be, notwithstanding any other provisions herein to the contrary, and shall not be limited by the terms of Section 3. Buyer shall, at all times, keep the Property free and clear of any mechanics', materialmen's or design professional's claims or liens arising out of or relating to its investigations of the Property. The foregoing provisions of this Section 6.2 shall not apply to, and Buyer shall have no liability for, or obligation to protect, indemnify, defend or hold Seller (or any other person or party) harmless from or against any of the following: (i) the discovery by Buyer or any of Buyer's Agents of any Hazardous Material on,

under or affecting the Property, except to the extent that Buyer and Buyer's Agents exacerbate such condition in any material respect; (ii) the discovery by Buyer or Buyer's Agents of adverse physical, environmental, economic, neighborhood or other conditions at, on, in, under, around or affecting the Property, except to the extent that Buyer and Buyer's Agents exacerbate such condition in any material respect; or (iii) events, occurrences or conditions resulting from the acts or omissions of Seller or Seller's agents or representatives, except to the extent Buyer and Buyer's Agents exacerbate such events, occurrences or condition in any material respect. Notwithstanding anything in this Section 6.2 to the contrary, Buyer shall have no duty or obligation to identify or repair any condition in, on or affecting the Property that Buyer or Buyer's Agents discover or of which they are aware that may or could be unsafe or dangerous unless and to the extent such unsafe or dangerous condition was caused by the Buyer or Buyer's Agents.

6.3 Buyer shall maintain in full force and effect during the term of this Agreement, the public liability insurance covering Buyer and its activities at the Property on the terms and

with the coverages described in the ACORD Certificate of Liability Insurance attached hereto as Exhibit K, naming Seller as an additional insured under all such liability insurance.

7. Due Diligence Period. Buyer shall have until December 30, 2010, ("Due Diligence Period") to inspect and investigate the Property, including roof, plumbing, soils, electrical, sprinkler, water, sewer, mechanical, engineering, heating, ventilation and air conditioning and life safety systems, structural integrity of the Improvements, measurement of the square footage of the Land and Improvements, legal status and requirements pertaining to the Property (including applicable building codes, zoning, environmental, public health and fire safety laws), hazardous substance inspections including preparation of an environmental assessment, suitability of the Property for Buyer's purposes and all other matters of significance to Buyer. Buyer agrees to keep the results of such testing and inspections confidential, except to the extent that disclosure is required by law (in which case Buyer will notify Seller in writing prior to making any such disclosure). Buyer shall order and pay for all costs and expenses with respect to such inspections and investigations. If, in Buyer's sole and absolute discretion, Buyer desires to proceed with its acquisition of the Property, Buyer shall deliver written notice to Seller (the "**Approval Notice**"), prior to the expiration of the Due Diligence Period, stating that it approves the Property, in which case the parties shall proceed to complete the Closing (subject to the terms and conditions of this Agreement). If Buyer fails to deliver the Approval Notice prior to the expiration of the Due Diligence Period or if such Approval Notice seeks to modify any of the terms or provisions of this Agreement, Buyer will be deemed to have disapproved the Property and to have exercised its right to terminate this Agreement pursuant to this Section 7, in which case this Agreement shall automatically terminate as of the expiration of the Due Diligence Period and the Initial Deposit, together with all interest earned thereon, shall be returned to Buyer. Further, if Buyer fails to deposit the full Additional Deposit in Escrow prior to the expiration of the Due Diligence Period, regardless of whether Buyer has delivered the Approval Notice, Buyer will be deemed to have disapproved the Property and to have exercised its right to terminate this Agreement pursuant to this Section 7, in which case this Agreement shall automatically terminate as of the expiration of the Due Diligence Period and the Initial Deposit, together with all interest earned thereon, shall be returned to Buyer. Notwithstanding anything in this Agreement to the contrary, Buyer may elect, at any time prior to the expiration of the Due Diligence Period, for any reason or no reason, to terminate this Agreement, upon which termination the Deposit and all interest earned thereon shall be refunded to Buyer and the parties shall have no further obligation to each other excepts for those obligations which expressly survive such termination.

8. Acceptance of Property "As Is". ACKNOWLEDGING BUYER'S OPPORTUNITY TO INSPECT AND INVESTIGATE THE PROPERTY AS PROVIDED IN THIS AGREEMENT, BUYER AGREES TO TAKE THE PROPERTY "AS IS" WITH ALL FAULTS AND CONDITIONS THEREON, SUBJECT ONLY TO THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER SET FORTH IN THIS AGREEMENT OR THE OTHER AGREEMENTS ENTERED INTO BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE. ANY INFORMATION, REPORTS, STATEMENTS, DOCUMENTS OR RECORDS ("**DISCLOSURES**") PROVIDED OR MADE TO BUYER OR ITS CONSTITUENTS BY SELLER, ITS AGENTS, REPRESENTATIVES OR EMPLOYEES CONCERNING THE PROPERTY SHALL NOT CONSTITUTE REPRESENTATIONS OR

WARRANTIES. BUYER SHALL NOT RELY ON SUCH DISCLOSURES BUT, RATHER, BUYER SHALL RELY SOLELY ON ITS OWN INSPECTION OF THE PROPERTY AND THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT. ACCORDINGLY, BUYER'S DELIVERY OF THE APPROVAL NOTICE PURSUANT TO THE PROVISIONS OF SECTION 7 (DUE DILIGENCE PERIOD) ABOVE, SHALL CONSTITUTE BUYER'S ACKNOWLEDGMENT AND AGREEMENT TO THE FOLLOWING: (i) BUYER HAS REVIEWED, EVALUATED AND VERIFIED THE DISCLOSURES AND DOCUMENTS AND HAS CONDUCTED ALL INSPECTIONS, INVESTIGATIONS, TESTS, ANALYSES, APPRAISALS AND EVALUATIONS OF THE PROPERTY

(INCLUDING FOR TOXIC OR HAZARDOUS MATERIALS, SUBSTANCES OR WASTES (DEFINED AND REGULATED AS SUCH PURSUANT TO SECTIONS 25316 AND 25501 OF THE CALIFORNIA HEALTH & SAFETY CODE, THE RESOURCE CONSERVATION AND RECOVERY ACT, THE COMPREHENSIVE ENVIRONMENTAL RESPONSE COMPENSATION AND LIABILITY ACT OF 1980, AS AMENDED (**"CERCLA"**) OR ANY SIMILAR LAWS AND ALL REGULATIONS PROMULGATED THEREUNDER)) AS BUYER CONSIDERS NECESSARY OR APPROPRIATE TO SATISFY ITSELF FULLY WITH RESPECT TO THE CONDITION AND ACCEPTABILITY OF THE PROPERTY (ALL OF SUCH INSPECTIONS, INVESTIGATIONS AND REPORTS BEING HEREIN COLLECTIVELY CALLED THE "**INVESTIGATIONS**"); (ii) SELLER HAS PERMITTED BUYER ACCESS TO THE PROPERTY AND HAS DELIVERED TO, OR MADE AVAILABLE TO, BUYER ALL OF THE MATERIALS REFERENCED IN SECTION 4 (INCLUDING THE DOCUMENTS AND MATERIALS IDENTIFIED ON EXHIBIT B) (COLLECTIVELY, THE "**DOCUMENTS**"); AND (iii) BUYER HAS COMPLETED ITS DUE DILIGENCE WITH RESPECT TO THE PROPERTY AND THE DOCUMENTS TO ITS SATISFACTION, IS THOROUGHLY FAMILIAR WITH THE PHYSICAL CONDITION OF THE PROPERTY, AND SUBJECT ONLY TO THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT OR THE OTHER AGREEMENTS ENTERED INTO BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE, IS ACQUIRING THE PROPERTY BASED EXCLUSIVELY UPON ITS OWN INVESTIGATIONS AND INSPECTIONS OF THE PROPERTY AND THE DOCUMENTS.

FURTHER, BUYER'S DELIVERY OF THE APPROVAL NOTICE PURSUANT TO THE PROVISIONS OF SECTION 7 (DUE DILIGENCE PERIOD) ABOVE, SHALL CONSTITUTE BUYER'S ACKNOWLEDGMENT AND AGREEMENT TO THE PROVISIONS OF THIS SECTION 8 AND THAT, REGARDLESS OF THE CONTENT OF ANY OF THE DOCUMENTS OR ANY STATEMENTS THAT SELLER, ITS AGENTS, EMPLOYEES, OFFICERS, CONTRACTORS, PARTNERS OR MEMBERS MAY HAVE MADE TO BUYER, ITS AGENTS, EMPLOYEES, OFFICERS, CONTRACTORS, PARTNERS OR MEMBERS PRIOR TO OR DURING THE DUE DILIGENCE PERIOD, OTHER THAN THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT AND THE OTHER AGREEMENTS ENTERED INTO BY AND BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE, SELLER HAS NOT MADE, DOES NOT MAKE AND SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS, WARRANTIES, PROMISES, COVENANTS, AGREEMENTS OR GUARANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, ORAL OR WRITTEN, PAST, PRESENT OR FUTURE, OF, AS TO,

CONCERNING OR WITH RESPECT TO: (1) THE NATURE, QUALITY OR CONDITION OF THE PROPERTY, INCLUDING, WITHOUT LIMITATION, THE WATER, SOIL AND GEOLOGY; (2) THE INCOME TO BE DERIVED FROM THE PROPERTY; (3) THE SUITABILITY OF THE PROPERTY FOR ANY AND ALL ACTIVITIES AND USES THAT BUYER MAY CONDUCT THEREON; (4) THE COMPLIANCE OF OR BY THE PROPERTY OR ITS OPERATION WITH ANY LAWS, RULES, ORDINANCES OR REGULATIONS OF ANY APPLICABLE GOVERNMENTAL AUTHORITY OR BODY; (5) THE HABITABILITY, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OF THE PROPERTY; OR (6) ANY OTHER MATTER WITH RESPECT TO THE PROPERTY. BUYER SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS REGARDING TERMITES OR WASTES, AS DEFINED BY THE U.S. ENVIRONMENTAL PROTECTION AGENCY REGULATIONS AT 40 C.F.R., OR ANY HAZARDOUS SUBSTANCE, AS DEFINED BY CERCLA AND REGULATIONS PROMULGATED THEREUNDER.

EXCEPT WITH RESPECT TO HAZARDOUS MATERIALS THAT WERE DISCHARGED, RELEASED OR DISPOSED BY SELLER OR ITS MEMBERS, MANAGERS, PARTNERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES AND REPRESENTATIVES IN VIOLATION OF APPLICABLE ENVIRONMENTAL LAWS AS OF THE DATE OF SUCH DISCHARGE, DISPOSAL OR RELEASE, BUYER, ITS SUCCESSORS AND ASSIGNS, HEREBY WAIVE, RELEASE AND AGREE NOT TO MAKE ANY CLAIM OR BRING ANY COST RECOVERY ACTION OR CLAIM FOR CONTRIBUTION OR OTHER ACTION OR CLAIM AGAINST SELLER (COLLECTIVELY OR INDIVIDUALLY) OR ITS RELATED ENTITIES, AND ITS AND THEIR MEMBERS, MANAGERS, PARTNERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, HEIRS AND ASSIGNS (COLLECTIVELY, "**SELLER AND ITS AFFILIATES**") BASED ON, (x) ANY FEDERAL, STATE, OR LOCAL ENVIRONMENTAL OR HEALTH AND SAFETY LAW OR REGULATION, INCLUDING CERCLA OR ANY STATE EQUIVALENT, OR ANY SIMILAR LAW NOW EXISTING OR HEREAFTER ENACTED; (y) ANY DISCHARGE, DISPOSAL, RELEASE, OR ESCAPE OF ANY CHEMICAL, OR ANY MATERIAL WHATSOEVER, ON, AT, TO, OR FROM THE PROPERTY; OR (z) ANY CONDITIONS WHATSOEVER ON, IN, UNDER, OR IN THE VICINITY OF THE PROPERTY. EXCEPT WITH RESPECT TO ANY CLAIMS ARISING OUT OF ANY BREACH OF COVENANTS, REPRESENTATIONS OR WARRANTIES EXPRESSLY SET FORTH IN THIS AGREEMENT OR THE DOCUMENTS EXECUTED IN CONNECTION WITH THIS AGREEMENT, BUYER, ON BEHALF OF ITSELF AND ITS PARTNERS, MEMBERS, MANAGERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, HEIRS AND ASSIGNS HEREBY RELEASES, SELLER AND ITS AFFILIATES, FROM ANY AND ALL CLAIMS OF ANY KIND WHATSOEVER, KNOWN OR UNKNOWN, WITH RESPECT TO ANY ASPECT OF THE PROPERTY, INCLUDING THE FOREGOING MATTERS, AND SPECIFICALLY WAIVES WITH RESPECT TO ALL SUCH MATTERS THE PROVISIONS OF CALIFORNIA CIVIL CODE SECTION 1542, AND ANY COMPARABLE LAW APPLICABLE IN THE STATE WHERE THE PROPERTY IS LOCATED, REGARDING THE MATTERS COVERED

BY A GENERAL RELEASE, WHICH PROVIDES AS FOLLOWS:

"A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

BUYER AND SELLER REPRESENT AND ACKNOWLEDGE THAT THIS SECTION 8 WAS EXPLICITLY NEGOTIATED AND BARGAINED FOR AS A MATERIAL PART OF BUYER'S CONSIDERATION BEING PAID. Terms appearing in this Section 8 in all capital letters that have been defined elsewhere in this Agreement shall have the meanings set forth in such definitions.

9. Conditions to Closing.

9.1 Buyer's Conditions to Closing. Buyer's obligation to purchase the Property is conditioned upon the satisfaction of each of the following conditions each of which is for the exclusive benefit of Buyer. Buyer may, at any time or times before the Closing, waive one or more of the following conditions, but only in writing and any such waiver will not affect its rights and remedies with respect to the remaining conditions:

(a) Buyer shall have received the requisite Tenant Estoppels as and when required under Section 4.5(b). If Buyer has not received the requisite Tenant Estoppels at least six (6) business days prior to the Closing Date, Buyer shall have the one-time right to extend the Closing Date by an additional two (2) business days by delivering written notice of Buyer's exercise of such right to Seller no later than the date five (5) business days prior to the Closing Date. If Buyer timely exercises such right, the Closing Date shall be extended by two (2) business days.

(b) The Rent Roll and Delinquency Report (as defined in Sections 11.1(h) and 11.1(i) below) shall have been updated to a date not earlier than three (3) business days prior to the Closing Date, and such updated Rent Roll and Delinquency Report shall not identify any material adverse change (with a change being deemed to be material and adverse only if the change would expose Buyer to damages or a loss of income in excess of Thirty-Five Thousand and No/100ths Dollars ($35,000)) in the aggregate as to all Leases with the Government Tenants and Major Non-Governmental Tenants as compared to the status of such Leases as shown on the Rent Roll and Delinquency Report delivered to Buyer two (2) business days prior to the expiration of the Due Diligence Period pursuant to Sections 11.1(h) and 11.1(i) below;

(c) No Government Tenant or Major Non-Government Tenant shall have notified Seller or Buyer of any material adverse change in its Tenant Estoppel (with a change being deemed to be material and adverse only if the change would expose Buyer to damages or a loss of income in excess of Thirty-Five Thousand and No/100ths Dollars ($35,000) in the aggregate as to all such Tenant Estoppels); no proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against any of the Major Non-Government Tenants that have not been terminated; no general assignment for the benefit of creditors has

been made by any of the Major Non-Government Tenants; and no trustee or receiver of any of the Major Non-Government Tenants' property has been appointed;

(d) Seller's performance of all its obligations hereunder;

(e) The truth, completeness and accuracy, in all material respects, of each representation and warranty made by Seller as of the Contract Date and the Closing; and

(f) The issuance at Closing of the Title Policy.

(g) Delivery of the fully executed amendments (the "**State Lease Amendments**") to each of the Leases with the State of California, acting by and through the Director of the Department of General Services, extending the term of such Leases, with such extension term commencing on the date the amendments are executed, for an additional eight (8) years (Buyer acknowledging that after the 53rd month of such extension term the State will have an ongoing termination right exercisable with thirty (30) days notice).

9.2 Seller's Conditions. Seller's obligation to sell the Property is conditioned upon the satisfaction of each of the following conditions, each of which is for the exclusive benefit of Seller. Seller may, at any time before the Closing, waive one or more of the following conditions, but only in writing and any such waiver will not affect its rights and remedies with respect to the remaining conditions:

(a) The performance by Buyer of all its obligations hereunder; and

(b) The truth, completeness and accuracy, in all material respects, of each representation and warranty made by Buyer as of the Contract Date

and the Closing.

9.3 Seller Default. If, at the Closing, (i) Seller is in default of any of its obligations hereunder, or (ii) any of Seller's representations or warranties set forth in Section 11.1 are untrue, inaccurate or incorrect when given, in any material respect, or (iii) the Closing otherwise fails to occur by reason of Seller's failure or refusal to perform its obligations hereunder in a prompt and timely manner, and any such circumstance described in any of clauses (i), (ii) or (iii) continues for five (5) business days after written notice from Buyer to Seller, which written notice shall detail such default, untruth or failure, as applicable, then Buyer shall have the right, to elect, as its sole and exclusive remedy, to (a) terminate this Agreement by written notice to Seller, promptly after which (A) the Deposit and all interest earned thereon shall be returned to Buyer, and (B) Seller shall pay to Buyer any title, escrow, legal and inspection fees incurred by Buyer and any other expenses incurred by Buyer in connection with its review of the Property, and the negotiation, documentation and performance of this Agreement (including, without limitation, the fees and expenses of environmental and engineering consultants, legal and accounting fees and expenses, and other out-of-pocket third party charges related to the transactions contemplated by this Agreement and their consummation), subject to a cap of $125,000 (collectively, "**Buyer's Costs**"), in which case, the parties shall have no further rights or obligations hereunder except for obligations which expressly survive the termination of this Agreement, or (b) waive the condition and proceed to Closing, or (c) seek specific performance

of this Agreement by Seller. As a condition precedent to Buyer exercising any right it may have to bring an action for specific performance hereunder, Buyer must commence such an action within ninety (90) days after the occurrence of Seller's default. Buyer agrees that its failure to timely commence such an action for specific performance within such ninety (90) day period shall be deemed a waiver by it of its right to commence an action for specific performance as well as a waiver by it of any right it may have to file or record a notice of *lis pendens* or notice of pendency of action or similar notice against any portion of the Property. Notwithstanding the foregoing, if by Seller's affirmative acts the remedy of specific performance has been rendered unavailable to Buyer, Buyer shall have and may assert against Seller as a result of Seller's default under this Agreement, any and all rights available at law and in equity, without imposition of the limitations in this Agreement on Buyer's rights, remedies or damages.

10. Closing.

10.1 Closing Date. The consummation of the purchase and sale of the Property (the "**Closing**") shall be held at the offices of the Title Company (or at such other location as the parties may agree) on January 19, 2011 (the "**Closing Date**"). Buyer acknowledges that Seller is required to defease the existing securitized loan that is currently secured by a deed of trust on the Property (the "**Existing Loan**") in order to deliver title to the Property free and clear of the lien of such deed of trust (the "**Existing Deed of Trust**"). In connection with such defeasance, Buyer agrees to cooperate in good faith with all usual and customary requirements imposed by the master loan servicer, bond trustee and ratings agency for such defeasance transaction so long as Buyer is not required to incur any additional liability or expense in so doing. The parties acknowledge that, in light of the defeasance, the Grant Deed (as defined below) will be recorded, and the Seller's proceeds will be disbursed, one day after the Closing Date. Seller may extend the Closing Date by up to three (3) business days to accommodate such defeasance. Seller shall be solely responsible for any and all costs, fees and expenses in connection with such defeasance, and any yield maintenance or other premiums or payments required in connection with such defeasance. The defeasance of the Existing Loan shall not be a condition to Seller's obligation to close the Escrow.

10.2 Seller's Deposits Into Escrow. Seller shall deposit the following documents and items into escrow at least one (1) business day prior to the Closing Date:

(a) a duly executed and acknowledged grant deed conveying the Property and Improvements to Buyer in the form of the attached Exhibit F, together with a separate transfer tax affidavit (the "**Grant Deed**");

(b) a duly executed bill of sale and general assignment, in the form of the attached Exhibit G (the "**Assignment**"), transferring the Personal Property, Leases, Service Contracts, Approvals, Warranties and Intangible Property to Buyer;

(c) an affidavit in the form of the attached Exhibit H stating that Seller is not a "foreign person" under IRC Section 1445(f)(3);

(d) tenant notice letters for all tenants at the Property informing them of the sale of the Property and assignment of the Leases to Buyer, in the form of attached Exhibit I;

(e) a duly executed affidavit in the form required by the California Franchise Tax Board certifying that no withholding of any amount of the Purchase Price is required in connection with the Closing;

(f) Seller's share of the closing costs as described in Section 10.5 below or instructions to Title Company to deduct same from the Purchase Price;

(g) an owner's title affidavit in the form of the attached Exhibit J;

(h) the Rent Roll, updated to a date no earlier than three (3) business days prior to the Closing Date, certified by Seller as true and correct;

(i) A certification that all of the representations and warranties set forth in Section 11.1 remain true, complete and accurate, except to the extent of any exceptions to such representations and warranties identified in such certification; and

(j) such other documents as may reasonably be required to complete the Closing.

10.3 Seller's Deliveries to Buyer Outside of Escrow. Seller shall deliver to Buyer at the Property (except as otherwise provided below) on or before the Closing Date, all of the following:

(a) originals, to the extent in Seller's possession or control, or copies of the Leases and the Service Contracts, which copies are certified by Seller as true and correct;

(b) the original Estoppel Certificates, duly executed by the Tenants, which shall be delivered to Buyer's counsel, James Moore of Boutin Jones Inc.;

(c) all keys and security codes to the Property;

(d) electronic or hard copies of all Documents; and

(e) originals or copies of all Lease files and Property files, including all records, instruments and correspondence related to maintenance and repair, the Tenants, the Leases, construction and alteration of the Improvements (base building and tenant improvements), and operation of the Property, to the extent such files are located at the Real Property.

10.4 Buyer's Deposits into Escrow. Buyer shall deposit the following into escrow at least one (1) business day prior to the Closing Date:

(a) the balance of the Purchase Price in immediately available funds;

(b) Buyer's share of the closing costs as described in Section 10.5. below;

(c) two original duly executed counterparts of the Assignment; and

(d) such other documents as may reasonably be required to complete the Closing.

10.5 Adjustment and Proration. All accounts receivable and all accounts payable shall be prorated between Buyer and Seller as of 12:01 a.m. on the Closing Date, on the basis of a 365-day year, with Seller entitled to all accounts receivable and responsible for all accounts payable with respect to the period prior to such date and time, and with Buyer entitled to all accounts receivable and responsible for all accounts payable with respect to the period from and after such date and time. Prior to Closing, Seller shall prepare for review, comment and agreement by Buyer a proration statement for the Property, and each party shall be credited or charged at the Closing, in accordance with the following:

(a) Accounts Receivable. Seller shall account to Buyer for any Rents actually collected by Seller for the month in which the Closing occurs, and Buyer shall be credited for its pro rata share applicable to the period from and after the Closing Date. For purposes of this Agreement, the term "**Rents**" means and includes Fixed Rents and Additional Rents; "**Fixed Rents**" means the periodic fixed rent payable by a Tenant under its Lease; and "**Additional Rents**" means all amounts, other than Fixed Rents, due from any Tenant under any Lease, including without limitation, percentage rents, escalation charges for real estate taxes, parking charges, marketing fund charges, reimbursement of operating expenses or common area expenses, maintenance escalation rents or charges, cost of living increases or other charges of a similar nature, if any, and any additional charges and expenses payable under any Lease.

(b) Accounts Payable. For purposes of this Agreement, the term "**Expenses**" means all operating expenses normal to the operation and maintenance of the Property, including without limitation real property taxes and assessments, current installments of any improvement bonds or assessments which are a lien on the Property or which are pending and may become a lien on the Property, water, sewer and utility charges, amounts payable under any Service Contract for any period in which the Closing occurs, permits, licenses and inspection fees. Expenses shall not include expenses which are of a capital nature.

(i) Prepaid Expenses. To the extent Expenses have been paid prior to the Closing Date for any part of the period on or after the Closing Date, Seller shall account to Buyer for such prepaid Expenses, and Seller shall be credited for the amount of such prepaid expenses applicable to the period after the Closing Date.

(ii) Unpaid Expenses. To the extent Expenses relating to the period prior to the Closing Date are unpaid as of the Closing Date but are

ascertainable, Buyer shall be credited for Seller's pro rata share of such Expenses for the period prior to the Closing Date.

(iii) Service Contracts. Payments due under any Service Contracts shall be prorated as of the Closing Date, and Buyer shall be liable for all payments accruing

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thereunder after the Closing. Seller shall be responsible for all payments under all contracts and agreements not assumed by Buyer

(c) Property Taxes. Seller shall be responsible for all real and personal property ad valorem taxes and special assessments applicable to the period prior to the Closing Date; Buyer shall be responsible for all real and personal property ad valorem taxes and special assessments applicable to the period from and after the Closing Date. With respect to any property tax appeal or reassessment filed by Seller for the current tax year or tax years (or portions thereof) prior to the Closing, Seller shall be entitled to the full amount of any refund or rebate resulting therefrom applicable to the period before the Closing Date, except to the extent such amounts are payable to, or otherwise accrue to the benefit of, the Tenants pursuant to the Leases, which amounts Seller shall promptly refund to such Tenants.

(d) Utility Charges. All utility (including electricity, gas, water, sewer and telephone) charges will be prorated to the Closing Date as Expenses. All refundable utility security deposits, if any, will be retained by Seller.

(e) Government Tenants. Buyer acknowledges that the Government Tenants pay Rents in arrears. Accordingly, Seller shall receive a credit at Closing for the Rents that accrue under the Leases of the Government Tenants in the month that Closing occurs, to the extent any rents accrue under such Leases.

(f) Molina Rents and Reimbursements. If, as of the Closing Date, Seller is due any amounts from Molina under its Lease that are ascertainable, Seller shall receive a credit at Closing for such amounts. Likewise, if any amounts are due and owing from Seller to Molina at Closing, Seller shall pay such amounts to Molina at or before Closing. Any amounts that are due and owing from Seller to Molina after Closing shall be paid by Seller to Molina as and when such amounts come due, after deduction for all amounts then due and owing to Seller by Molina or Buyer.

(g) Post-Closing. If the amount of any proration cannot be determined at the Closing, the adjustments will be made between the parties as soon after Closing as possible, as follows:

(i) Non-delinquent Rents. If after the Closing either Buyer or Seller collects any non-delinquent Rents applicable to the month in which the Closing occurred (or if Seller collects any Rents applicable to any month following the month in which the Closing occurred), such Rents shall be prorated as of the Closing Date and paid to the party entitled thereto not later than five (5) business days following receipt, except to the extent such party received a credit at Closing for such Rents.

(ii) Delinquent Rents for Month in which the Closing Occurred. If after the Closing Date either Buyer or Seller receives from any Tenant Rents that were delinquent as of the Closing Date and that relate to the rental period in which the Closing occurred, then such Rents shall be applied in the following order of priority: First, to reimburse Buyer for all out-of-pocket third-party collection costs actually incurred by Buyer in collecting

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such Rents; second, to satisfy such Tenant's Rent obligations relating to the period after the Closing Date; and third, to satisfy such delinquent Rent obligations relating to the period prior to the Closing Date. Buyer agrees to use commercially reasonable efforts to collect any such delinquent rents but Buyer has no obligation to institute any collection action or otherwise incur any material cost in connection therewith. Seller shall have no right to pursue or continue the collection of such delinquent Rents from any Tenant in occupancy as of the Closing Date, but Seller shall have the right to continue to prosecute any collection proceedings that were initiated prior to the Closing against any tenant no longer in occupancy as of the Closing Date. Notwithstanding the foregoing, if Molina owes any Rents for any period prior to Closing for which Seller did not receive a credit at Closing, Buyer shall pay all Rents received from Molina to Seller until such Rents owed to Seller have been paid in full.

(iii) Expenses. With respect to any invoice received by Buyer or Seller after the Closing Date for Expenses that relate to the period in which the Closing occurred, the party receiving such invoice shall give the other party written notice of such invoice, and the other party shall have thirty days to review and approve the accuracy of any such invoice. If the parties agree that the Invoice is accurate and should be paid, the parties shall compute each party's pro rata share, and deliver a check for that amount in favor of the vendor.

(h) Survival of Obligations. The obligations of Seller and Buyer under this Section 10.5 shall survive the Closing.

10.6 Items Not to be Prorated. There shall be no prorations or adjustments of any kind with respect to:

(a) Insurance Premiums. Insurance Premiums shall not be prorated. Seller will terminate its coverages as of the Closing Date, and Buyer shall be responsible for obtaining its own coverages as of the Closing Date.

(b) Delinquent Fixed Rents for Full Months Prior to the Month in which the Closing Occurred. Delinquent Fixed Rents with respect to Tenants under the Leases applicable to months prior to the calendar month in which the Closing occurred shall remain the property of Seller, and Buyer shall have no claim thereto whether collected by Seller or Buyer, before or after the Closing, and no responsibility of any kind with respect thereto except as specifically set forth herein. Seller shall not take or continue to take collection measures from or after the Closing. Buyer agrees to use commercially reasonable efforts to collect any delinquent Fixed Rents owed Seller, but Buyer has no obligation to institute any collection action or otherwise incur any material costs in connection therewith. Except with respect to the Rents collected from Molina, Fixed Rents collected from Tenants after the Closing Date shall be applied in the following order of priority: First, to reimburse Buyer for all out-of-pocket third-party collection costs actually incurred by Buyer in collecting such Rents; second, to satisfy such Tenant's Rent obligations relating to the period after the Closing Date; and third, to satisfy such delinquent Rent obligations relating to periods prior to the Closing Date. In the event that Buyer collects any such delinquent Fixed Rents, Buyer shall apply such Fixed Rents as contemplated above and shall promptly pay over to Seller any amounts properly owed to Seller.

(c) Additional Rents Relating to Full or Partial Months Prior to the Closing Date. If Additional Rents relating to full or partial months prior to the Closing Date are not finally adjusted between Seller and any Tenant until after the Closing Date, then any refund to which any Tenant may be entitled shall be the obligation of Seller, and any additional amounts due from the Tenant for such period shall be the property of Seller. Buyer shall have no obligation with respect to any such refund due to any Tenant and no claim to any such amounts due from any Tenant, except that Buyer shall promptly pay to Seller any such delinquent Additional Rent amounts as it actually collects. If Seller receives any refund of expenses paid prior to the Closing and relating to a period prior to the Closing, and such expenses were reimbursed in whole or in part by any Tenant, Seller shall refund to each Tenant its share of any such refund. Buyer agrees to use commercially reasonable efforts to collect any such Additional Rents but Buyer has no obligation to institute any collection action or otherwise incur any material cost in connection therewith.

(d) Security Deposits. Seller shall deliver to Buyer (or credit to Buyer at Closing) all prepaid rents, security deposits, letters of credit and other collateral actually held by Seller or any of its affiliates or successors in interest under any of the Leases, to the extent not applied by Seller prior to the Closing Date to the extent permitted under the Leases. From and after the Contract Date, Seller shall not apply any security deposits without the Buyer's prior written consent.

(e) Survival. The terms of Section 10.6 shall survive the Closing.

10.7 Closing Costs. The Closing costs for this transaction shall be paid as follows:

(a) Seller shall pay (i) any brokerage fees to the Selling Broker as required under Section 18.7 below; (ii) one-half of all transfer and sales taxes (including documentary transfer taxes); (iii) all costs, expenses and fees related to the defeasance of the Existing Loan; (iv) the cost of the Title Policy, up to but not to exceed an amount equal to the cost of owner's standard CLTA coverage title insurance in the amount of the Purchase Price; (v) one-half of the escrow fees; and (vi) all other costs and expenses allocated to Seller pursuant to this Agreement.

(b) Buyer shall pay (i) any brokerage fees to the Buying Broker as required under Section 18.7 below; (ii) one half of all transfer and sales taxes (including documentary transfer taxes); (iii) the increased cost of the Title Policy associated with ALTA extended coverage and endorsements requested by Buyer (except for "gap" coverage); (iv) all recording fees (other than in connection with any documents recorded in connection with the defeasance of the Existing Loan); (v) one-half of the escrow fees; and (vi) all other costs and expenses allocated to Buyer pursuant to this Agreement.

(c) All other costs shall be paid in accordance with customary practices in the County of Los Angeles.

10.8 Closing. Pursuant to Section 10.1 above, Title Company shall close the escrow for this transaction when it is in a position to issue the Title Policy and has received from Seller

and Buyer the items required of each in Sections 10.2 and 10.4 above. Title Company shall close escrow by doing the following:

(a) Recording the Grant Deed in the Official Records of the County of Los Angeles;

(b) Delivering to Buyer the Title Policy, the original documents and items listed in Section 10.2 above, and a closing statement for the escrow consistent with this Agreement and signed by Buyer and Seller (the "**Closing Statement**"), and any refund due Buyer; and

(c) Delivering to Seller the amount due Seller as shown on the Closing Statement, the original documents listed in Section 10.4 above, and a signed original of Seller's Closing Statement.

10.9 Possession. Seller shall deliver possession of the Property to Buyer on the Closing Date, subject to the rights of the Tenants under the Leases.

11. Representations and Warranties.

11.1 Representations and Warranties of Seller. Seller hereby makes the following representations and warranties to Buyer, which representations and warranties shall survive the Closing, and all of which (i) are material and are being relied upon by Buyer, and (ii) are true, complete and accurate as of the date hereof.

(a) Organization. Seller is a limited liability company, duly organized, validly existing and in good standing under the laws of the State of Delaware, and qualified to do business, and in good standing, in the State of California.

(b) Authorization. This Agreement has been duly authorized, executed, and delivered by Seller; the obligations of Seller under this Agreement are legal, valid, and binding obligations of Seller; and this Agreement does not, and at the time of Closing will not, (i) violate or conflict with the organizational documents of Seller or any member of Seller acting on Seller's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Seller, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Seller is a party or by which Seller is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Seller. All documents that are executed by Seller and that are delivered to Buyer at the Closing will be, at the time of Closing, duly authorized, executed, and delivered by Seller; the obligations of Seller under such documents will be, at the time of Closing, legal, valid, and binding obligations of Seller; and such documents will not, at the time of Closing, (i) violate or conflict with the organizational documents of Seller or any member of Seller acting on Seller's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Seller, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Seller is a party or by which Seller is bound, or

(iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Seller.

(c) Bankruptcy. No proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against Seller which have not been terminated; no general assignment for the benefit of creditors has been made by Seller; and no trustee or receiver of Seller's property has been appointed.

(d) Not a Foreign Person. Seller is not a foreign person within the meaning of section 1445(f)(3) of the Internal Revenue Code of 1986. Seller has read and understands the provisions of sections 18662 and 18668 of the California Revenue and Tax Code (the "**Act**") and has a "permanent place of business" within California within the meaning of the Act and the regulations and guidelines of the California Franchise Tax Board promulgated from time to time pursuant thereto.

(e) Litigation. Except as disclosed in writing to Buyer, no litigation or proceeding is pending or, to Seller's knowledge, threatened that affects the Property or Seller's ability to consummate the transactions contemplated by this Agreement.

(f) Violations. Except as disclosed in writing to Buyer, Seller has not received any written notice of any violation by the Property of any applicable rule, regulation, ordinance or government directive from any administrative or governmental authority that has not been cured.

(g) Leases; Landlord Defaults. There are no leases, rental agreements, license agreements or occupancy rights affecting the Property other than those listed on Exhibit C and any matters of record. Seller has not received any written notice of a default by Seller from any Tenant under any of the Leases that has not been cured, other than as set forth in the Tenant Estoppels.

(h) Rent Roll. Exhibit C contains a complete and correct list of all existing Leases, setting forth with respect to each Lease, the following minimum information (the "**Rent Roll**"): the name of the Tenant, the number of the room or suite occupied by the Tenant, the square footage of the space, the commencement and expiration dates, the amount of the monthly base rent payment, the current monthly additional rent payment for the Tenant share of Real Property expenses and taxes, the amount of any security deposit or prepaid rent, and the amount and due date of any payments due Tenants in the future as reimbursement for costs of tenant improvements. Seller shall deliver an updated Rent Roll to Buyer two (2) business days prior to the expiration of the Due Diligence Period, which shall be accurate as of the date set forth on the updated Rent Roll (which date shall not be more than three (3) business days prior to the date the updated Rent Roll is delivered to Buyer). Seller shall deliver a further updated Rent Roll to Buyer three (3) business days prior to the Closing Date, which shall be accurate as of the date set forth on the updated Rent Roll (which date shall not be more than three (3) business days prior to the date the updated Rent Roll is delivered to Buyer).

(i) Delinquency Report. With the exception of delinquencies in the payment of rents which are set forth on the Rent Roll, Seller has not delivered written notice to any Tenant of any default in the payment of rent under its Lease that has not been cured. Exhibit C contains a true and correct report (the "**Delinquency Report**") showing the name of each Tenant as to which a delinquency currently exists as to the payment of Rents and specifying the amount of each such delinquency, and the period of time during which each such delinquency has been outstanding. Seller shall deliver an updated Delinquency Report to Buyer two (2) business days prior to the expiration of the Due Diligence Period, which shall be accurate as of the date set forth on the updated Delinquency Report (which date shall not be more than three (3) business days prior to the date the updated Delinquency Report is delivered to Buyer). Seller shall deliver a further updated Delinquency Report to Buyer three (3) business days prior to the Closing Date, which shall be accurate as of the date set forth on the updated Delinquency Report (which date shall not be more than three (3) business days prior to the date the updated Delinquency Report is delivered to Buyer).

(j) Leases. The Documents contain a true, correct and complete copy of each Lease. Each such Lease constitutes the entire agreement between Seller and each other party thereto. As of the Closing Date, no rents due under, or any other interest in, any of the Leases will be assigned to any party other than Buyer, or otherwise pledged or encumbered in any way.

(k) Tenant Improvements; Lease Costs. Except as set forth in Exhibit C, all of the improvements to be constructed by Seller under each of the Leases, have been fully completed and paid for. Except as set forth in Exhibit C, Seller has paid, in full, any leasing commissions, except for future contingent obligations set forth in the Rent Roll.

(l) Service Contracts. Exhibit E contains a true and complete list of all Service Contracts. The Documents include true and complete copies of all Service Contracts. To Seller's knowledge, there have been no material defaults by any Party to a Service Contract which have not been cured. To Seller's knowledge, Seller is not in breach or default under any Service Contract which has not been cured. The Service Contracts constitute the entire agreement between Seller and the other parties to the Service Contracts.

(m) Insurance. Exhibit L correctly identifies the policies of casualty and liability insurance currently in effect with respect to the Property. All premiums for such insurance have been paid in full. Seller has not received any notice or request from any insurance company or Board of Fire Underwriters (or organization exercising functions similar thereto) canceling or threatening to cancel any of said policies or denying or disputing coverage thereunder.

(n) Commission Agreements. Except as expressly set forth in the Leases or on Exhibit C, there are no lease brokerage agreements, leasing commission agreements or other agreements providing for payments of any amounts for leasing activities or procuring tenants with respect to the Property, other than such commissions as may be due on future lease renewals, expansions or extensions.

(o) Environmental Releases. To Seller's knowledge, no Hazardous Materials have been discharged, released or disposed of by Seller or its members, managers, partners, directors, officers, shareholders, trustees, beneficiaries, agents, employees and representatives in violation of applicable Environmental Laws as of the date of such discharge, disposal or release As used herein, the term "Hazardous Materials" means without regard to amount and/or concentration any hazardous or toxic substance, material or waste wherever located expressly including but not limited to petroleum and petroleum derived compounds, which is included within the definition of any hazardous or toxic material, substance or waste in any federal, state or local statutes, laws, ordinances or regulations applicable to the Property, as well as any soils, ground or surface waters, wetlands or other environmental media which may be contaminated by such Hazardous Material, including the following: (a) those substances defined as a hazardous substance, hazardous waste, hazardous material, toxic substance, solid waste, pollutant or contaminant under any Environmental Law, as defined below; (b) those substances listed in the United States Department of Transportation Table [49 CFR § 172.101], or by the Environmental Protection Agency, or any successor agency, as hazardous substances [40 CFR Part 302]; (c) other substances, materials, and wastes that are regulated or classified as hazardous or toxic under federal, state or local laws or regulations applicable to the Property; and (d) any material, waste, or substance that is a petroleum or refined petroleum product or byproduct, asbestos, or any rock, including serpentine rock, which contains or might contain asbestos, chlorinated solvents, biologic waste, polychlorinated biphenyl, designated as a hazardous substance pursuant to 33 USCS §1321 or listed pursuant to 33 USCS §1317, a flammable explosive, or a radioactive material. As used herein, the term "Environmental Law" means all federal, state, local or municipal laws, rules, orders, regulations, statutes, ordinances, codes, decrees or requirements of any government authority applicable to the Property and regulating, relating to, or imposing liability or standards of conduct concerning any Hazardous Material, or pertaining to environmental conditions on or under the Property described in this Agreement, as now in effect, including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA) [42 USCS §§9601 et seq.]; the Resource Conservation and Recovery Act of 1976 (RCRA) [42 USCS §§6901 et seq.]; the Clean Water Act, also known as the Federal Water Pollution

Control Act (FWPCA) [33 USCS §§1251 et seq.]; the Toxic Substances Control Act (TSCA) [15 USCS §§2601 et seq.]; the Hazardous Materials Transportation Act (HMTA) [49 USCS §§1801 et seq.]; the Insecticide, Fungicide, Rodenticide Act (7 USCS §§136 et seq.]; the Superfund Amendments and Reauthorization Act [42 USCS §§6901 et seq.]; the Clean Air Act [42 USCS §§7401 et seq.]; the Safe Drinking Water Act [42 USCS §§300f et seq.]; the Solid Waste Disposal Act [42 USCS §§6901 et seq.]; the Surface Mining Control and Reclamation Act [30 USCS §§1201 et seq.]; the Emergency Planning and Community Right to Know Act [42 USCS §§11001 et seq.]; the Occupational Safety and Health Act [29 USCS §§655 and 657]; the California Underground Storage of Hazardous Materials Act [Health and Safety Code §§25280 et seq.]; the California Hazardous Materials Account Act [Health and Safety Code §§25100 et seq.]; the California Safe Drinking Water and Toxic Enforcement Act [Health and Safety Code §§24249.5 et seq.]; the Porter-Cologne Water Quality Act [Water Code §§13000 et seq.], together with any amendments of or regulations promulgated under the statutes cited above, and any other federal, state or local law, statute, ordinance or regulation applicable to the Property now in effect that pertains to the regulation or protection of the environment, including ambient air, soil, soil vapor, groundwater, surface water, or land use.

For purposes of the representations and warranties given by Seller in this Agreement, the phrase "to Seller's knowledge" or other terms regarding the knowledge of Seller, shall mean the actual, current knowledge of Kennard P. Perry and Cory Kristoff, excluding constructive or imputed knowledge or duty of inquiry, existing as of the Contract Date and the Closing. In no event shall there be any personal liability on the part of any of the foregoing individuals on account of any breach of any representation or warranty of Seller herein.

11.2 Material Changes; Survival. Two (2) business days prior to the expiration of the Due Diligence Period, Seller shall deliver to Buyer a certification that all of the representations and warranties set forth in Section 11.1 remain true, complete and accurate, except to the extent of any exceptions to such representations and warranties identified in such certification. Further, if, prior to the Closing, Seller becomes aware of any fact or circumstance that would materially change a representation or warranty of Seller in this Agreement, then Seller shall promptly, and in all events at least five (5) business days prior to the Closing Date (which date shall be extended if necessary to give Buyer five business days to review such material change), give written notice of such changed fact or circumstance to Buyer. If, prior to Closing, upon Seller's notice or otherwise, Buyer becomes aware of the material untruth or inaccuracy of, or facts or circumstances that would change materially, any representation or warranty of Seller in this Agreement that was true when made by Seller, then Buyer shall have the option of: (i) waiving such breach of representation or warranty or material adverse change and completing its purchase of the Property pursuant to this Agreement; (ii) reaching agreement with Seller to adjust the terms of this Agreement to compensate Buyer for such change; or (iii) terminating this Agreement and receiving the return of the Deposit as Buyer's sole remedy prior to Closing. All of Seller's representations and warranties shall survive the Closing; provided, however, that Seller's representations and warranties set forth in Sections 11.1(d) through 11.1(i) shall survive the Closing only with respect to written claims alleging a specific breach of one or more of those representations and warranties received by Seller prior to the first anniversary of the Closing Date. Buyer shall not be entitled to any right or remedy for any inaccuracy in or breach of any representation, warranty or covenant under this Agreement or any conveyance document unless the amount of damages, in the aggregate, proximately caused by all such breaches or inaccuracies exceeds Fifty Thousand and No/100ths Dollars ($50,000). If Buyer's aggregate damages exceed Fifty Thousand and No/100ths Dollars ($50,000), Buyer shall be entitled to recover the entire first Fifty Thousand and No/100ths Dollars ($50,000) of damages suffered by Buyer. Notwithstanding anything to the contrary in this Agreement the aggregate liability of Seller under this Agreement to Buyer for any and all actions or claims by Buyer with respect to these representations and warranties that survive the Closing shall be limited to One Million Five Hundred Thousand Dollars ($1,500,000).

11.3 Representations and Warranties of Buyer. Buyer hereby makes the following representations and warranties to Seller, which representations and warranties shall survive the Closing and all of which (i) are material and are being relied upon by Seller, (ii) are true, complete and accurate in all respects as of the date hereof and shall be true, complete and accurate as of the Closing Date, and (iii) shall survive the Closing:

(a) Organization. Buyer is a limited liability company, duly organized, validly existing and in good standing under the laws of the State of Delaware, and is qualified to do business, and is in good standing, in the State of California.

(b) Authorization. This Agreement has been duly authorized, executed, and delivered by Buyer; the obligations of Buyer under this Agreement are legal, valid, and binding obligations of Buyer; and this Agreement does not, and at the time of Closing will not, (i) violate or conflict with the organizational documents of Buyer or any member of Buyer acting on Buyer's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Buyer, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Buyer is a party or by which Buyer is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Buyer. All documents that are delivered to Seller at the Closing will be, at the time of Closing, duly authorized,

executed, and delivered by Buyer; the obligations of Buyer under such documents will be, at the time of Closing, legal, valid, and binding obligations of Buyer; and such documents will not, at the time of Closing, (i) violate or conflict with the organizational documents of Buyer or any member of Buyer acting on Buyer's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Buyer, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Buyer is a party or by which Buyer is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Buyer.

(c) Bankruptcy. No proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against Buyer which have not been terminated; no general assignment for the benefit of creditors has been made by Buyer; and no trustee or receiver of Buyer's property has been appointed.

12. Risk of Loss; Insurance Proceeds; Condemnation.

12.1 Damage or Destruction. In the event of damage or destruction of the Improvements that occurs prior to the Closing Date that (i) would require the expenditure of an amount less than one percent (1%) of the Purchase Price to repair, and (ii) does not permit any Government Tenant or Major Non-Government Tenant to terminate its Lease (each of the foregoing events, a "**Material Damage Event**"), Buyer and Seller shall consummate this Agreement, and Seller shall (a) assign to Buyer at Closing all rights to insurance proceeds on account of such damage or destruction, including any insurance proceeds previously received by Seller with respect to such damage or destruction, and (b) pay to Buyer the amount of the deductible or retention applicable to such damage or destruction under the insurance policy. In the event such damage or destruction results in or causes a Material Damage Event, Buyer or Seller may elect to terminate this Agreement by written notice to the other within ten (10) days after the Material Damage Event. If neither party elects to terminate this Agreement, Seller shall assign the insurance proceeds and pay the applicable deductible or retention to Buyer at Closing and Seller shall have no further responsibility to Buyer for such damage or destruction. If either party elects to terminate this Agreement, the Deposit and all interest thereon shall be refunded to Buyer and the parties shall no further obligation to each other except for those obligations which expressly survive the termination of this Agreement.

12.2 Eminent Domain. If, prior to the Closing, a taking by eminent domain of all or any portion of the Land or Improvements is pending, and such taking would (i) materially and adversely interfere with the use of the Property for its current permitted uses, (ii) materially and adversely affect ingress, egress or parking for the Property or any Tenant's access to its space, (iii) would permit the termination of any Lease by any Government Tenant or Major Non-Government Tenant, or (iv) has a value exceeding one percent (1%) of the Purchase Price (each a "**Material Taking**"), Buyer or Seller shall have the right, by delivering written notice to the other within ten (10) days after Seller delivers written notice to Buyer of such pending taking, to terminate this Agreement, in which event the Deposit and all interest thereon shall be returned to Buyer. If neither party elects to terminate this Agreement or if the taking would not result in or cause a Material Taking, then this Agreement shall remain in effect, and Seller shall assign to Buyer at Closing its rights to the compensation and damages due Seller on account of such taking (and will not settle any proceedings relating to such taking without Buyer's prior written consent) and Seller shall have no further responsibility to Buyer for such taking. Seller shall promptly (and in any event prior to the Closing) notify Buyer of any condemnation affecting the Property.

The provisions of this Section 12 shall supersede the provisions of any applicable laws with respect to the subject matter of this Section 12.

13. Assignment. Buyer may not, at any time, assign this Agreement or Buyer's rights or obligations under this Agreement, either directly or indirectly, without the prior written consent of Seller, which Seller may withhold in its sole and absolute discretion. Subject to the foregoing, this Agreement shall be binding upon, inure to the benefit of, and be enforceable by the parties hereto and their respective heirs, devisees, executors, administrators, legal representatives, successors and assigns. In connection with any approved assignment, the assignee shall assume the assignor's obligations hereunder, but assignor shall nevertheless remain liable therefor.

14. Seller's Covenants During Contract Period. Between Seller's execution of this Agreement and the Closing, or earlier termination of this Agreement as permitted hereunder, Seller shall (i) maintain the Property in good order, condition and repair, reasonable wear and tear excepted; (ii) not make any material physical changes to the Improvements; (iii) continue to manage the Property in the manner in which it is being managed; (iv) not enter into any contracts or agreements affecting the Property unless such contracts can be completed or terminated prior to the Closing or Buyer, in its sole discretion, agrees to assume such contract or agreement as of the Closing Date, in which case such contracts shall be included within the term "**Service Contracts**"; (v) not enter into any lease, amendment of lease or other agreement pertaining to the Property, or permit any tenant of the Property to enter into any sublease or assignment of lease, except as provided in Section 14.1; (vi) after the end of the Due Diligence Period, not offer the Property for sale publicly or otherwise solicit, make, pursue, negotiate or accept offers for the sale of the Property to or from any party; (viii) maintain the insurance described on Exhibit L in full force and effect, except as otherwise approved by Buyer; and (ix) not dispose of or encumber the Property or any part thereof, except for dispositions of personal property in the ordinary course of business. From and after the Contract Date, Seller shall provide Buyer with regular written updates as to the status of any leasing activity at the Property.

14.1 New Leases and Lease Amendments; Lease Expenses.

(a) If Seller desires to enter into any new lease affecting the Property (each a "**New Lease**") or any termination, amendment, modification, expansion or renewal of any existing Lease (each, a "**Lease Amendment**"), after the Contract Date but prior to Closing, Seller shall provide Buyer with a copy of the proposed New Lease or Lease Amendment and a copy of the landlord's anticipated improvement costs, tenant improvement allowances, brokerage commissions and out-of-pocket costs and expenses in connection with the New Lease or Lease Amendment for Buyer's review and approval, which approval shall not be unreasonably withheld; provided, however, Buyer shall not have the right to disapprove any New Lease or Lease Amendment prior to the expiration of the Due Diligence Period. Buyer shall advise Seller, in writing, whether Buyer approves or reasonably disapproves such proposed New Lease or Lease Amendment within three (3) business days after Buyer's receipt of the proposed New Lease or Lease Amendment; provided, however, if Buyer fails to notify Seller within such three (3) business day period, Buyer shall be deemed to have approved the proposed transaction. If after the expiration of the Due Diligence Period, Buyer reasonably disapproves of the proposed New Lease or Lease Amendment, Seller shall not enter into such New Lease or Lease Amendment. If Buyer unreasonably disapproves of the proposed New Lease or Lease Amendment, Seller shall have the full right, power and authority to execute such New Lease or Lease Amendment so long as Seller delivers to Buyer at least three (3) business days' prior written notice of such execution; provided, however, that after receipt of such notice, Buyer shall have the right to terminate this Agreement, upon written notice delivered to Seller within three (3) business days after receipt of Seller's notice of execution of such New Lease or Lease Amendment. If Buyer timely exercises such termination right, this Agreement shall terminate and the Deposit and all interest thereon shall be returned to Buyer. In all other events, this Agreement shall remain in full force and effect. Notwithstanding the foregoing, Seller acknowledges that it shall not enter into any extension or expansion of the AECOM Technology Corp. Lease during the term of this Agreement without Buyer's approval, which may be withheld at Buyer's sole discretion.

(b) New Lease Expenses. If the Closing occurs, Buyer shall assume and be responsible for (and to the extent previously paid by Seller, reimburse Seller on the Closing Date for) a pro rata portion of any and all improvement costs, tenant improvement allowances, brokerage commissions and out-of-pocket costs and expenses actually paid or incurred by Seller (collectively the "**New Lease Expenses**") arising out of or in connection with those New Leases and Lease Amendments entered into by Seller pursuant to the foregoing provisions of this Section 14.1; such pro rata portion shall equal the product of (i) the New Lease Expenses multiplied by (ii) a fraction, the numerator of which is the number of months of the lease term of the New Lease (or the number of months of the term of any exercised extension period provided by any Lease Amendment, as applicable) remaining as of the Closing Date, and the denominator of which is the total number of months of such lease term (or exercised extension period, as applicable). Seller shall be responsible for the remaining pro rata portion of the New Lease Expenses. All New Leases and Lease Amendments entered into by Seller pursuant to this Section 14.1 shall be part of the Leases, shall be deemed included on Exhibit C and shall be assumed by Buyer upon Closing.

(c) Existing Lease Expenses. Seller shall be responsible for the cost of tenant improvement work and leasing commissions required to be paid under or with respect to all Leases (and amendments thereto) entered into prior to the Contract Date and the cost of tenant improvement work, leasing commissions required to be paid under or with respect to the State Lease Amendments and the scheduled rent-free periods set forth in the State Lease Amendments (collectively, "**Existing Lease Expenses**"), and if Seller fails to deliver Buyer evidence reasonably acceptable to Buyer confirming that such Existing Lease Expenses have been paid prior to the Approval Date, Seller shall give Buyer a credit therefore at Closing which shall be calculated as follows: Buyer and Seller shall attempt to agree on the amount of the credit for such Existing Lease Expenses during the Due Diligence Period, which amount shall equal 100% of the anticipated post-Closing Existing Lease Expenses ("**Closing Leasing Credit**"). If Seller and Buyer can agree on the Closing Leasing Credit on or before the Approval Date, such amount shall be credited against the Purchase Price due from Buyer at Closing. If Seller and Buyer cannot agree on the Closing Leasing Credit at least five (5) business days prior to the expiration of the Due Diligence Period, then at least three (3) business days prior to the expiration of the Due Diligence Period, Seller shall give Buyer written notice of the amount of the Closing Leasing Credit that Seller is willing to offer. If Buyer timely delivers the Approval Notice, Buyer shall be deemed to have accepted Seller's proposed Closing Leasing Credit and Buyer will proceed with the acquisition of the Property under the terms of this Agreement. Except as otherwise agreed to by Seller and Buyer, the Closing Leasing Credit shall constitute Seller's sole and only obligations with respect to the Existing Lease Expenses, and as of the Closing Date Buyer shall assume all such obligations (as to leasing commissions only, up to the amount set forth for leasing commissions in the Closing Lease Credit) and indemnify and hold Seller harmless with respect thereto (as to leasing commissions only, up to the amount set forth for leasing commissions in the Closing Lease Credit).

15. ARBITRATION OF DISPUTES. IN THE EVENT OF ANY DISPUTE BETWEEN THE PARTIES ARISING UNDER OR RELATED TO THIS AGREEMENT, SUCH DISPUTE, SHALL BE RESOLVED BY BINDING ARBITRATION BEFORE A SINGLE ARBITRATOR. SUCH ARBITRATION MAY BE INITIATED BY EITHER PARTY BY DELIVERING WRITTEN NOTICE OF INTENT TO ARBITRATE TO THE OTHER PARTY AND TO THE SAN FRANCISCO OFFICE OF THE AMERICAN ARBITRATION ASSOCIATION ("**AAA**"), WHICH NOTICE SHALL DESCRIBE THE DISPUTE AND THE PARTY'S PROPOSAL FOR RESOLVING THE DISPUTE IN DETAIL. WITHIN THIRTY (30) DAYS AFTER DELIVERY OF SUCH NOTICE EACH PARTY SHALL PROVIDE ALL RELEVANT DOCUMENTS AND

MATERIALS THAT PERTAIN TO THE DISPUTE. THE PARTIES SHALL FIRST ENDEAVOR TO AGREE ON THE ARBITRATOR, BUT IF THEY ARE UNABLE TO DO SO WITHIN TEN (10) DAYS AFTER THE ARBITRATION HAS BEEN INITIATED, THE ARBITRATOR SHALL BE SELECTED, WITHIN THIRTY (30) DAYS AFTER THE ARBITRATION WAS INITIATED, USING THE AAA PROCEDURES. THE ARBITRATOR SHALL BE A RETIRED SUPERIOR COURT JUDGE OR A LICENSED, PRACTICING ATTORNEY WHO IS SUBSTANTIALLY FAMILIAR WITH THE REAL ESTATE LAW, CUSTOM, PRACTICE, OR PROCEDURE, IN THE AREA IN WHICH THE PROPERTY IS LOCATED, PERTINENT TO THE DISPUTE BEING ARBITRATED, IN EITHER CASE WITH NOT LESS THAN TWENTY (20) YEARS CONTINUOUS EXPERIENCE AS A JUDGE AND/OR REAL ESTATE PRACTITIONER. IN

ESTABLISHING WHETHER AN ARBITRATOR IS ABLE TO SERVE, THE PARTIES SHALL ADVISE HIM OR HER OF THE NAMES OF ALL PARTIES AND THEIR AFFILIATES AND PRINCIPAL OFFICERS AND OWNERS, AND CONFIRM THAT THERE IS NO CONFLICT OF INTEREST, WHICH FOR PURPOSES HEREOF SHALL MEAN NO BUSINESS OR PERSONAL CONNECTIONS WITH THE ARBITRATOR, OR HIS OR HER FIRM, WITH ANY OF SUCH PARTIES EITHER CURRENTLY OR AT ANY TIME DURING THE IMMEDIATELY PRECEDING THREE (3) YEARS. THE ARBITRATION SHALL BE CONDUCTED PURSUANT TO THE AAA'S COMMERCIAL ARBITRATION RULES, AS MODIFIED BY THIS SECTION 15, OR BY SUCH OTHER ORGANIZATION AND RULES AS THE PARTIES MAY MUTUALLY AGREE UPON. IF AAA IS NOT AVAILABLE AND THE PARTIES CANNOT AGREE ON AN ALTERNATE CHOICE, THE PROVISIONS OF CALIFORNIA CODE OF CIVIL PROCEDURE SECTION 1280 ET. SEQ. SHALL APPLY. ALL ARBITRATION PROCEEDINGS SHALL BE CONFIDENTIAL, AND NEITHER PARTY NOR THE ARBITRATOR MAY DISCLOSE THE CONTENT OR RESULTS OF ANY ARBITRATION HEREUNDER WITHOUT THE WRITTEN CONSENT OF BOTH PARTIES. THE ARBITRATOR SHALL FOLLOW THE LAW (INCLUDING APPLICABLE STATUTES OF LIMITATIONS) AND ALL RULES OF EVIDENCE UNLESS THE PARTIES STIPULATE TO THE CONTRARY. ANY PROVISIONAL REMEDY (INCLUDING PRELIMINARY OR PERMANENT INJUNCTIONS AND WRITS OF ATTACHMENT AND POSSESSION) WHICH WOULD BE AVAILABLE FROM A COURT OF LAW OR EQUITY SHALL BE AVAILABLE FROM THE ARBITRATOR PENDING COMPLETION OF THE ARBITRATION. THE BENEFITED PARTY OF SUCH PROVISIONAL REMEDY SHALL BE ENTITLED TO ENFORCE SUCH REMEDY IN COURT IMMEDIATELY, EVEN THOUGH A FINAL ARBITRATION AWARD HAS NOT YET BEEN RENDERED. WITHIN THIRTY (30) DAYS AFTER HIS OR HER APPOINTMENT, THE ARBITRATOR SHALL HEAR AND DECIDE THE DISPUTE SUBMITTED TO ARBITRATION HEREUNDER AND SHALL PROMPTLY PREPARE A WRITTEN DECISION ON THE MERITS OF THE MATTERS IN DISPUTE, WHICH DECISION SHALL STATE THE FACTS AND LAW RELIED UPON AND THE REASONS FOR THE ARBITRATOR'S DECISION. THE ARBITRATOR MAY, AT HIS OR HER DISCRETION, ELECT WHETHER TO MEET WITH THE PARTIES AND WHETHER TO CONDUCT A HEARING ATTENDED BY ALL PARTIES; PROVIDED, HOWEVER, THAT FOR DISPUTES INVOLVING $50,000.00 OR MORE, THE ARBITRATOR SHALL CONDUCT A HEARING. DISCOVERY SHALL BE ALLOWED IN ACCORDANCE WITH CALIFORNIA CODE OF CIVIL PROCEDURE 1283.05. THE ARBITRATOR SHALL HAVE COMPLETE DISCRETION TO RESOLVE DISCOVERY DISPUTES, TO ORDER THE PRODUCTION OF DOCUMENTS AND PRESENTATION OF WITNESSES AND TO LIMIT SUCH DISCOVERY, INCLUDING THE NUMBER AND SCOPE OF DEPOSITIONS THAT MAY BE TAKEN BY THE PARTIES. PRIOR TO ISSUING HIS OR HER FINAL WRITTEN DECISION, THE ARBITRATOR SHALL INFORM THE PARTIES, IN WRITING, OF THE ARBITRATOR'S EXPECTED DECISION ON THE MATTER AND THE REASONS THEREFORE AND GIVE THE PARTIES FIVE (5) BUSINESS DAYS TO SUBMIT ADDITIONAL ARGUMENTS OR INFORMATION, IN WRITING, TO THE ARBITRATOR AND THE OTHER PARTIES. THE AWARD OR DECISION OF THE ARBITRATOR, WHICH MAY INCLUDE AN ORDER OF SPECIFIC

PERFORMANCE, SHALL BE FINAL AND BINDING ON ALL PARTIES AND ENFORCEABLE IN ANY COURT OF COMPETENT JURISDICTION; PROVIDED, HOWEVER, THAT THE AWARD MAY BE VACATED OR CORRECTED FOR ANY OF THE REASONS PERMITTED UNDER AND PURSUANT TO CALIFORNIA CODE OF CIVIL PROCEDURE SECTIONS 1286.2 OR 1286.6. THE ARBITRATOR SHALL HAVE NO AUTHORITY TO MODIFY ANY OF THE TERMS OF THIS AGREEMENT. THE FEES AND EXPENSES OF THE ARBITRATOR AND THE COSTS AND ATTORNEYS' FEES OF THE PREVAILING PARTY SHALL BE PAID BY THE PARTY WHO IS NOT THE PREVAILING PARTY, AS DEFINED IN SECTION 18.6 (ATTORNEYS' FEES) AND DETERMINED BY THE ARBITRATOR IN ITS DECISION.

NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTE ARISING OUT OF THE MATTERS INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED BY CALIFORNIA LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE THE DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY

http://sec.gov/Archives/edgar/data/1179929/000095012311023069/a58840exv10w27.htm[1/6/2012 11:09:22 AM]

AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THE ‘ARBITRATION OF DISPUTES’ PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE CALIFORNIA CODE OF CIVIL PROCEDURE. YOUR AGREEMENT TO THIS ARBITRATION PROVISION IS VOLUNTARY.

WE HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THE ‘ARBITRATION OF DISPUTES’ PROVISION TO NEUTRAL ARBITRATION

______________________________	______________________________
Seller	Buyer

16. Indemnification. Each party hereby agrees to indemnify, defend, protect and hold harmless the other party from and against any and all claims, demands, liabilities, costs and damages, including without limitation, reasonable attorneys’ fees (collectively, “**Claims**”) suffered by the other party and resulting from or arising out of all third-party tort claims and similar claims of the type that would typically be insured under a Commercial General Liability Insurance Policy which are based on actions, facts or circumstances existing or occurring during the indemnifying party’s ownership of the Property, excluding any Claims related to hazardous substances. All of the indemnifications set forth in this Section 16 shall survive the Closing and conveyance of the Property to Buyer.

17. Miscellaneous.

18. Notice. All notices and any other communications permitted or required under this Agreement must be in writing and will be effective (i) immediately upon delivery in person or by facsimile, provided delivery is made during regular business hours or receipt is acknowledged by

a person reasonably believed by the delivering party to be employed by the recipient and that for all facsimiles, good and complete transmission is confirmed by the sending facsimile machine and a copy of the notice is concurrently mailed pursuant to clause (iii) below; or (ii) upon the actual delivery as evidenced by executed receipt of the recipient if delivered by a nationally recognized delivery service for overnight delivery, provided delivery is made during regular business hours or receipt is acknowledged by a person reasonably believed by the delivering party to be employed by the recipient; or (iii) or the date shown on the return receipt if delivered by the United States Postal Service, certified mail, return receipt requested, postage prepaid and with the return receipt returned to the sender marked as delivered, undeliverable or rejected. In the case of any notices sent pursuant to clauses (ii) or (iii) above, the sender shall also send a copy of such notice by email, which email shall be sent no later than 6:00 p.m. (Pacific Time) on the date such notice is deposited with the delivery service or United States Postal Service. The inability to deliver because of a changed address of which no notice was given, or rejection or other refusal to accept any notice, shall be deemed to be the receipt of the notice as of the first date of such inability to deliver or rejection or refusal to accept. Any notice to be given by any party hereto may be given by the counsel for such party. All notices must be properly addressed and delivered to the parties at the addresses set forth below, or at such other addresses as either party may subsequently designate by written notice given in the manner provided in this Section 18:

Seller:
200 Oceangate, LLC
c/o The Swig Company, LLC
220 Montgomery Street, 20th Floor
San Francisco, CA 94104
Attn: Kennard P. Perry
Telephone: (415) 291-1140
Facsimile: (415) 291-8373
Email: kperry@swigco.com

with copy to:
Farella Braun + Martel LLP
235 Montgomery Street
San Francisco, CA 94104
Attn: Anthony D. Ratner
Telephone: (415) 954-4448
Facsimile: (415) 954-4480
Email: tratner@fbm.com

Buyer:

Prior to Closing:
Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825

Attn: General Counsel
Telephone: (916) 646-9193 x114663
Facsimile: (916) 646-4572
Email: Jeff.Barlow@Molinahealthcare.com

with copy to: Boutin Jones Inc.
555 Capitol Mall, Suite 1500
Sacramento, CA 95814
Attn: James R. Moore
Telephone: (916) 321-4444
Facsimile: (916) 441-7597
Email: jmoore@boutininc.com

After Closing: Molina Center LLC
200 Oceangate, Suite 100
Long Beach, CA 90802
Attn: John Molina
Telephone: (562) 435-3666 x111128
Facsimile: (562) 495-7770
Email: John.Molina@Molinahealthcare.com

with a copy to:

Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attn: General Counsel
Telephone: (916) 646-9193 x114663
Facsimile: (916) 646-4572
Email: Jeff.Barlow@Molinahealthcare.com

18.1 Headings. The headings used herein are for purposes of convenience only and should not be used in construing the provisions hereof.

18.2 Covenant of Further Assurances. The parties hereby agree to execute and deliver such other documents and instruments (including, without limitation, additional escrow instructions in conformity with this Agreement), and to take such other actions, whether before or after Closing, as may reasonably be required and which may be necessary to consummate this transaction and to otherwise effectuate the agreements of the parties hereto; provided that such additional documents, instruments, or actions shall not impose upon the parties any obligations, duties, liabilities or responsibilities which are not expressly provided for in this Agreement.

18.3 Entire Agreement. This document represents the final, entire and complete agreement between the parties with respect to the subject matter hereof and supersedes all other prior or contemporaneous agreements, communications or representations, whether oral or written, express or implied, including any letters of intent, including that certain Confidentiality Agreement 200 & 300 Oceangate by and between Molina and Seller. The parties acknowledge and agree that they may not and are not relying on any representation, promise, inducement, or other statement, whether oral or written and by whomever made, that is not contained expressly in this Agreement. This Agreement may only be modified by a written instrument signed by representatives authorized to bind both parties. Oral modifications are unenforceable.

18.4 Partial Invalidity. If any term, covenant or condition of this Agreement or its application to any person or circumstances shall be held to be illegal, invalid or unenforceable, the remainder of this Agreement or the application of such term or provisions to other persons or circumstances shall not be affected, and each term hereof shall be legal, valid and enforceable to the fullest extent permitted by law, unless an essential purpose of this Agreement would be defeated by the loss of the illegal, unenforceable, or invalid provision. In the event of such partial invalidity, the parties shall seek in good faith to agree on replacing any such legally invalid provisions with valid provisions which, in effect, will, from an economic

viewpoint, most nearly and fairly approach the effect of the invalid provision and the intent of the parties in entering into this Agreement.

18.5 No Waiver. No consent or waiver by either party to or of any breach or non-performance of any representation, condition, covenant or warranty shall be enforceable unless in a writing signed by the party entitled to enforce performance, and such signed consent or waiver shall not be construed as a consent to or waiver of any other breach or non-performance of the same or any other representation, condition, covenant, or warranty.

18.6 Attorneys' Fees. In the event of any arbitration or litigation between the parties, whether based on contract, tort or other cause of action or involving bankruptcy or similar proceedings, in any way related to this Agreement, the non-prevailing party shall pay to the prevailing party all reasonable attorneys' fees and costs and expenses of any type, without restriction by statute, court rule or otherwise, incurred by the prevailing party in connection with any action or proceeding (including arbitration proceedings, any appeals and the enforcement of any judgment or award), whether or not the dispute is litigated or prosecuted to final judgment. The "prevailing party" shall be determined based upon an assessment of which party's major arguments or positions taken in the action or proceeding could fairly be said to have prevailed (whether by compromise, settlement, abandonment by the other party of its claim or defense, final decision, after any appeals, or otherwise) over the other party's major arguments or positions on major disputed issues.

18.7 Brokers and Finders. Neither party has had any contact or dealings regarding the Property, through any licensed real estate broker or other persons who can claim a right to a commission or finder's fee in connection with this transaction, except for CB Richard Ellis, Inc., representing Seller (the "**Selling Broker**") and McKinney Advisory Group, Inc., representing Buyer (the "**Buying Broker**"). The parties agree that Seller shall pay a brokerage commission to Selling Broker, pursuant to its separate agreement with the Selling Broker. The parties agree that Buyer shall pay any amount owing to Buying Broker pursuant to its separate agreement with the Buying Broker. In the event that any other party claims a commission or finder's fee in this transaction, the party through whom the party makes its claim shall be responsible for said commission or fee and shall indemnify the other against all costs and expenses (including reasonable attorneys' fees) incurred in defending against the same. This indemnification obligation shall survive the Closing or termination of this Agreement.

18.8 Time of the Essence. Time is of the essence of this Agreement.

18.9 Governing Law; Forum. This Agreement is entered into and shall be governed by and construed in accordance with the laws of the State of California (without giving effect to its choice of law principles).

18.10 Interpretation. All parties have been represented by counsel in the preparation and negotiation of this Agreement, and this Agreement shall be construed according to the fair meaning of its language. The rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be employed in interpreting this Agreement. Unless the context clearly requires otherwise, (i) the plural and singular numbers shall each be deemed to include the other; (ii) the masculine, feminine, and neuter genders shall each be deemed to include the others; (iii) "shall," "will," or "agrees" are mandatory, and "may" is permissive; (iv) "or" is not exclusive; (v) "includes" and "including" are not limiting, absent express language to the contrary; (vi) "days" means calendar days unless specifically provided otherwise; and (vii) "business day" means any day other than Saturday, Sunday, or any day that is an "optional bank holiday" under Section 7.1 of the California Civil Code, whether or not any particular bank is open for business on such optional bank holiday.

18.11 IRS Form 1099-S Designation. In order to comply with information reporting requirements of Section 6045(e) of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations thereunder, the parties agree (i) to execute an IRS Form 1099-S Designation Agreement to designate the Title Company (the "**Designee**") as the party who shall be responsible for reporting the contemplated sale of the Property to the Internal Revenue Service (the "**IRS**") on IRS Form 1099-S; and (ii) to provide the Designee with the information necessary to complete Form 1099-S.

18.12 Third Party Beneficiaries. This Agreement has been made solely for the benefit of the parties hereto and their respective successors and permitted assigns, and nothing in this Agreement is intended to, or shall, confer upon any other person any benefits, rights or remedies under or by reason of this Agreement.

18.13 Compliance With Laws. Each party shall comply with all applicable laws, rules, regulations, orders, consents and permits in the performance of all of their obligations under this Agreement.

18.14 Counterparts. This Agreement may be signed in any number of counterparts with the same effect as if the signatures to each counterpart were upon a single instrument, and is intended to be binding when all parties have delivered their signatures to the other parties. Signatures may be delivered by facsimile transmission or by e-mail in a portable document format (*pdf*). All counterparts shall be deemed an original of this Agreement.

18.15 Exhibits. All Recitals and Exhibits referred to in this Agreement are incorporated herein by reference and shall be deemed part of this Agreement.

18.16 Authority. The individuals executing this Agreement on behalf of Seller and Buyer individually represent and warrant that he or she has been authorized to do so and has the power to bind the party for whom they are signing.

18.17 Exchange Transaction. Buyer agrees upon the request of Seller to cooperate with Seller in closing all or part of this transaction as an exchange pursuant to Internal Revenue Code Section 1031, provided that:

(a) Buyer shall incur no additional expense or liability in connection therewith and shall not be required to make any representations or warranties, incur any personal liabilities or hold title to any property other than the Property;

(b) Seller shall indemnify, protect, defend and hold Buyer harmless from any claims, liabilities, demands, causes of action, judgments, expenses, costs and attorneys' fees in connection with such exchange or which result from Buyer's compliance with this paragraph, which obligation shall survive the Closing or termination of this Agreement; and

(c) The Closing is not extended or delayed by the exchange and the completion of the exchange is not a condition to Seller's obligation to close the Escrow.

18.18 Confidentiality. Buyer and Seller shall each maintain as confidential any and all material or information about the other, the terms of this Agreement, and the Property, and shall not disclose such information to any third party, except, in the case of Buyer, to Buyer's investment bankers, lender or prospective lenders, insurance and reinsurance firms, accountants, attorneys, environmental and other consultants, as may be reasonably required for the consummation of this transaction, as required by law or in connection with any arbitration or litigation between the parties, and except, in the case of Seller, to Seller's existing lender, attorneys, accountants and other professional consultants, as may be reasonably required for the consummation of this transaction, as required by law or in connection with any arbitration or litigation between the parties. Neither party shall issue a press release or other public statement about this Agreement or the transactions contemplated by this Agreement without the other party's prior written consent, unless such release or statement is required by law. Seller acknowledges that Buyer's ultimate parent is a publicly traded company and that Buyer is, therefore, subject to laws and regulations regarding the disclosure and dissemination of business information. Buyer acknowledges that in the event this Agreement terminates for any reason, Seller has the right and the obligation to disclose to subsequent purchasers of the Property the price and material terms of this Agreement, and Buyer agrees that such disclosure is a permitted disclosure under this Section 18.18.

[*Signatures on following page*]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Contract Date.

SELLER:

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.,
a Delaware corporation
its Manager

By: ____________________
Jeanne R. Myerson
President

BUYER:

MOLINA CENTER LLC,
a Delaware limited liability company

By: Molina Healthcare, Inc., a Delaware corporation

By: ____________________

Name: ____________________
Title: ____________________

NOTE: BOTH PARTIES MUST INITIAL THE AGREEMENT AT SECTIONS 3.2 AND 15.

EXHIBIT A

DESCRIPTION OF THE LAND

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGLES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY AND ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 and 7278-003-036

EX-12.1 3 a58840exv12w1.htm EX-12.1

Exhibit 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2010	2009(1)	2008(1)	2007	2006
	(Dollars in thousands)				
Earnings:					
Income before income taxes	$ 89,492	$38,157	$ 94,324	$ 92,722	$73,458
Add fixed charges:					
Interest expense, including amortization of debt discount and exp	15,509	13,777	13,231	5,605	2,353
Estimated interest portion of rental expense	4,524	5,181	4,370	3,988	2,682
Total fixed charges	20,033	18,958	17,601	9,593	5,035
Total earnings available for fixed charges	$109,525	$57,115	$111,925	$102,315	$78,493
Fixed Charges from above	$ 20,033	$18,958	$ 17,601	$ 9,593	$ 5,035
Ratio of Earnings to Fixed Charges	5.6	3.0	6.4	10.7	15.6
Total rent expense	$ 25,134	$20,723	$ 17,481	$ 18,127	$12,193
Interest factor	18%	25%	25%	22%	22%
Interest component of rental expense	$ 4,524	$ 5,181	$ 4,370	$ 3,988	$ 2,682

(1) 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.

EX-21.1 4 a58840exv21w1.htm EX-21.1

Exhibit 21.1

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 Texas Insurance Company*	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
Abri Health Plan, Inc.	Wisconsin

* Subsidiary of Molina Healthcare of Texas, Inc.

EX-23.1 5 a58840exv23w1.htm EX-23.1

EXHIBIT 23.1

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, No. 333-153246, and No. 333-170571) 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 8, 2011, 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, 2010.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 8, 2011

EX-31.1 6 a58840exv31w1.htm EX-31.1

EXHIBIT 31.1

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, 2010 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 8, 2011

EX-31.2 7 a58840exv31w2.htm EX-31.2

EXHIBIT 31.2

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, 2010, 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 8, 2011

EX-32.1 8 a58840exv32w1.htm EX-32.1

EXHIBIT 32.1

**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, 2010 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 8, 2011

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.

EX-32.2 9 a58840exv32w2.htm EX-32.2

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, 2010 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 8, 2011

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.