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UNITED STATES
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, 2015

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, 2015, the last business day of our most recently completed second fiscal quarter, was approximately $2,823.5 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, 2015).

As of February 23, 2016, approximately 56,199,000 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 2016 Annual Meeting of Stockholders to be held on April 27, 2016, are incorporated by reference into Part III of this Form 10-K.

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Molina Healthcare, Inc.
Form 10-K
For the Year Ended December 31, 2015
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This Annual Report on Form 10-K ("Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the headings "Business," and "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly from the results discussed in the forward-looking statements. Factors that might cause such differences include, but are not limited to, those discussed in Part I, Item 1A of this Form 10-K under the heading "Risk Factors." Each of the terms "Company," "Molina Healthcare," "we," "our," and "us," as used herein refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

PART I

Item 1: Business

OVERVIEW

Our Vision and Mission

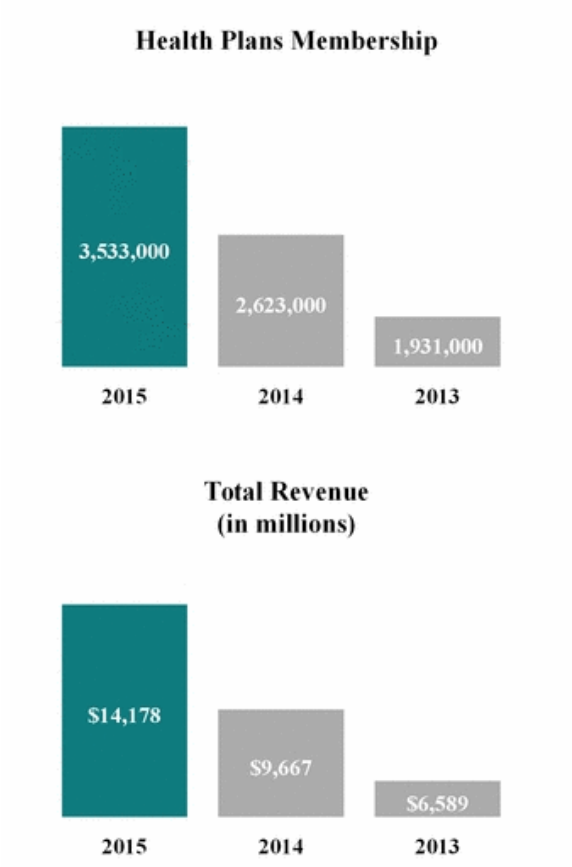
Molina Healthcare, Inc. offers cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program.We envision a future where everyone receives quality health care, and our mission is to provide quality health care to people receiving government assistance. To execute on our vision and mission, we dedicate ourselves to the following core values:

- Caring - We care about those we serve and advocate on their behalf.
- Enthusiasm - We enthusiastically address problems and seek creative solutions.
- Respect - We respect each other and value ethical business practices.
- Focus - We focus on our mission.
- Thrift - We are careful with scarce resources.
- Accountability - We are personally accountable for our actions and collaborate to get results.
- Feedback - We strive to improve the organization and achieve meaningful change through feedback and coaching.

Our Strategy

The primary objectives of our strategy over the past 35 years have been to grow and diversify our revenue; sustain our mission by being profitable; and to always remain focused on providing access to high quality healthcare for our members.

According to the U.S. Department of Health and Human Services (HHS), by late 2015 nearly 18 million people nationally gained health insurance by signing up for Medicaid or the Health Insurance Marketplace (Marketplace), since several of the Affordable Care Act's coverage provisions took effect. The uninsured rate has fallen from a high of 18% to nearly 11%; the lowest uninsured rate in 50 years according to an ongoing study by the Centers for Disease Control and Prevention. We have participated in this trend by enrolling approximately 1.6 million members since January 2014, including more than a half million Medicaid expansion members and 205,000 low-income Marketplace members. In total, as of December 31, 2015, our health plans served over 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals.



Beyond growing the number of members we serve, we believe our most important contribution lies in our commitment to provide access to quality health care for our members. To that end, we have set about expanding and deepening the care capabilities that we provide, focusing on quality outcomes, care integration, and measurable results. For example, the National Committee for Quality Assurance (NCQA) has accredited nine of our 12 Medicaid managed care plans. Our newer Illinois and South Carolina health plans are preparing for NCQA accreditation review in 2016. Our Puerto Rico health plan, which began serving members in 2015, will seek NCQA accreditation as soon as it is eligible to do so. We believe that these objective measures of the quality of the services we provide are increasingly important to state Medicaid agencies.

In addition, as states continue to seek cost-effective strategies to manage the care of individuals with more complex healthcare and behavioral needs, we believe that the movement toward the integration of behavioral health and medical care will continue.

Our growth strategy has four components:

- Growth and retention in our existing markets;
- Expansion into new geographies;
- Transitioning members and benefits from fee for service to managed care; and
- Developing and acquiring new products and capabilities.

Significant accomplishments in support of our strategic growth initiatives during 2015 and early 2016 included:

- *Growth and retention in our existing markets.*
    - We retained and grew existing business with our re-procurement wins in Michigan and Washington. Our new contract in Michigan expanded our service area across all of the Lower Peninsula, spanning an additional 18 counties. The Washington win, along with the acquisition described below, strengthens our position in the southwestern region of that state.
    - Our Florida and Michigan health plans acquired Medicaid contracts which added approximately 192,000 new members in 2015.
    - We have announced and/or closed on Medicaid contract acquisitions in Illinois, Michigan and Washington that we expect to add approximately 257,000 new members in the first quarter of 2016.
    - Our Marketplace enrollment grew from approximately 15,000 members in 2014, to over 200,000 members as of December 31, 2015.
    - Molina Medicaid Solutions entered into a 10-year contract with the state of New Jersey to design and operate that state's new Medicaid management information system (MMIS).
- *Expansion into new geographies.* Our Puerto Rico health plan began serving its first members in April 2015. As of December 31, 2015, our Puerto Rico plan enrollment amounted to approximately 348,000 members.

- *Transitioning members and benefits from fee for service to managed care.* In 2015, we saw strong growth in our Medicare-Medicaid Plan (MMP) and Aged, Blind or Disabled (ABD) programs. While smaller programs in total membership, they translate to strong revenue growth because these members bring much higher premiums when

compared with our other members, including those in the Temporary Assistance for Needy Families, Medicaid expansion and Marketplace programs.

- *Developing and acquiring new products and capabilities*. We acquired Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC, a division of The Providence Service Corporation. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia. We believe this acquisition will complement our Health Plans segment services with behavioral health and other services that focus on social determinants of health, as we increasingly arrange for healthcare services for members with complex needs.

Finally, to support our future growth initiatives, in 2015 we raised approximately $1.1 billion under debt and equity financing transactions, and supplemented our financing resources under a new unsecured $250 million revolving credit facility.

Our Strengths

From a strategic perspective, we believe our organizational structure allows us to participate in an expanding sector of the economy and continue our mission to provide quality health care to people receiving government assistance. Our approach to our business is based on the following strengths:

Flexible Health Services Portfolio. We offer a comprehensive suite of Medicaid services, ranging from quality care, disease management, cost management, and direct delivery of health care services, to state-level Medicaid management information systems (MMIS) administration through our Molina Medicaid Solutions segment. 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. We believe that our Molina Medicaid Solutions platform, which is based on commercial off-the-shelf technology, has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Focus on People Receiving Government Assistance. Our experience over more than 35 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.

Scalable Administrative Infrastructure. Our operations share common systems platforms, which allow for economies of scale and common experience in meeting the needs of state Medicaid programs. We have centralized and standardized various functions and practices to increase administrative efficiency. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Consistent Medicaid National Brand. 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 Health Plans membership to 3.5 million members as of December 31, 2015, added Molina Medicaid Solutions, and introduced new capabilities with the acquisition of Pathways.

Seasoned Management Team. 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, whose tenure with Molina is over 19 years. The rest of our named executive officers have been with Molina for periods ranging from 10 years to 20 years. We believe that this extensive experience allows senior management to take a longer-term view of our operations, while maintaining consistency.

Unique Culture. We believe that we are unique culturally because of our employees' dedication to our core values and our mission. Many of our employees seek to work here—and continue to work here—because of our shared belief that we envision a future where everyone receives quality healthcare.

OUR INDUSTRY

Medicaid

Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all jurisdictions is currently about 59%, and ranges from a federally established FMAP floor of 50% to as high as 74%.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program (TANF), which covers primarily low-income mothers and children. In states that have elected to participate, Medicaid expansion provides eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Another common state-administered Medicaid program is for ABD Medicaid beneficiaries, which covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients, and typically use more services because of their critical health issues. Additionally, the Children's Health Insurance Program (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.

Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. To improve quality and provide more uniform and 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.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with 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 (CMS). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (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.

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.

Medicaid Management Information Systems

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. 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 actively participate in this market.

Competition

The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of health care reform, 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, quality of provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., and Aetna Inc. 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, ACS (owned by Xerox Corporation), Computer Services Corporation, and CNSI.

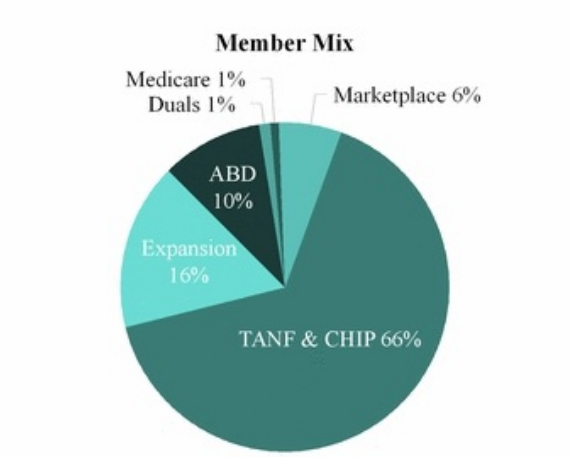
BUSINESS OPERATIONS

Our Structure

We currently manage our operations through three reportable segments: the Health Plans segment, the Molina Medicaid Solutions segment, and Other, which includes our recent Pathways acquisition described above. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition activity and changing laws and regulations. Therefore, these reportable segments may change in the future.

We derive our revenues primarily from health insurance premiums. Refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," and Note 20, "Segment Information," for revenue information by state health plan, and segment revenue, profit and total asset information, respectively.

Health Plans. The Health Plans segment consists of operational health plans in 11 states and the Commonwealth of Puerto Rico, and our direct delivery business. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate health plans. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements that limit the ability of our health plan subsidiaries to pay dividends to us. As of December 31, 2015, the components of our membership by program, are indicated in the following chart.



Molina Medicaid Solutions. The Molina Medicaid Solutions segment provides design, development, implementation (DDI), and business process outsourcing (BPO) 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. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia; the U.S. Virgin Islands; and a contract to provide pharmacy rebate administration services for the Florida Medicaid program. The Molina Medicaid Solutions segment supports state Medicaid agency administrative needs, reduces the variability in our earnings resulting from fluctuations in medical care costs, improves our operating profit margin percentages, and improves our cash flow by adding a business for which there are no restrictions on dividend payments.

Other. Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly. Additionally, 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.

Pricing

Medicaid. Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members' health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Medicare. Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment.

Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

Marketplace. For our Marketplace plans, we develop premium rates during early spring each year for policies effective January 1st of the following year. We develop our premium rates based on our estimates of projected member utilization, medical unit costs, member risk acuity, and administrative costs, with the intent of realizing a target pretax percentage profit margin. Our

actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval.

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 proved 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 predictive modeling 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 such as the following:

- *Disease Management Programs.* We develop specialized disease management programs that address the particular health care needs of our members. "*motherhood matters!*℠" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. "*breathe with ease!*" 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 15. "*Healthy Living with Diabetes*" is a diabetes disease management program. "*Heart Healthy 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 members 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.

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 (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 (DRGs) capitation, and case rates.

Direct Delivery. The clinics we operate 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 we operate assist us in developing and implementing community education, disease management, and other programs. Direct clinic management experience also enables us to better understand the needs of our contracted providers.

Reinsurance

Our health plans currently have reinsurance agreements with an unaffiliated insurer to cover certain claims. We enter into these contracts to reduce the risk of catastrophic losses which in turn reduce our capital and surplus requirements. We frequently evaluate reinsurance opportunities and review our reinsurance and risk management strategies on a regular basis.

Management Information Systems

All of our health plan information technology 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 federal health care privacy regulations, 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 (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.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT system).

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. 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 HHS. 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.

CONTRACTING AND REGULATORY COMPLIANCE

Government Contracts

Medicaid. In all the states in which we operate health plans, we enter into a contract with the state's Medicaid agency to offer managed care benefits to Medicaid-eligible individuals. Some states award contracts to any applicant demonstrating that it meets the state's requirements, while 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.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. We are regulated by the state 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. For example, we must demonstrate that:

- Our provider network is adequate;
- Our quality and utilization management processes comply with state requirements;
- We have adequate procedures in place for responding to member and provider complaints and grievances;
- We can meet requirements for the timely processing of provider claims;
- We can collect and analyze the information needed to manage our quality improvement activities;
- We have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs;
- 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; and
- We have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Our state contracts 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 dis-enrollment 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.

The contractual relationship with the state is generally for a period of three to four years and is renewable on an annual or biennial 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 (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. For instance, in early 2012 our Missouri health plan was notified that it was not awarded a new contract under that state's RFP, and therefore its contract expired in that year.

Medicare. Under annually renewable contracts with CMS, our state health plans offer Medicare Advantage special needs plans which include a mandatory Part D prescription drug benefit. Molina Medicare Options Plus, our trade name for these plans, serves beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically under-served families and individuals. We employ sales personnel, and engage independent brokers, agents and consultants to enroll new Molina Medicare Options Plus members. None of our health plans operates a Medicare Advantage private fee-for-service plan.

Federal regulations 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. Additionally, there are certain restrictions on agent and broker compensation.

Molina Medicaid Solutions. We continually monitor the status of various states' legacy MMIS capabilities and contracts to determine whether Molina Medicaid Solutions' value proposition and core strengths will address a state's MMIS goals. Once an RFP with a Medicaid agency is won, our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we deliver extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the initial term of our most recently implemented Molina Medicaid Solutions contract in New Jersey is 10 years in total, consisting of 2.5 years allocated for the delivery of DDI services, followed by 7.5 years for the performance of BPO services. In most of these engagements option years are offered which span 2-3 years. The terms of some of our other established Molina Medicaid Solutions contracts—which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements)—are shorter in duration than our more recent contracts.

The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 75% of the costs incurred in operating a certified MMIS. Federal certification increases the share of the claims processing costs the federal government will pay for monthly operations. With an uncertified system, the federal government contributes approximately 50% of claims processing costs, with the state paying the other half. With a certified system, the federal government pays 75% of costs, reducing the state's share.

Other. Substantially all of Pathways' revenue is derived from contracts with state or local government agencies and government intermediaries, the majority of which are negotiated fee-for-service arrangements. A significant number of these contracts allow the payer to terminate the contract immediately for cause, such as for our failure to meet our contract obligations. Additionally, these contracts typically permit the payer to terminate the contract at any time prior to its stated expiration date without cause, at will and without penalty to the payer, either upon the expiration of a short notice period, typically 30 days, or immediately, in the event federal or state appropriations supporting the programs serviced by the contract are reduced or eliminated.

Regulatory Compliance

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 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 organizations, including those operating in the Medicaid and Medicare programs.

States' Risk-Based Capital Requirements. 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 (RBC) requirements. The RBC requirements are based on guidelines established

by the National Association of Insurance Commissioners (NAIC) and are administered by the states. All of our state health plans are subject to RBC requirements, except California and Florida. 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. For further information regarding RBC requirements, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 19, "Commitments and Contingencies."

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.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (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.

Health care reform 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.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the American Recovery and Reinvestment Act of 2009, or 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. As required by ARRA, the Secretary of HHS has promulgated regulations implementing various provisions of the HITECH Act. The Final Omnibus Rule promulgated by HHS in January 2013, included the Final Breach Notification Rule as well as provisions that apply the HIPAA regulatory scheme to business associates. We anticipate that HHS will promulgate additional rules under the HITECH Act to implement provisions of the statute which were not addressed in the Final Omnibus Rule. The various requirements of the HITECH Act and the Final Omnibus Rule have different compliance dates, and in some cases, the applicable compliance date may depend on the publication of additional rules or guidance by HHS. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with such provisions. With respect to additional requirements that may be issued in the future by HHS, it is our intention to implement any such 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 Act 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.

Federal and State Self-Referral Prohibitions. We may be subject to federal and state statutes banning payments for referrals of patients and referrals by physicians to healthcare providers with whom the physicians have a financial relationship. Section 1877 of the Social Security Act, also known as the "Stark Law," prohibits physicians from making a "referral" for "designated health services" for Medicare (and in many cases Medicaid) patients from entities or facilities in which such physicians directly or indirectly hold a "financial relationship." A financial relationship can take the form of a direct or indirect ownership, investment or compensation arrangement. A referral includes the request by a physician for, or ordering of, or the certifying or re-certifying the need for, any designated health services.

Certain services that we provide may be identified as "designated health services" for purposes of the Stark Law. We cannot provide assurance that future regulatory changes will not result in other services we provide becoming subject to the Stark Law's ownership, investment or compensation prohibitions in the future.

Many states, including some states where we do business, have adopted similar or broader prohibitions against payments that are intended to induce referrals of clients. Moreover, many states where we operate have laws similar to the Stark Law prohibiting physician self-referrals. We contract with a significant number of human services providers and practitioners, including therapists, physicians and psychiatrists, and arrange for these individuals or entities to provide services to our clients. While we believe that these contracts are in compliance with the Stark Law, no assurance can be made that such contracts will not be considered in violation of the Stark Law.

For-profit ownership. Certain of the agencies for which we provide services restrict our ability to contract directly as a for-profit organization. Instead, these agencies contract directly with a not-for-profit organization and in certain cases we negotiate to provide administrative and management services to the not-for-profit providers. The extent to which other agencies impose such requirements may affect our ability to continue to provide the full range of services that we provide or limit the organizations with which we can contract directly to provide services.

Corporate practice of medicine and fee splitting. Some states in which we operate prohibit general business entities, such as us, from "practicing medicine," which definition varies from state to state and can include employing physicians, professional therapists and other mental health professionals, as well as engaging in fee-splitting arrangements with these health care providers. Among other things, we currently contract with professional therapists to provide intensive home based counseling and with nurse practitioners to perform comprehensive health assessments. We believe that we have structured our operations appropriately, however, we could be alleged or found to be in violation of some or all of these laws. If a state determines that some portion of our business violates these laws, it may seek to have us discontinue those portions or subject us to penalties, fines, certain license requirements or other measures. Any determination that we have acted improperly in this regard may result in liability to us. In addition, agreements between the corporation and the professional may be considered void and unenforceable.

Professional licensure and other requirements. Many of our employees are subject to federal and state laws and regulations governing the ethics and practice of their professions. In addition, professionals who are eligible to participate in Medicare and Medicaid as individual providers must not have been excluded from participation in government programs at any time. Our ability to provide services depends upon the ability of our personnel to meet individual licensure and other requirements.

OTHER INFORMATION

Intellectual Property

We have registered and maintain various service marks, trademarks and trade names that we use in our businesses, including marks and names incorporating the "Molina" or "Molina Healthcare" phrase, and from time to time we apply for additional registrations of such marks. We utilize these and other marks and names in connection with the marketing and identification of products and services. We believe such marks and names are valuable and material to our marketing efforts.

Employees

As of December 31, 2015, we had approximately 21,000 employees. Our employee base is multicultural and reflects the diverse membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Available Information

Molina Healthcare, Inc. is a C corporation under Delaware law incorporated in 2002. Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

You can access our website at *www.molinahealthcare.com* to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors

committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Executive Officers of the Registrant

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
J. Mario Molina, M.D.	57	President and Chief Executive Officer
John C. Molina, J.D.	51	Chief Financial Officer
Terry P. Bayer	65	Chief Operating Officer
Joseph W. White	57	Chief Accounting Officer
Jeff D. Barlow	53	Chief Legal Officer and Corporate Secretary

Dr. Molina 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 of Directors since 1996. Dr. Molina is the brother of John C. Molina.

Mr. Molina has served as Chief Financial Officer since 1995. He also has served as a member of the Board of Directors since 1994. Mr. Molina is the brother of Dr. J. Mario Molina.

Ms. Bayer has served as Chief Operating Officer since 2005.

Mr. White has served as Chief Accounting Officer since 2007.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010.

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 U.S. Securities Exchange Commission, or 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 Segment

Numerous risks associated with the Affordable Care Act and its implementation, and changes to health care regulatory laws, 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 (collectively, the Affordable Care Act, or ACA). The ACA enacted comprehensive changes to the U.S. health care system, elements of which have been phased in at various stages over the past several years. The most significant changes effected by the ACA were implemented as of January 1, 2014. There are a multitude of risks associated with the scope of change in the health care system represented by the ACA, including, but not limited to, the following:

- *Risks associated with the duals expansion*. Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for the nearly 50 million elderly and under-65 disabled beneficiaries in 2012. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered coverage beginning in the second quarter of 2015. At December 31, 2015, our membership included approximately 51,000 integrated MMP members.

  There are numerous risks associated with the initial implementation of a new program, with a health plan's expansion into a new service area, and with the provision of medical services to a new population which has not previously been

in managed care. One such risk is the development of actuarially sound rates. Because there is limited historical information on which to develop rates, certain assumptions are required to be made which may subsequently prove to have been inaccurate. Rates of utilization could be significantly higher than had been projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, because of our lack of actuarial experience for that program, region, or population, our reserve levels may be set at an inadequate level. For instance, these problems arose at our Texas health plan in 2012, leading to extremely elevated medical care costs and substantial losses at the health plan. All of these risks are present in the implementation of the duals demonstration programs. In the event these risks materialize at one or more of our health plans, the negative results of the health plan or plans could adversely affect our business, financial condition, cash flows, or results of operations.

- *Risks associated with Medicaid expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have participated in Medicaid expansion. At December 31, 2015, our membership included approximately 557,000 Medicaid expansion members, or 16% of total membership. The new enrollees in our health plans represent a population that is different from the population of Medicaid enrollees we have historically managed. All of the risk factors described above with regard to the duals demonstration programs apply equally to Medicaid expansion.
- *Risks associated with health insurance marketplaces*. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois, Puerto Rico and South Carolina. At December 31, 2015, our membership included approximately 205,000 Marketplace members, with approximately 133,000, or 65%, of those members in Florida. All of the risk factors described above with regard to the duals demonstration programs apply equally to our participation in the insurance marketplaces.
- *Risk associated with implementing regulations*. There are many parts of the ACA that require further guidance in the form of regulations. Due to the breadth and complexity of the ACA, the lack of implementing regulations and interpretive guidance, and the phased nature of the ACA's implementation, the overall impact of the ACA on our business and on the health industry in general over the coming years is difficult to predict and not yet fully known, and implementing regulations could contain provisions that have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Changes to health care regulatory laws under the ACA, including the recently proposed Medicaid managed care rule, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The health care regulatory law landscape is constantly changing. For example, on May 26, 2015, CMS posted a new proposed rule to the Federal Register regarding Medicaid programs and CHIP, Medicaid managed care, CHIP delivered in managed care, Medicaid and CHIP comprehensive quality strategies, and revisions related to third party liability that, if implemented, would, among other things, impose a medical loss ratio of 85% for Medicaid and CHIP programs, establish a Medicaid managed care quality rating system like the five-star system for Medicare Advantage plans, and expand health plans' responsibilities in program integrity efforts. It is difficult to predict what final rules may be adopted and implemented by CMS, and if the final rule would result in any 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 net of premium tax, 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, continuing operations of 89.1%, for the year ended December 31, 2015 had been one percentage point higher, or 90.1%, our net income from continuing operations for the year ended December 31, 2015 would have been approximately $1.08 per diluted share rather than our actual income from continuing operations of $2.58 per diluted share, a decrease of approximately 58%.

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 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.

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 remain elevated at the same time that state budgets are suffering from significant fiscal strain. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it is a prime target for cost-containment efforts. The states in which we operate our health plans regularly face significant budgetary pressures. These budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. 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.

We are unable to determine how any future congressional spending cuts will affect Medicare and Medicaid reimbursement. There likely will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The Commonwealth of Puerto Rico may become unable to pay the premiums of our Puerto Rico health plan.

The government of Puerto Rico currently faces major fiscal and liquidity challenges. The government recently warned that it may lack sufficient resources to fund all necessary governmental programs and services as well as meet debt service obligations for fiscal year 2016. The extreme financial difficulties faced by the Commonwealth may make it impossible for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2015, our Puerto Rico health plan served approximately 348,000 members, and had recognized premium revenue of approximately $192 million in the fourth quarter of 2015, or approximately $64 million per month. It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility. Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract 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" (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 duals, Medicaid expansion members, or aged, blind or disabled Medicaid members, is impacted by the more limited experience we have had with those populations.

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 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.

Large-scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.

Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions. For example, natural disasters, such as a major earthquake in Los Angeles or Cascadia, or a major hurricane in Florida or South Carolina, could have a significant impact on the health of a large number of our covered members. Other conditions that could impact our members include an influenza epidemic, or newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikungunya virus, conditions for which vaccines may not exist, are not effective, or have not been widely administered. In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction. All of these conditions, and others, could have a significant impact on the health of the population of wide-spread areas. We seek to set our IBNP reserves appropriately to account for anticipatable spikes in utilization, such as for the flu season. However, if one of our health plan states were to experience a large-scale natural disaster, a viral epidemic or pandemic, a significant terrorism attack, or some other large-scale event affecting the health of a large number of our members, our covered medical expenses in that state would rise, which could have a material adverse effect on our business, cash flows, financial condition, and results of operations, or, in the event of extreme circumstances, could threaten our viability.

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. In the event the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states, and our premium revenues could be materially reduced as a result. 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. 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.

If we sustain a cyber-attack or suffer privacy or data security breaches that disrupt our operations or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information, vandalize our systems, create system disruptions, or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our systems are also susceptible to human error. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world, we may be unable to proactively address these techniques or to implement adequate preventive measures. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, acts of malicious insiders, or other similar events that could negatively affect our systems and our and our members' data. The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. While we currently expend significant resources and have implemented solutions, processes and procedures to protect against cyber-attacks and security breaches, we may need to expend significant additional resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

In 2014, Gilead's pricing of the hepatitis C drug, Sovaldi, at $84,000 per standard course of therapy received major attention as a health care policy and public policy matter. Because of the relatively high incidence of hepatitis C throughout the nation, particularly in the Medicaid population, the pricing of specialty drugs for the treatment of hepatitis C represents a major public health and public financing problem. In the case of Sovaldi, because of its advent on the health care market in early 2014, the cost of the drug was generally not factored into our 2014 capitation rates, thus threatening to undermine the actuarial soundness of those rates. New high priced specialty drugs and generic drugs are expected to enter the health care market in 2015. In addition, 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, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. We will seek to work with state Medicaid agencies to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals. In the event we are required to bear the high costs of new specialty drugs or generic drugs without an appropriate rate adjustment or other reimbursement mechanism, or if new regulations or mandates affect our pharmaceutical costs, our business, financial condition, cash flows, or results of operations could be adversely affected.

States may not adequately compensate us for the value of drug rebates that were previously earned by us but that are now collectible by the states.

The 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 have renegotiated or discontinued 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 continue to remain at levels that are much lower than prior to ACA implementation. There are provisions in the ACA that require rates paid to Medicaid managed care plans 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 11 state health plans, and commenced operations with our Puerto Rico health plan in April 2015. If we are unable to continue to operate in any of those jurisdictions, or if our current operations in any portion of the jurisdictions we are in are significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of jurisdictions 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, an unexpected increase in utilization, general economic conditions, and similar factors in those jurisdictions. Our inability to continue to operate in any of the jurisdictions 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.

A large portion of our premium revenues are subject to risks related to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost-plus and performance-based reimbursement programs.

A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost floors and corridors, administrative cost and profit ceilings, cost-plus reimbursement, premium stabilization programs, and profit-sharing arrangements. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are potentially subject to differing interpretations by ourselves and the relevant government agency with whom we contract. In the event the applicable government agency disagrees with our interpretation or implementation of a particular contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to the government agency. Any interpretation of these contract provisions at variance with our interpretation and implementation of the provision, or that is inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. In the event we are unsuccessful in achieving the stated performance

measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

Failure to attain profitability in any new start-up operations, including in our new Puerto Rico health plan, 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 are 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 or commonwealth 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 or commonwealth, 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 or commonwealth will also result in 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 commonwealth, or expanding a health plan in an existing state or commonwealth could have a material adverse effect 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 have a material adverse effect 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. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Centene's acquisition of Health Net could affect the Los Angeles county subcontract of our California health plan.

Our California health plan operates in Los Angeles County, California as a subcontractor to Health Net, which holds a direct Medi-Cal contract with the state of California. Health Net has entered into a merger agreement with Centene Corporation, with the merger expected to close in early 2016. We currently do not expect there to be any material change to our Los Angeles county subcontract in connection with Centene's acquisition of Health Net. However, if Centene seeks to modify our subcontract or otherwise refuses to perform under the contract, our business, financial condition, cash flows, or results of operations may be adversely affected.

Reductions in Medicare payments could reduce our earnings potential for our Medicare Advantage plans and our duals demonstration programs.

The Sequestration Transparency Act of 2012 included a 2% reduction of payments from CMS to our Medicare Advantage plans beginning April 1, 2013. Medicare Advantage plans will continue to be affected until Congress lifts the sequestration mandated under the Sequestration Transparency Act of 2012. Such reduction in our Medicare payments may have an adverse effect on our earnings potential for our Medicare Advantage plans and our duals demonstration programs. In addition, reductions to provider reimbursement rates associated with sequestration may adversely impact our relations with the impacted providers.

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 at all, or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years, or that we will not complete acquisitions that turn out to be unfavorable. 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. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

In addition, we may be unable to successfully identify, consummate, and integrate future acquisitions, including integrating the acquired businesses on our information technology platform, or to implement our operations strategy in order to operate acquired businesses profitably. Furthermore, we may incur significant transaction expenses in connection with a potential acquisition which may or may not be consummated. These expenses could impact our selling, general and administrative expense ratio.

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 and regulations, 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 are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could 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 make or have made related payments to providers and are unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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 federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. 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. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, improper marketing, and the violation of patient privacy rights. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services (HHS), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *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. We are currently defending one *qui tam* action where the federal government has declined to intervene: *United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al*. Other qui tam actions may have been filed against us of which we are presently unaware, or other qui tam actions may be filed against us in the future. In the event we are subject to liability under these or other *qui tam* actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

HHS released rules pursuant to the Health Insurance Portability and Accountability Act, or HIPAA, which mandate the use of standard formats in electronic health care transactions. HHS also published rules requiring the use of standardized code sets and unique identifiers for providers. These new standardized code sets, known as ICD-10, require substantial investments from health care organizations, including us. We implemented ICD-10 effective as of October 1, 2015. Use of the ICD-10 code sets require significant administrative changes and may result in errors and otherwise negatively impact our service levels. In addition, 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 health plans. In those cases, there is no pre-established understanding between the provider and our health 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 health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, results of operations, and cash flows.

The insolvency of a delegated provider could obligate us to pay its 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 when the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which we do not participate. These actions and the resulting negative publicity could become associated with or imputed to us, regardless of our 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 we do not 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. We received $125 million in dividends from our regulated health plan subsidiaries during 2015. We did not receive any dividends from our regulated health plan subsidiaries during 2014, because significant growth across all of our health plans necessitated that the plans retain their cash to meet increasing net worth requirements. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2015 and 2014, without approval of the regulatory authorities, were approximately $121 million and $96 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 the senior notes or the revolving credit facility.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our use and disclosure of individually identifiable information, including health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations, including HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of individually identifiable information, including protected health information, or PHI. HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities for compliance with the HIPAA Privacy and Security Standards. Investigations of violations that indicate willful neglect, for which penalties are now mandatory, are statutorily required. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the civil monetary penalty fine paid by the violator.

HIPAA further requires covered entities to notify affected individuals "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach" if their unsecured PHI is subject to an unauthorized access, use, or disclosure. If a breach affects 500 patients or more, it must be reported to HHS and local media without unreasonable delay, and HHS will post the name of the breaching entity on its public website. If a breach affects fewer than 500 individuals, the covered entity must log it and notify HHS at least annually. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal

penalties, divert management's time and energy, 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 Segment

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 provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida. If we are unable to continue to operate in any of those six jurisdiction, or if our current operations in any of those jurisdictions are 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, 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. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. 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 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 business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business could 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 a material 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 and damage our reputation.

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 or retain existing MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance of contracts, including those with respect to 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 revenues and profitability.

Our business may be adversely affected by the transition from traditional fee-for-service to Medicaid managed care.

In order to save on costs, a number of state Medicaid programs are expected to pursue the transition from a fee-for-service focus of their Medicaid programs to a Medicaid managed care focus. A shift in Medicaid payment models from fee-for-service to managed care will require a concomitant shift in the focus of MMIS. In connection with such a transition, MMIS must also make a transition from a system built around claims adjudication to one that performs analytics and can be used to manage Medicaid population health outcomes. In the event Molina Medicaid Solutions is unable to accomplish this transition, our business, financial condition, cash flows, or results of operations may be adversely affected.

Risks Related to our General Business Operations

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

We expect to continue to grow our membership and to expand into other markets through acquisitions and other opportunities. Continued rapid growth could place a significant strain on our management and on our other 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, or 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, health care regulatory law-based litigation, 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. As an 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 our clinics or caused by one of our employees. We maintain medical malpractice insurance for our clinics in an amount which we believe to be 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 are unsuccessful or without merit, we may 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 business, financial condition, cash flows, or results of operations.

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, results of operations, and cash flows, 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 identify 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 New York Stock Exchange, 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.

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 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 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, such as the health care federal excise tax discussed above. 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 could have a material 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. It is critical that we recruit, manage, enable, and retain talent to successfully execute our strategic objections which requires aligned policies, a positive work environment, and a robust succession and talent development process. Further, particularly in light of the changing health care environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. If we are unsuccessful in recruiting, retaining, managing, and enabling such personnel and are unable to meet upcoming challenges and opportunities, our operations could be negatively impacted.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not

fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could adversely impact our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2015, goodwill was $519 million, and intangible assets, net, were $122 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives.

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable.

The determination of the value of goodwill, and intangible assets, net, requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

We are subject to the risks of owning and leasing real property.

We are a tenant under numerous leases in multiple states, including a 25-year lease of an approximately 460,000 square foot office building housing our principal executive offices in Long Beach, California. We also own a 186,000 square-foot office building in Troy, Michigan, a 26,700 square-foot data center in Albuquerque, New Mexico, a 24,000 square-foot community clinic in Pomona, California, and 40 properties in Pennsylvania, which are primarily residential housing facilities. Accordingly, we are subject to all of the risks generally associated with leasing and owning real estate, which include, but are not limited to: the possibility of environmental contamination, the costs associated with fixing any environmental problems and the risk of damages resulting from such contamination; adverse changes in the value of the property due to interest rate changes, changes in the neighborhood in which the property is located, or other factors; ongoing maintenance expenses and costs of improvements; the possible need for structural improvements in order to comply with changes in zoning, seismic, disability act, or other requirements; inability to renew or enter into leases for space not utilized by us on commercially acceptable terms or at all; and possible disputes with neighboring owners or other individuals and entities.

Our substantial indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of any variable rate debt, and prevent us from meeting our our outstanding indebtedness.

We have a significant amount of indebtedness. As of December 31, 2015, our total indebtedness was approximately $1,609 million, including lease financing obligations. As of December 31, 2015, we also had $244 million available for borrowing under our revolving credit facility. Our substantial indebtedness could have significant consequences, including:

- increasing our vulnerability to adverse economic, industry, or competitive developments;
- requiring a substantial portion of our cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund operations, make capital expenditures, and pursue future business opportunities;
- exposing us to the risk of increased interest rates to the extent of any future borrowings, including borrowings under the revolving credit facility, at variable rates of interest;
- making it more difficult for us to satisfy our obligations with respect to our indebtedness, including the revolving credit facility and our outstanding senior notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indenture governing our outstanding senior notes and the agreements governing such other indebtedness;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product and service development, debt service requirements, acquisitions, and general corporate or other purposes; and

- limiting our flexibility in planning for, or reacting to, changes in our business or market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged and who, therefore, may be able to take advantage of opportunities that our substantial indebtedness may prevent us from exploiting.

Despite our high indebtedness level, we and our subsidiaries are able to incur substantial additional amounts of debt, including secured debt, which could further exacerbate the risks associated with our substantial indebtedness.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. Although the indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances, the amount of indebtedness that could be incurred in compliance with these restrictions could be substantial. As of December 31, 2015, we had approximately $244 million available for additional borrowing under our revolving credit facility. In addition, the indentures governing our outstanding senior notes and the credit agreement governing our revolving credit facility do not prevent us from incurring obligations that do not constitute prohibited indebtedness thereunder. If new debt is added to our and our subsidiaries' existing debt levels, the related risks that we now face would increase.

The terms of our debt impose, and will impose, restrictions on us that may affect our ability to successfully operate our business and our ability to make payments on our outstanding senior notes.

The indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain various covenants that could materially and adversely affect our ability to finance our future operations or capital needs and to engage in other business activities that may be in our best interest. These covenants limit our ability to, among other things:

- incur additional indebtedness or issue certain preferred equity;
- pay dividends on, repurchase, or make distributions in respect of our capital stock, prepay, redeem, or repurchase certain debt or make other restricted payments;
- make certain investments;
- create certain liens;
- sell assets, including capital stock of restricted subsidiaries;
- enter into agreements restricting our restricted subsidiaries' ability to pay dividends to us;
- consolidate, merge, sell, or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates; and
- designate our restricted subsidiaries as unrestricted subsidiaries.

All of these covenants may restrict our ability to expand or to pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, such as prevailing economic conditions and changes in regulations, and if such events occur, we cannot be sure that we will be able to comply. A breach of these covenants could result in a default under the indentures for our outstanding senior notes and/or the credit agreement governing the revolving credit facility including, as a result of cross default provisions and, in the case of the revolving credit facility permit the lenders to cease making loans to us. If there were an event of default under the indentures governing our outstanding senior notes and/or the credit agreement governing the revolving credit facility, holders of such defaulted debt could cause all amounts borrowed under these instruments to be due and payable immediately. Our assets or cash flow may not be sufficient to repay borrowings under our outstanding debt instruments in the event of a default thereunder.

In addition, the restrictive covenants in the credit agreement governing the revolving credit facility require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests will depend on our ongoing financial and operating performance, which, in turn, will be subject to economic conditions and to financial, market, and competitive factors, many of which are beyond our control.

If our operating performance declines, we may be required to obtain waivers from the lenders under the revolving credit facility, from the holders of our outstanding senior notes or from the holders of other obligations, to avoid defaults thereunder. If we are not able to obtain such waivers, our creditors could exercise their rights upon default, and we could be forced into bankruptcy or liquidation.

We may not have the funds necessary to pay the amounts due upon conversion or required repurchase of our outstanding notes, and our indebtedness may contain limitations on our ability to pay the amounts due upon conversion or required repurchase.

In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Notes. In September 2014, we issued $301.6 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Notes. As of December 31, 2015, the aggregate outstanding principal amount of our 1.125% Notes and our 1.625% Notes was $550 million and $302 million, respectively. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The 1.125% Notes met the stock price trigger in the quarter ended December 31, 2015, and are convertible to cash through at least March 31, 2016. Because the 1.125% Notes may be converted into cash within 12 months, the $448 million carrying amount is reported in current portion of long-term debt as of December 31, 2015. In addition, holders of our 1.625% Notes may convert their notes into cash during any calendar quarter (and only during such calendar quarter) if the last reported sales price of our common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on February 23, 2016 was $62.28 per share. As of December 31, 2015, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash. As of December 31, 2015, we had sufficient available cash, combined with borrowing capacity available under our revolving credit facility, to fund such conversions.

In addition, in the event of a change in control or the termination in trading of our stock, each holder of our 1.125% Notes and our 1.625% Notes would have the right to require us to purchase some or all of their notes at a purchase price in cash equal to 100% of the principal amount of the notes, plus any accrued and unpaid interest.

In the event of conversions or required repurchases, we may not have enough available cash or be able to obtain financing at the time we are required to comply with our conversion or repurchase obligations. In addition, our ability to comply with these obligations may be limited by law, by regulatory authority, or by agreements governing our future indebtedness. The indentures for the 1.125% Notes and the 1.625% Notes provide that it would be an event of default if we do not make the cash payments due upon conversion or required repurchase of the notes. The occurrence of an event of default under one or both of these indentures may also constitute an event of default under our revolving credit facility and under our other indebtedness we may have outstanding at such time. Any such default could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Our borrowings under the revolving credit facility are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness could increase even though the amount borrowed remained the same, and our net income could decrease. The applicable margin with respect to the loan under the revolving credit facility is a percentage per annum equal to a reference rate plus the applicable margin. In order to manage our exposure to interest rate risk, in the future we may enter into derivative financial instruments, typically interest rate swaps and caps, involving the exchange of floating for fixed rate interest payments. If we are unable to enter into interest rate swaps, it may adversely affect our cash flow and may impact our ability to make required principal and interest payments on our indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments, including the revolving credit facility, and the indentures governing our outstanding senior notes, may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which would harm our ability to incur additional indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies may increase our future borrowing costs and reduce our access to capital.

Our debt currently has a non-investment grade rating, and there can be no assurance that any rating assigned by the rating agencies to our debt or our corporate rating will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, future circumstances relating to the basis of the rating, such as adverse changes, so warrant. A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies would likely increase our future borrowing costs and reduce our access to capital, which could have a materially adverse impact on our financial condition and results of operations.

Risks Related to Our Common Stock

Delaware law and our charter documents may impede or discourage a takeover, which could cause the market price of our common stock to decline.

We are a Delaware corporation, and the anti-takeover provisions of Delaware law impose various impediments to the ability of a third party to acquire control of us, even if a change in control would be beneficial to our existing stockholders. In addition, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock and certain provisions of Delaware law and our certificate of incorporation and bylaws could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock and the value of our convertible senior notes.

Members of the Molina family own a significant amount 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 owned or were entitled to receive upon certain events approximately 26% of our capital stock as of December 31, 2015. 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 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, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our 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 150,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2015, approximately 56,000,000 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 us, 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.

Item 1B: Unresolved Staff Comments

None.

Item 2: Properties

As of December 31, 2015, the Health Plans segment leased a total of 84 facilities, the Molina Medicaid Solutions segment leased a total of 12 facilities and the Other segment leased a total of 215 facilities. We own a 186,000 square-foot office building in Troy, Michigan and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. We own a 26,700 square-foot data center in Albuquerque, New Mexico and 40 properties in Pennsylvania, which are primarily residential housing facilities, under our Other segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operations growth prospects to determine if additional space is required, and where it would be best located.

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. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana v. Molina Medicaid Solutions et al. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. The petitioner seeks actual damages to be proved at trial, plus interest. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The relator seeks treble damages in the amount of $3 billion, plus interest and penalties. The Department of Justice has declined to intervene. The District Court dismissed this action as to Molina without leave to amend as to some allegations and with leave to amend as to other allegations. On October 22, 2015, the Relator filed a third amended complaint. We believe that we have several meritorious defenses to the claims of the Relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Item 4: Mine Safety Disclosures

None.

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 23, 2016, there were approximately 120 holders of record of our common stock. The high and low intra-day sales prices of our common stock for specified periods are set forth below:

	High	Low
2015		
First Quarter	$ 67.58	$ 49.37
Second Quarter	$ 73.98	$ 57.35
Third Quarter	$ 82.37	$ 65.72
Fourth Quarter	$ 70.82	$ 55.49
2014		
First Quarter	$ 39.21	$ 32.41
Second Quarter	$ 46.17	$ 32.86
Third Quarter	$ 48.03	$ 39.23
Fourth Quarter	$ 54.57	$ 40.79

Dividends

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business growth. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend 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. Additionally, the indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain various covenants that limit our ability to pay dividends on our common stock.

Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, in "Liquidity and Capital Resources," under the subheading "Regulatory Capital and Dividend Restrictions."

Unregistered Issuances of Equity Securities

None.

Stock Repurchase Programs

Securities Repurchases and Repurchase Programs. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This newly authorized repurchase program extends through December 31, 2016.

Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2015, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (1)	Average Price Paid per Share (1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (2)	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs (2)
October 1 — October 31	94	$ 66.79	—	$ 50,000,000
November 1 — November 30	576	$ 62.00	—	$ 50,000,000
December 1 — December 31	104,222	$ 59.15	—	$ 50,000,000
	104,892	$ 59.17	—	

(1) During the quarter we withheld 104,892 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

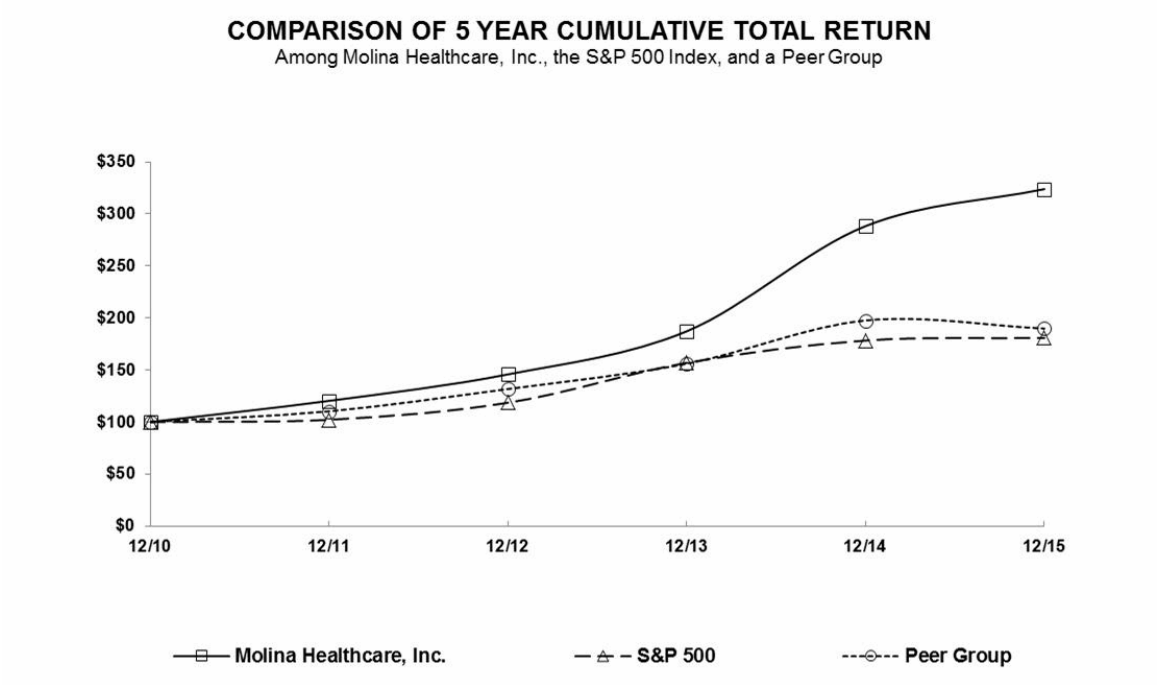
(2) Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. This repurchase program expired December 31, 2015.

STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the SEC (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, 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 (S&P 500) and a peer group index for the five-year period from December 31, 2010 to December 31, 2015. The comparison assumes $100 was invested on December 31, 2010, in the Company's common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.

The peer group index consists of Brookdale Senior Living, Inc. (BKD), Catamaran Corporation (CTRX), Centene Corporation (CNC), Community Health Systems, Inc. (CYH), DaVita HealthCare Partners, Inc. (DVA), Health Net, Inc. (HNT), Kindred Healthcare, Inc. (KND), Laboratory Corporation of America Holdings (LH), Life Point Hospitals, Inc. (LPNT), Magellan Health, Inc. (MGLN), Omnicare, Inc. (OCR), Quest Diagnostics, Inc. (DGX), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).



	December 31,					
Name	2010	2011	2012	2013	2014	2015
Molina Healthcare, Inc.	$ 100.00	$ 120.27	$ 145.75	$ 187.16	$ 288.31	$ 323.86
S&P 500	100.00	102.11	118.45	156.82	178.29	180.75
Peer Group	100.00	110.25	131.73	155.98	197.59	189.81

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, Continuing Operations") for the five years ended December 31, 2015 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 dollar amounts are presented in millions, except per-share data. The data under the caption "Operating Statistics, Continuing Operations" has not been audited.

	Year Ended December 31,				
	2015 (1)	2014	2013	2012	2011
Statements of Income Data:					
Revenue:					
Premium revenue	$ 13,241	$ 9,023	$ 6,179	$ 5,544	$ 4,212
Service revenue (1)	253	210	205	188	160
Premium tax revenue	397	294	172	159	155
Health insurer fee revenue	264	120	—	—	—
Investment income	18	8	7	5	5
Other revenue	5	12	26	18	8
Total revenue	14,178	9,667	6,589	5,914	4,540
Operating expenses:					
Medical care costs	11,794	8,076	5,380	4,991	3,664
Cost of service revenue (1)	193	157	161	141	144
General and administrative expenses	1,146	765	666	519	393
Premium tax expenses	397	294	172	159	155
Health insurer fee expenses	157	89	—	—	—
Depreciation and amortization	104	93	73	63	48
Total operating expenses	13,791	9,474	6,452	5,873	4,404
Operating income	387	193	137	41	136
Other expenses, net:					
Interest expense	66	57	52	17	16
Other (income) expense, net	(1)	1	4	1	—
Total other expenses, net	65	58	56	18	16
Income from continuing operations before income taxes	322	135	81	23	120
Income tax expense	179	73	36	10	43
Income from continuing operations	143	62	45	13	77
Income (loss) from discontinued operations, net of tax expense (benefit) (2)	—	—	8	(3)	(56)
Net income	$ 143	$ 62	$ 53	$ 10	$ 21
Basic net income per share: (3)					
Income from continuing operations	$ 2.75	$ 1.34	$ 0.98	$ 0.28	$ 1.69
(Loss) income from discontinued operations	—	(0.01)	0.18	(0.07)	(1.24)
Basic net income per share	$ 2.75	$ 1.33	$ 1.16	$ 0.21	$ 0.45
Diluted net income per share: (3)					
Income from continuing operations	$ 2.58	$ 1.30	$ 0.96	$ 0.27	$ 1.67
(Loss) income from discontinued operations	—	(0.01)	0.17	(0.06)	(1.22)
Diluted net income per share	$ 2.58	$ 1.29	$ 1.13	$ 0.21	$ 0.45
Weighted average shares outstanding:					
Basic	52	47	46	46	46
Diluted	56	48	47	47	46
Operating Statistics, Continuing Operations: (3)					
Medical care ratio (4)	89.1%	89.5%	87.1%	90.0%	87.0%
General and administrative expense ratio (5)	8.1%	7.9%	10.1%	8.8%	8.7%
Net profit margin(5)	1.0%	0.6%	0.7%	0.2%	1.7%
Members (6)	3,533,000	2,623,000	1,931,000	1,797,000	1,618,000

	December 31,				
	2015	2014	2013	2012	2011
Balance Sheet Data:					
Cash and cash equivalents	$ 2,329	$ 1,539	$ 936	$ 796	$ 494
Total assets [7]	6,576	4,435	2,988	1,901	1,631
Long-term debt, including current maturities [7] [8]	1,609	887	770	261	216
Total liabilities [7]	5,019	3,425	2,095	1,119	876
Stockholders' equity	1,557	1,010	893	782	755

(1) Service revenue and cost of service revenue include revenue and costs generated by our Pathways subsidiary, which was acquired on November 1, 2015.

(2) Income (loss) from discontinued operations is presented net of income tax expense (benefit), which was insignificant in 2015 and 2014, and $(10), and $(1), and $1, in 2013, 2012 and 2011, respectively.

(3) Source data for calculations in thousands.

(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, utilization of medical services, our ability to effectively manage costs, contract changes, and changes in accounting estimates related to incurred but not paid claims. See Item 7 in this Form 10-K, "Management's Discussion and Analysis of Financial Condition and Results of Operations," for further discussion.

(5) Computed as a percentage of total revenue.

(6) Number of members at end of period.

(7) We have reclassified certain amounts in prior periods to conform to the 2015 presentation. Specifically, deferred issuance costs relating to our senior notes are now reported as a direct deduction of the applicable debt liabilities. Additionally, aggregate deferred income taxes are now reported as non-current. Both reclassifications are a result of recently adopted accounting pronouncements. See Item 8 in this Form 10-K, "Financial Statements and Supplementary Data," for further discussion.

(8) Includes senior notes, lease financing obligations, and other long-term debt.

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 Items 6 and 8 of this Form 10-K, Selected Financial Data, and Financial Statements and Supplementary Data, respectively. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth in Part I, Item 1A of this Form 10-K, Risk Factors.

Overview

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of December 31, 2015, these health plans served over 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

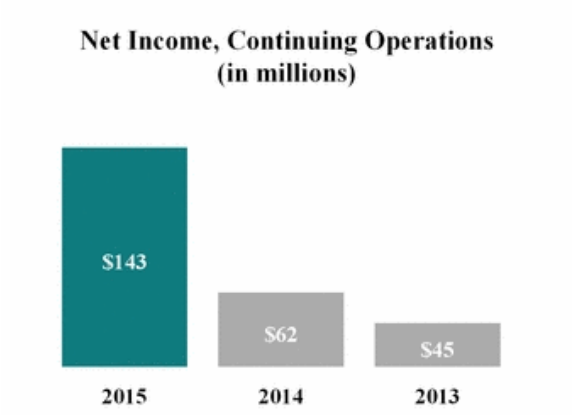
Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

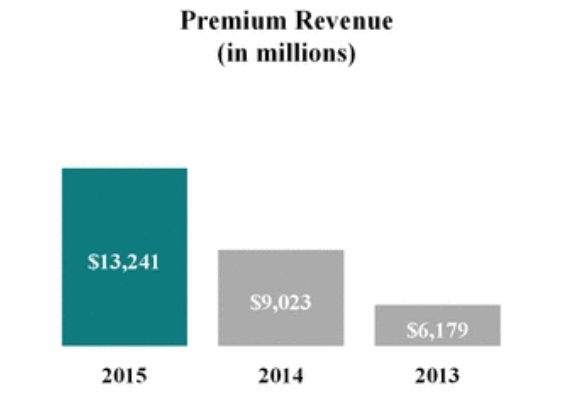
Refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," for a comprehensive description of our Health Plans and Molina Medicaid Solutions revenues and costs, and how we recognize them.We report revenue and costs attributable to Pathways as service revenue and cost of service revenue, respectively.

Beginning in 2013, after our Medicaid contract with the state of Missouri expired, we have reported the results relating to the Missouri health plan as discontinued operations for all periods presented. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise noted.

Fiscal Year 2015 Financial Highlights

- Earnings per diluted share nearly doubled in 2015 when compared with 2014, while net income more than doubled. Substantial increases in revenue, along with improved operating efficiency, were responsible for our improved performance. Our after-tax margin increased to 1.0% in 2015 from 0.6% in 2014.
- Strong enrollment growth across all of our programs, combined with a 5% increase in premium revenue per member, generated over $4 billion, or 47%, more premium revenue in 2015 compared with 2014.
- Medical care costs as a percentage of premium revenue (the "medical care ratio") decreased to 89.1% in 2015, from 89.5% in 2014.
- General and administrative expenses as a percentage of revenue (the "general and administrative expense ratio") increased slightly to 8.1% in 2015, versus 7.9% in 2014, primarily as a result of dramatic growth in our Marketplace membership. Excluding Marketplace broker and exchange fees from both years, the general and administrative expense ratio decreased to 7.5% in 2015 from 7.9% in 2014.
- Debt and equity financing transactions generated net cash of $1,062 million.





Market Updates—Health Plans

Medicare-Medicaid Plans. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered coverage beginning in the second quarter of 2015. At December 31, 2015, our membership included approximately 51,000 integrated MMP members.

Florida. On November 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to operation of the Medicaid business, of Integral Health Plan, Inc.

On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc.

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. We assumed approximately 58,000 Medicaid members in this acquisition.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. We assumed approximately 21,000 Medicaid members in this acquisition.

On November 30, 2015, we announced that our Illinois health plan entered into an agreement to assume the membership and certain Medicaid assets of Better Health Network, LLC (Better Health). As of November 30, 2015, Better Health served approximately 40,000 members in the Medicaid Family Health program in Cook County. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the first half of 2016.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. We assumed approximately 81,000 Medicaid and MIChild members in this acquisition.

In October 2015, the Michigan Department of Health and Human Services announced that Molina Healthcare of Michigan was recommended to serve the state's Medicaid members under Michigan's Comprehensive Health Plan, which commenced on January 1, 2016. The new contract has a five-year term with three one-year extensions, and covers Regions 2 through 6, and 8 through 10 of the state, representing an expansion into 18 additional counties compared with the previous Michigan Medicaid contract.

On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc.

Puerto Rico. Effective April 1, 2015, our Puerto Rico health plan served its first members. As of December 31, 2015, our Puerto Rico plan enrollment amounted to approximately 348,000 members.

Washington. In November 2015, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to negotiate and enter into managed care contracts for the Southwest region of the state's Apple Health Fully Integrated Managed Care Program. The start date is scheduled for April 1, 2016.

On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid membership and certain Medicaid assets of Columbia United Providers, Inc. We assumed approximately 57,000 Medicaid members in this acquisition.

Market Update—Molina Medicaid Solutions

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate that state's new Medicaid management information system (MMIS). The new contract was effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's incumbent MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Market Update—Other

Pathways. On November 1, 2015, we acquired all of the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia.

Financial Performance Summary

The following table summarizes our financial and operating performance from continuing operations for the years ended December 31, 2015, 2014, and 2013. All dollar amounts are presented in millions, except per-share data.

	Year Ended December 31,			Year Ended December 31,		
	2015	2014	% Change	2014	2013	% Change
Revenue:						
Premium revenue	$ 13,241	$ 9,023	46.7 %	$ 9,023	$ 6,179	46.0 %
Service revenue	253	210	20.5	210	205	2.4
Premium tax revenue	397	294	35.0	294	172	70.9
Health insurer fee revenue	264	120	120.0	120	—	—
Investment income	18	8	125.0	8	7	14.3
Other revenue	5	12	(58.3)	12	26	(53.8)
Total revenue	14,178	9,667	46.7	9,667	6,589	46.7
Operating expenses:						
Medical care costs	11,794	8,076	46.0	8,076	5,380	50.1
Cost of service revenue	193	157	22.9	157	161	(2.5)
General and administrative expenses	1,146	765	49.8	765	666	14.9
Premium tax expenses	397	294	35.0	294	172	70.9
Health insurer fee expenses	157	89	76.4	89	—	—
Depreciation and amortization	104	93	11.8	93	73	27.4
Total operating expenses	13,791	9,474	45.6	9,474	6,452	46.8
Operating income	387	193	100.5	193	137	40.9
Other expenses, net:						
Interest expense	66	57	15.8	57	52	9.6
Other (income) expense, net	(1)	1	(200.0)	1	4	(75.0)
Total other expenses, net	65	58	12.1	58	56	3.6
Income from continuing operations before income tax expense	322	135	138.5	135	81	66.7
Income tax expense	179	73	145.2	73	36	102.8
Income from continuing operations	$ 143	$ 62	130.6 %	$ 62	$ 45	37.8 %
Diluted net income per share, continuing operations (1)	$ 2.58	$ 1.30	98.5 %	$ 1.30	$ 0.96	35.4 %
Diluted weighted average shares outstanding	56	48	16.7 %	48	47	2.1 %
Non-GAAP Measures: (2)						
Adjusted net income per share, continuing operations (1)(3)	$ 3.11	$ 1.93	61.1 %	$ 1.93	$ 1.55	24.5 %
EBITDA	$ 508	$ 305	66.6 %	$ 305	$ 225	35.6 %
Operating Statistics: (1)						
Medical care ratio (4)	89.1%	89.5%		89.5%	87.1%	
Service revenue ratio (5)	76.4%	74.6%		74.6%	79.0%	
General and administrative expense ratio (6)	8.1%	7.9%		7.9%	10.1%	
Premium tax ratio (4)	2.9%	3.2%		3.2%	2.7%	
Effective tax rate	55.5%	53.8%		53.8%	44.8%	
Net profit margin (6)	1.0%	0.6%		0.6%	0.7%	

(1) Source data for calculations of per-share amounts and ratios in thousands.
(2) See reconciliation of non-GAAP financial measures to U.S. GAAP below.
(3) Effective January 1, 2016, we will no longer exclude amortization of convertible notes and lease financing obligations from our presentation of adjusted net income and adjusted net income per share. We made this change because various capital transactions that we completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources of capital. We believe that this change will enhance the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors.
(4) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(5) Service revenue ratio represents cost of service revenue as a percentage of service revenue.
(6) Computed as a percentage of total revenue.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	As of December 31,		
	2015	2014	2013
Ending Membership by Health Plan:			
California	620,000	531,000	368,000
Florida	440,000	164,000	89,000
Illinois	98,000	100,000	4,000
Michigan	328,000	242,000	213,000
New Mexico	231,000	212,000	168,000
Ohio	327,000	347,000	255,000
Puerto Rico (1)	348,000	—	—
South Carolina (2)	99,000	118,000	—
Texas	260,000	245,000	252,000
Utah	102,000	83,000	86,000
Washington	582,000	497,000	403,000
Wisconsin	98,000	84,000	93,000
	3,533,000	2,623,000	1,931,000
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF), CHIP (3)	2,312,000	1,809,000	1,603,000
Medicaid Expansion (4)	557,000	385,000	—
Aged, Blind or Disabled (ABD)	366,000	347,000	289,000
Marketplace (4)	205,000	15,000	—
Medicare-Medicaid Plan (MMP) – Integrated (5)	51,000	18,000	—
Medicare Special Needs Plans (Medicare)	42,000	49,000	39,000
	3,533,000	2,623,000	1,931,000

(1) Our Puerto Rico health plan began serving members effective April 1, 2015.

(2) Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

(3) CHIP stands for Children's Health Insurance Program.

(4) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

(5) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures.

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA. The increases in EBITDA for both 2015 over 2014, and 2014 over 2013, were due primarily to increased net income and income taxes. The increases for both of these items are described below in Results of Operations, in the components of net income.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Net income	$ 143	$ 62	$ 53
Adjustments:			
Depreciation, and amortization of intangible assets and capitalized software	120	114	94
Interest expense	66	57	52
Income tax expense	179	72	26
EBITDA	$ 508	$ 305	$ 225

The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. The following tables reconcile net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations. The increases in adjusted net income and adjusted net income per diluted share for both 2015 over 2014, and 2014 over 2013, were due primarily to increased net income. Such increases are described below in Results of Operations, in the components of net income.

	Year Ended December 31,					
	2015		2014		2013	
	(In millions, except diluted per-share amounts)					
Net income, continuing operations	$ 143	$ 2.58	$ 62	$ 1.30	$ 45	$ 0.96
Adjustments, net of tax:						
Amortization of convertible senior notes and lease financing obligations	19	0.33	17	0.36	14	0.31
Amortization of intangible assets	11	0.20	13	0.27	13	0.28
Adjusted net income per diluted share, continuing operations (1)(2)	$ 173	$ 3.11	$ 92	$ 1.93	$ 72	$ 1.55

(1) Beginning in the first quarter of 2015, we revised the calculation of adjusted net income, continuing operations. We no longer subtract "depreciation, and amortization of capitalized software" and "share-based compensation" from net income, continuing operations to arrive at adjusted net income, continuing operations. We have made this change to better reflect how we evaluate financial performance, make financing and business decisions, and forecast and plans for future periods. All periods presented conform to this presentation.

(2) Effective January 1, 2016, we will no longer exclude amortization of convertible notes and lease financing obligations from our presentation of adjusted net income and adjusted net income per share. We made this change because various capital transactions that we completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources of capital. We believe that this change will enhance the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors.

Results of Operations, Continuing Operations

As described above, as of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015. The following table presents gross margin as the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the actual dollars earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. One of the key metrics used to assess the performance of the Health Plans segment is the medical care ratio; therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Health Plans:			
Premium revenue	$ 13,241	$ 9,023	$ 6,179
Less: medical care costs	11,794	8,076	5,380
Medical margin	$ 1,447	$ 947	$ 799
Molina Medicaid Solutions:			
Service revenue	$ 195	$ 210	$ 205
Less: cost of service revenue	140	157	161
Service margin	$ 55	$ 53	$ 44
Other:			
Service revenue	$ 58	$ —	$ —
Less: cost of service revenue	53	—	—
Service margin	$ 5	$ —	$ —

Health Plans Segment

Premium Revenue. 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, and, to a lesser degree, from Medicare contracts entered into with the Centers for Medicare and Medicaid Services (CMS), a federal government agency.

2015 Compared with 2014

In 2015, a 42% increase in membership and a 5% increase in revenue PMPM resulted in increased premium revenue of 47%, or over $4.2 billion, when compared with 2014.

Enrollment growth was primarily due to increased Medicaid expansion, Marketplace and integrated Medicare-Medicaid Plan (MMP) enrollment, and the start-up of the Puerto Rico health plan in April 2015.

2014 Compared with 2013

In 2014, premium revenue increased 46% over 2013, due to a 28% increase in membership, and an 18% increase in revenue PMPM.

Enrollment growth was primarily due to Medicaid expansion program membership added as a result of the Affordable Care Act, and membership added at our South Carolina and Illinois health plans. Higher PMPM premium revenue was primarily the result of the inclusion of long-term services and supports (LTSS) benefits in various Medicaid managed care programs in California, Florida, Illinois, New Mexico, and Ohio.

Premiums by Program. The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program, on a per-member per-month basis for the year ended December 31, 2015. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF, CHIP	$ 120.00	$ 280.00	$ 180.00
Medicaid Expansion	310.00	500.00	410.00
ABD	470.00	1,470.00	970.00
Marketplace	180.00	400.00	250.00
MMP – Integrated	1,170.00	3,220.00	2,030.00
Medicare	900.00	1,110.00	1,040.00

Medical Care Costs. 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 Estimates" below, and Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 11, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

2015 Compared with 2014

Our medical margin increased nearly 53% in 2015 over 2014, and our consolidated medical care ratio decreased to 89.1% in 2015 from 89.5% in 2014.

2014 Compared with 2013

Although medical margin increased nearly 20% in 2014 over 2013, our consolidated medical care ratio increased to 89.5% in 2014 from 87.1% in 2013.

The medical care ratio increased substantially in 2014 as a result of three developments:

- Much of our revenue growth has come from participation in Medicaid programs covering LTSS. Percentage profit margins for LTSS benefits are generally lower than percentage profit margins for acute medical benefits.
- Increases to our base premiums in recent years have not kept pace with medical cost trends.
- Lack of coordination in the design of profit caps and medical cost floors in some of our state Medicaid contracts is resulting in counterproductive outcomes. In some instances, givebacks due to profitable performance in one program cannot be offset against losses in other programs.

Medical Care Costs by Category. The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Year Ended December 31,								
	2015			2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 8,572	$ 218.35	72.7%	$ 5,673	$ 202.87	70.2%	$ 3,612	$ 160.43	67.1%
Pharmacy	1,610	41.01	13.7	1,273	45.54	15.8	935	41.54	17.4
Capitation	982	25.02	8.3	748	26.77	9.3	604	26.83	11.2
Direct delivery	128	3.26	1.1	96	3.44	1.2	48	2.14	0.9
Other	502	12.79	4.2	286	10.22	3.5	181	8.05	3.4
	$ 11,794	$ 300.43	100.0%	$ 8,076	$ 288.84	100.0%	$ 5,380	$ 238.99	100.0%

Financial Performance by Program. The following table presents the components of premium revenue and medical care costs by program.

	Year Ended December 31, 2015 (1)						
	Member Months[2]	Premium Revenue		Medical Care Costs		MCR[3]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	25.5	$ 4,483	$ 175.64	$ 4,122	$ 161.50	92.0%	$ 361
Medicaid Expansion	5.9	2,389	408.51	1,931	330.18	80.8	458
ABD	4.3	4,124	966.83	3,784	887.27	91.8	340
Marketplace	2.6	652	251.96	481	185.85	73.8	171
MMP	0.5	1,063	2,034.51	974	1,863.93	91.6	89
Medicare	0.5	530	1,038.15	502	982.50	94.6	28
	39.3	$ 13,241	$ 337.28	$ 11,794	$ 300.43	89.1%	$ 1,447

(1) Year ended December 31, 2014 and 2013 data not presented due to lack of comparability.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Financial Performance by State Health Plan. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Year Ended December 31, 2015						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.1	$ 2,200	$ 310.89	$ 1,926	$ 272.22	87.6%	$ 274
Florida	4.1	1,199	289.85	1,081	261.49	90.2	118
Illinois	1.2	397	328.93	367	303.72	92.3	30
Michigan	3.4	1,067	317.15	903	268.27	84.6	164
New Mexico	2.8	1,237	446.27	1,106	398.98	89.4	131
Ohio	4.1	2,034	499.34	1,718	421.61	84.4	316
Puerto Rico [1]	3.2	567	178.31	505	158.80	89.1	62
South Carolina [1]	1.3	348	267.25	278	213.30	79.8	70
Texas	3.1	1,961	621.37	1,809	573.32	92.3	152
Utah	1.2	331	286.22	300	259.32	90.6	31
Washington	6.6	1,602	242.36	1,470	222.36	91.7	132
Wisconsin	1.2	261	213.48	215	176.01	82.4	46
Other [2]	—	37	—	116	—	—	(79)
	39.3	$ 13,241	$ 337.28	$ 11,794	$ 300.43	89.1%	$ 1,447

	Year Ended December 31, 2014						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.6	$ 1,523	$ 270.51	$ 1,269	$ 225.37	83.3%	$ 254
Florida	1.1	439	397.79	419	379.95	95.5	20
Illinois	0.3	153	498.48	141	456.88	91.7	12
Michigan	2.8	781	278.68	661	235.81	84.6	120
New Mexico	2.5	1,076	435.17	996	402.92	92.6	80
Ohio	3.7	1,553	425.47	1,335	365.87	86.0	218
Puerto Rico [1]	—	—	—	—	—	—	—
South Carolina [1]	1.5	381	260.72	323	220.89	84.7	58
Texas	3.0	1,318	442.32	1,197	401.81	90.8	121
Utah	1.0	310	310.64	285	286.43	92.2	25
Washington	5.5	1,305	236.27	1,219	220.75	93.4	86
Wisconsin	1.0	156	150.87	136	130.91	86.8	20
Other [2]	—	28	—	95	—	—	(67)
	28.0	$ 9,023	$ 322.68	$ 8,076	$ 288.84	89.5%	$ 947

	Year Ended December 31, 2013						
	Member Months	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR	Medical Margin
California	4.2	$ 750	$ 177.10	$ 667	$ 157.46	88.9%	$ 83
Florida	1.0	265	272.23	231	237.57	87.3	34
Illinois	—	8	1,201.34	8	1,164.10	96.9	—
Michigan	2.6	676	261.91	571	221.09	84.4	105
New Mexico	1.5	447	299.36	384	257.62	86.1	63
Ohio	3.0	1,099	365.44	925	307.53	84.2	174
Puerto Rico (1)	—	—	—	—	—	—	—
South Carolina (1)	—	—	—	—	—	—	—
Texas	3.2	1,291	406.27	1,115	350.84	86.4	176
Utah	1.0	311	299.05	259	249.51	83.4	52
Washington	4.9	1,168	236.47	1,028	208.10	88.0	140
Wisconsin	1.1	143	135.40	114	107.91	79.7	29
Other (2)	—	21	—	78	—	—	(57)
	22.5	$ 6,179	$ 274.48	$ 5,380	$ 238.99	87.1%	$ 799

(1) Our Puerto Rico health plan began serving members effective April 1, 2015. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Individual Health Plan Analysis

2015 Compared with 2014

California. Premium revenue grew $677 million, or 44%, in 2015 compared with 2014, the result of higher membership. Overall, enrollment on a member-month basis increased 31% in 2015 compared with 2014. Increased premium revenue was also driven by a 15% increase in premium revenue PMPM, which was the result of the higher relative premium revenue PMPM among those programs experiencing enrollment growth (Medicaid expansion and MMP); and the addition of long-term care benefits to some of the California health plan's Medicaid membership. The medical care ratio increased to 87.6% in 2015, from 83.3% in 2014. During 2014, the plan benefited from the recognition of approximately $23 million in premium revenue and medical margin that related to 2013, as a result of certain programmatic changes implemented by the state of California. Absent this benefit, the medical care ratio of the California plan would have been 84.6% in 2014.

Florida. Premium revenue grew to $1,199 million in 2015, from $439 million in 2014, due to increased Marketplace membership. The medical care ratio decreased to 90.2% in 2015, from 95.5% in 2014, due to the lower medical care ratio of the Marketplace membership more than offsetting an increase in the medical care ratio for the Medicaid program.

Illinois. Premium revenue grew to $397 million in 2015, from $153 million in 2014, due to significant membership growth in late 2014. The medical care ratio increased to 92.3% in 2015, from 91.7% in 2014.

Michigan. Premium revenue grew $286 million, or 37%, in 2015 compared with 2014, due to increased Medicaid expansion membership and the startup of the MMP program. The medical care ratio of 84.6% for 2015 was unchanged from 2014.

New Mexico. Premium revenue grew $161 million, or 15%, in 2015 compared with 2014, due to substantial increases in membership in all Medicaid programs. The medical care ratio decreased to 89.4% in 2015, from 92.6% in 2014, due to improved profitability for the ABD and Medicaid expansion programs.

Ohio. Premium revenue grew $481 million, or 31%, in 2015 compared with 2014, due to growth in membership within the Medicaid expansion, and MMP programs. The medical care ratio decreased to 84.4% in 2015, from 86.0% in 2014, due to lower medical care ratios in these newer programs, as well as ABD.

Puerto Rico. The Puerto Rico health plan began serving members on April 1, 2015, and finished the year with a medical care ratio of 89.1%. See further discussion below, under *Financial Condition*, regarding the Commonwealth of Puerto Rico.

South Carolina. The medical care ratio decreased to 79.8% in 2015, from 84.7% in 2014. We believe that medical care ratios below 80% are not sustainable over time, and that the performance of the South Carolina health plan in 2014 is more representative of its likely long-term performance than are its financial results for 2015.

Texas. Premium revenue grew $643 million, or 49%, in 2015 compared with 2014, primarily due to the addition of ABD members receiving nursing facility benefits effective March 1, 2015, and the start-up of the Texas MMP program on that date. The medical care ratio increased to 92.3% in 2015, from 90.8% in 2014, primarily as a result of lower percentage margins on premiums to support nursing home services. As previously disclosed, we are unable to recognize certain quality related revenue in Texas because we do not have historical information, clear definitions, and clarity around minimum standards.

Utah. The medical care ratio of the Utah health plan decreased to 90.6% in 2015, from 92.2% in 2014, primarily due to improved financial performance of the plan's Medicare program.

Washington. Premium revenue grew $297 million, or 23%, in 2015 when compared with 2014, primarily due to growth in Medicaid expansion membership. The medical care ratio decreased to 91.7% in 2015, from 93.4% in 2014, as a lower medical care ratio for the ABD program more than offset a higher medical care ratio in the TANF and Medicaid expansion programs.

Wisconsin. Premium revenue grew $105 million, or 67%, in 2015 compared with 2014 as a result of increased Marketplace enrollment. The medical care ratio decreased to 82.4% in 2015, from 86.8% in 2014, primarily as a result of improvement in the financial performance of the Wisconsin health plan's Medicaid program.

2014 Compared with 2013

California. The medical care ratio for the California health plan decreased significantly to 83.3% in 2014 from 88.9% in 2013. Additionally, medical margin improved $171 million when compared with 2013. This improvement was the result of higher enrollment, primarily due to the addition of approximately 107,000 Medicaid expansion members; and premium increases effective October 1, 2013 (2.5%), and July 1, 2014 (5.5%). During 2014, the plan benefited from the recognition of approximately $23 million in premium revenue and medical margin that related to 2013 as a result of certain programmatic changes implemented by the state of California. In 2013, the plan recognized approximately $32 million of premium revenue related to 2012 and earlier years as a result of retroactive rate increases from the state of California. The plan served its first MMP members in 2014.

Florida. Due to the re-procurement undertaken by the Florida Agency for Health Care Administration starting in 2014, the Florida health plan transitioned many of its members to other health plans in the second quarter of 2014, and then added approximately 105,000 members in the second half of 2014, both from the addition of new service areas and through acquisitions. Although revenue increased approximately 66% at the plan for the year ended December 31, 2014, when compared with 2013, profitability fell in 2014. The higher medical care costs were the result of 1) the assumption of risk for LTSS benefits for certain members effective December 2013 (as noted above percentage profit margins for LTSS benefits are generally less than those for other benefits); and 2) our inability to recognize revenue related to a rate increase effective September 1, 2014, as a result of those rates not being finalized prior to year end.

Illinois. The medical care ratio for the Illinois health plan decreased to 91.7% in 2014, from 96.9% in 2013. The plan experienced significant growth in 2014; enrollment increased approximately 96,000 members overall, with 78,000 members added in the fourth quarter alone. This growth occurred primarily within the traditional TANF program, and to a lesser degree within the Medicaid expansion program. The Illinois health plan served its first MMP members in 2014.

Michigan. The medical care ratio of the Michigan health plan was consistent year over year, at 84.6% in 2014, compared with 84.4% in 2013.

New Mexico. Premium revenue at the New Mexico health plan increased 141% for 2014 compared with 2013, primarily as a result of the addition of Medicaid behavioral health and LTSS benefits effective January 1, 2014, and the addition of approximately 54,000 Medicaid expansion members during the course of 2014. The medical care ratio of the plan increased to 92.6% in 2014, from 86.1% in 2013. The higher medical care ratio was the result of: 1) the assumption of risk for LTSS benefits effective January 1, 2014; and 2) premium rates effective January 1, 2014 that did not keep pace with the increase in medical costs in 2014.

Ohio. The medical care ratio of the Ohio health plan increased to 86.0% in 2014, from 84.2% in 2013, primarily due to the increase in Medicaid expansion enrollment (which is incurring a medical care ratio slightly in excess of the plan's traditional experience), and the initiation of the Ohio MMP.

South Carolina. The South Carolina health plan began serving members on January 1, 2014, and finished the year with a medical care ratio of 84.7%.

Texas. Financial performance at the Texas health plan declined in 2014, when compared with 2013. The medical care ratio of the Texas health plan increased to 90.8% in 2014, from 86.4% in 2013. Our inability to recognize a portion of the plan's quality

revenue reduced income before taxes by approximately $26 million, or $0.33 per diluted share, for the year ended December 31, 2014. Approximately $20 million of this amount is related to measures for which we lack sufficient information to calculate our compliance. Removing quality revenue and profit-sharing adjustments would have resulted in a medical care ratio of approximately 88% in 2014 and 86% in 2013.

Utah. The medical care ratio of the Utah health plan increased to 92.2% in 2014, from 83.4% in 2013, due to deteriorating margins for both Medicaid and Medicare products.

Washington. Financial performance at the Washington health plan declined in 2014, when compared with 2013.The medical care ratio of the plan increased to 93.4% in 2014, compared with 88.0% in 2013, primarily due to the high cost of medical services relative to revenue for members served under the state's program for ABD members. The plan added approximately 102,000 Medicaid expansion members in 2014. The plan received a blended rate increase of approximately 3% effective January 1, 2015. For the plan's ABD membership, the rate increase effective January 1, 2015 was 11%.

Wisconsin. The medical care ratio of the Wisconsin health plan increased to 86.8% in 2014, compared with 79.7% in 2013.

Molina Medicaid Solutions Segment

2015 Compared with 2014

Service revenue declined $15 million in 2015 compared with 2014, primarily due to an extension of the Idaho contract under which we are now amortizing certain deferred revenues over a longer term. Service margin was consistent between 2015 and 2014, with 2015 showing a $2 million increase.

2014 Compared with 2013

Service margin improved $9 million for the year ended December 31, 2014, compared with 2013, primarily the result of increased revenues due to higher Medicaid transaction volumes and lower cost of services overall.

Other Segment

Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments. The Other segment service margin for the year ended December 31, 2015, was insignificant.

Consolidated Expenses

General and Administrative Expenses. General and administrative expenses increased slightly to 8.1% of revenue in 2015, from 7.9% in 2014, primarily the result of dramatic growth in our Marketplace membership. Excluding Marketplace broker and exchange fees from both years, the general and administrative expense ratio decreased to 7.5% in 2015 from 7.9% in 2014.

General and administrative expenses decreased to 7.9% of revenue in 2014, from 10.1% in 2013. The significant decline in the ratio of general and administrative expenses relative to total revenue was primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Premium Tax Expense. The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) decreased to 2.9% in 2015, from 3.2% in 2014. This decrease was primarily due to the current year increase in MMP revenues, which are not subject to premium taxes.

The premium tax ratio increased to 3.2% in 2014, from 2.7% in 2013. In June 2014, the state of Michigan instituted a 6% use tax on medical premiums. That state agreed to fund this tax through rate increases; as a result, we recorded approximately $30 million in additional premium revenue in 2014, as well as corresponding premium tax expense.

Health Insurer Fee (HIF) Revenue and Expenses. For our Medicaid program, actuarial standards require that we be reimbursed by state Medicaid agencies for both the expense associated with the HIF and the absence of tax deductibility for that expense. During 2015, we secured full reimbursement for our expenses under the HIF (including the absence of tax deductibility) and as a result HIF revenue, as a percentage of premium revenue, increased to 2.0% in 2015, from 1.3% in 2014. During 2015, we recognized approximately $20 million of HIF premium revenue meant to reimburse us for the cost of HIF expense recognized in 2014. Health insurer fee expenses, as a percentage of premium revenue, were 1.2% in 2015, compared with 1.0% in 2014.

In addition, both HIF revenue and expenses increased over the prior year proportionally to the increase in the total HIF tax base, which is assessed to all insurers. This base increased to $11.3 billion in 2015, from $8.0 billion in 2014. Refer to "Liquidity and Capital Resources—Financial Condition" below, for further discussion of the HIF.

Depreciation and Amortization. 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.

	Year Ended December 31,			
	2015		2014	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in millions)			
Depreciation, and amortization of capitalized software, continuing operations	$ 87	0.6%	$ 75	0.8%
Amortization of intangible assets, continuing operations	17	0.1	18	0.2
Depreciation and amortization, continuing operations	104	0.7	93	1.0
Amortization recorded as reduction of service revenue	1	—	3	—
Amortization of capitalized software recorded as cost of service revenue	21	0.1	38	0.4
Depreciation and amortization reported in statement of cash flows	$ 126	0.8%	$ 134	1.4%

	Year Ended December 31,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in millions)			
Depreciation, and amortization of capitalized software, continuing operations	$ 75	0.8%	$ 55	0.8%
Amortization of intangible assets, continuing operations	18	0.2	18	0.3
Depreciation and amortization, continuing operations	93	1.0	73	1.1
Amortization recorded as reduction of service revenue	3	—	3	—
Amortization of capitalized software recorded as cost of service revenue	38	0.4	18	0.3
Depreciation and amortization reported in statement of cash flows	$ 134	1.4%	$ 94	1.4%

Interest Expense. Interest expense increased to $66 million for the year ended December 31, 2015, compared with $57 million for the year ended December 31, 2014. The increase was due primarily to our issuance of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, in the fourth quarter of 2015. For further details regarding this transaction, please refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Debt."

Interest expense increased to $57 million for the year ended December 31, 2014, compared with $52 million for the year ended December 31, 2013. The increase was due primarily to our 3.75% Notes exchange transaction and related issuance of 1.625% Notes in 2014, and lease financing transactions executed in 2013. For further details regarding these transactions, please refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Debt."

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $30 million, $27 million and $23 million for the years ended December 31, 2015, 2014, and 2013, respectively.

We expect interest expense to continue to increase in the future due to interest on the 5.375% Notes which were issued in November 2015.

Income Taxes. The provision for income taxes in continuing operations is recorded at an effective rate of 55.5% for the year ended December 31, 2015, compared with 53.8% for the year ended December 31, 2014. The effective tax rate for 2015 is higher than 2014 primarily as a result of certain discrete tax benefits recorded in 2014 that were not recurring in 2015.

The provision for income taxes in continuing operations was recorded at an effective rate of 53.8% for the year ended December 31, 2014, compared with 44.8% for the year ended December 31, 2013. The increase is primarily due to the nondeductible health insurer fee in 2014 that did not exist in 2013.

Liquidity and Capital Resources

Introduction

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. 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 a short time before we pay 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, and 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 10 years or less (excluding variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. As of December 31, 2015, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted primarily of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased to $18 million for the year ended December 31, 2015, compared with $8 million for the year ended December 31, 2014, primarily due to the increase in invested assets. Our annualized portfolio yields for the year ended December 31, 2015 was 0.5%, and for both years ended December 31, 2014 and 2013, was 0.4%.

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. 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 unregulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use. We received $125 million in dividends from our regulated health plan subsidiaries, and $17 million in dividends from our unregulated subsidiaries during 2015. We did not receive any dividends from our regulated health plan subsidiaries during the year ended December 31, 2014, because significant growth across all of our health plans necessitated that the plans retain their cash to meet increasing net worth requirements. See further discussion in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 19, "Commitments and Contingencies," under the subheading "Regulatory Capital and Dividend Restrictions," and Note 22, "Condensed Financial Information of Registrant," under "Note C - Dividends and Capital Contributions."

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Year Ended December 31,				
	2015	2014	2013	2014 to 2015 Change	2013 to 2014 Change
	(In millions)				
Net cash provided by operating activities	$ 1,125	$ 1,060	$ 190	$ 65	$ 870
Net cash used in investing activities	(1,420)	(536)	(543)	(884)	7
Net cash provided by financing activities	1,085	79	493	1,006	(414)
Net increase in cash and cash equivalents	$ 790	$ 603	$ 140	$ 187	$ 463

Operating Activities. Cash provided by operating activities was $1,125 million in 2015 compared with $1,060 million in 2014, an increase of $65 million. This increase was due primarily to increased net income of $81 million, and collection of premiums receivable at our California health plan in the first quarter of 2015. These sources of cash were partially offset by:

- A decrease in amounts due to government agencies of $268 million, primarily due to a fourth quarter 2015 Medicaid expansion-related payment to the state of Washington's Medicaid authority of $247 million. Changes in this account

relate primarily to Health Plans segment programs that contain medical cost floors or medical cost corridors. Under such programs, a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs; and

- The change in medical claims and benefits payable, which resulted in the use of $49 million, primarily because membership and related medical costs grew at a higher rate in 2014 than in 2015, resulting in a lower year-over-year change in 2015.

In 2014, cash provided by operating activities was $1,060 million compared with $190 million for 2013, an increase of $870 million. This increase was primarily due to a $442 million increase in amounts due to government agencies because of a significant increase in amounts accrued for medical cost floor contract provisions, primarily associated with our Medicaid expansion membership. In addition, medical claims and benefits payable increased $356 million due to significant membership growth in 2014.

Investing Activities. Cash used in investing activities increased to $1,420 million in 2015, compared with $536 million in 2014, an increase of $884 million. This increase was due in part to higher purchases of investments, net of sales and maturities, amounting to $477 million, a result of cash generated from 2015 financing activities, described below.

In addition, cash paid for business acquisitions increased $406 million. As described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 1 ,"Basis of Presentation," we closed several business acquisitions in 2015. Additionally, we announced several Health Plans acquisitions in 2015 that did not close until January 1, 2016. Because the closing dates for these acquisitions fell on January 1, 2016, a holiday, approximately $101 million was recorded to prepaid expenses and other assets as of December 31, 2015, for purchase price amounts funded in December 2015. Such amounts are reported in investing activities in the accompanying consolidated statements of cash flows.

In 2014, cash used in investing activities was $536 million, comparable with $543 million in 2013.

Financing Activities. Cash provided by financing activities was $1,085 million in 2015, primarily due to net proceeds from our fiscal 2015 offerings of 5.375% Notes, amounting to $689 million, and common stock, amounting to $373 million. In 2014, cash provided by financing activities was $79 million, which included primarily $123 million net proceeds from our fiscal 2014 offering of 1.625% Notes, partially offset by $50 million paid to settle contingent consideration liabilities associated with our 2013 business acquisitions. In 2013, net proceeds from our 1.125% Notes offering and lease financing transactions provided $623 million, which was partially offset by $53 million used to purchase treasury stock and $88 million to repay debt.

Financial Condition

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.

On a consolidated basis, at December 31, 2015, our working capital was $1,484 million compared with $1,028 million at December 31, 2014. At December 31, 2015, our cash and investments amounted to $4,241 million, compared with $2,666 million of cash and investments at December 31, 2014.

Regulatory Capital. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us.

Based upon current statutes and regulations, 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 approximately $1,229 million at December 31, 2015, and $859 million at December 31, 2014. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $612 million and $203 million as of December 31, 2015, and 2014, respectively.

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "Ba3" by Moody's Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

Health Insurer Fee. Effective January 1, 2014, the ACA requires most health plans to pay a fee based on premium revenue (the Health Insurer Fee, or HIF). The HIF is not tax deductible. Actuarial standards require that states reimburse us for the HIF we incur related to Medicaid revenue, in addition to paying us a "tax gross up" to compensate us for incremental income taxes we pay because the HIF is not tax deductible. During 2015, we secured full reimbursement for our expenses under the HIF.

The following table provides the details of our HIF revenue reimbursement by health plan to date in 2015 (in millions):

	HIF Reimbursement Revenue, Gross[1]					
	Year Ended December 31, 2015					
	Recognized					Necessary for Full Reimbursement
	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Total	
2015 HIF:						
California	$ —	$ 17	$ 6	$ 8	$ 31	$ 31
Florida	2	2	2	2	8	8
Illinois	1	1	1	1	4	4
Michigan	—	—	21	7	28	28
New Mexico	7	8	8	7	30	30
Ohio	12	12	12	12	48	48
South Carolina	3	3	3	3	12	12
Texas	6	6	6	5	23	23
Utah	—	—	4	2	6	6
Washington	11	11	6	9	37	37
Wisconsin	1	1	1	2	5	5
Subtotal, Medicaid	43	61	70	58	232	232
Marketplace	—	—	1	1	2	2
Medicare	6	4	4	5	19	19
	49	65	75	64	253	$ 253
2014 HIF:						
California	—	12	—	—	12	
Michigan	—	—	7	—	7	
Utah	—	—	1	—	1	
	$ 49	$ 77	$ 83	$ 64	$ 273	
Recognized in:						
Health insurer fee revenue	$ 48	$ 74	$ 81	$ 61	$ 264	
Premium tax revenue	1	3	2	3	9	
	$ 49	$ 77	$ 83	$ 64	$ 273	

(1) Amounts in the table include our estimate of the full economic impact of the excise tax including premium tax and the income tax effect.

Future Sources and Uses of Liquidity

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. Our ability to borrow under the Credit Facility is subject to compliance with certain covenants. As of December 31, 2015, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Announced Acquisitions. As described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 1, "Basis of Presentation," we announced several Health Plans acquisitions in 2015 that did not close until January 1, 2016. Because the closing dates for these acquisitions fell on January 1, 2016, a holiday, approximately $101 million was recorded to prepaid expenses and other assets as of December 31, 2015, for purchase price amounts funded in December 2015. Such amounts are reported in investing activities in the accompanying consolidated statements of cash flows. The total aggregate purchase price for these acquisitions amounted to approximately $115 million.

Convertible Senior Notes. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Notes. In September 2014, we issued $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Notes. As of December 31, 2015, the aggregate outstanding principal amount of our 1.125% Notes and our 1.625% Notes was $550 million and $302 million, respectively. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The 1.125% Notes met the stock price trigger in the quarter ended December 31, 2015, and are convertible to cash through at least March 31, 2016. Because the 1.125% Notes may be converted into cash within 12 months, the $448 million carrying amount is reported in current portion of long-term debt as of December 31, 2015. In addition, holders of our 1.625% Notes may convert their notes into cash during any calendar quarter (and only during such calendar quarter) if the last reported sales price of our common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on February 23, 2016 was $62.28 per share. As of December 31, 2015, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash. As of December 31, 2015, we had sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

States' Budgets. From time to time the states in which our health plans operate may delay premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of December 31, 2015, our Illinois health plan served approximately 98,000 members, and recognized premium revenue of approximately $397 million for the year ended December 31, 2015. As of February 23, 2016, Illinois is current with its premium payments.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs including health care-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. Our Puerto Rico health plan became operational on April 1, 2015. As of December 31, 2015, the plan served approximately 348,000 members and recognized premium revenue of approximately $192 million in the fourth quarter of 2015, or approximately $64 million per month. As of February 23, 2016, the Commonwealth continues to pay us weekly for current membership.

It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility. Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter.

It has been our practice in the past, and will remain so in the future, to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Critical Accounting Estimates

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 estimates relate to:

- *Health Plans segment medical claims and benefits payable* (see discussion below).
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- *Health Plans segment quality incentives.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- *Molina Medicaid Solutions segment revenue and cost recognition.* For a comprehensive discussion of this topic, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

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,		
	2015	2014	2013
	(In millions)		
Fee-for-service claims incurred but not paid (IBNP)	$ 1,191	$ 871	$ 424
Pharmacy payable	88	71	45
Capitation payable	140	28	20
Other (1)	266	231	181
	$ 1,685	$ 1,201	$ 670

(1) "Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. As of December 31, 2015, 2014 and 2013, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $167 million, $119 million and $151 million, respectively.

The determination of our liability for medical claims and 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 medical claims and 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 (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 $1,191 million of our total medical claims and benefits payable of $1,685 million as of December 31, 2015.

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 provision for adverse

claims deviation, 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 hypothetical change in our estimate of claims liability as of December 31, 2015 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2015, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in millions.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 348
(4)%	232
(2)%	116
2%	(116)
4%	(232)
6%	(348)

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 hypothetical change in our estimate of claims liability as of December 31, 2015 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 millions.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (202)
(4)%	(135)
(2)%	(67)
2%	67
4%	135
6%	202

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 56 million diluted shares outstanding for the year ended December 31, 2015. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2015, net income for the year ended December 31, 2015 would increase or decrease by approximately $37 million, or $0.66 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2015, net income for the year ended December 31, 2015 would increase or decrease by approximately $21 million, or $0.38 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $183 million, or $3.29 per diluted share, and $106 million, or $1.91 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 $37 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 deviation 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 deviation. The provision for adverse claims deviation 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, 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 deviation.

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.

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.

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for additional information regarding the specific factors used to determine our changes in estimates of IBNP for all periods presented in the accompanying consolidated financial statements.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than 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,		
	2015	2014	2013
	(Dollars in millions, except per-member amounts)		
Balances at beginning of period	$ 1,201	$ 670	$ 495
Components of medical care costs related to:			
Current period	11,935	8,123	5,434
Prior periods (1)	(141)	(46)	(53)
Total medical care costs	11,794	8,077	5,381
Change in non-risk provider payables	48	(32)	111
Payments for medical care costs related to:			
Current period	10,448	7,064	4,932
Prior periods	910	450	385
Total paid	11,358	7,514	5,317
Balances at end of period	$ 1,685	$ 1,201	$ 670
Benefit from prior periods as a percentage of:			
Balance at beginning of period	11.8%	6.9%	10.7%
Premium revenue	1.1%	0.5%	0.9%
Medical care costs	1.2%	0.6%	1.0%
Claims Data:			
Days in claims payable, fee for service	48	49	43
Number of members at end of period	3,533,000	2,623,000	1,931,000
Number of claims in inventory at end of period	380,800	307,700	145,800
Billed charges of claims in inventory at end of period	$ 816	$ 719	$ 277
Claims in inventory per member at end of period	0.11	0.12	0.08
Billed charges of claims in inventory per member end of period	$ 230.91	$ 273.92	$ 143.19
Number of claims received during the period	40,173,300	27,597,000	21,317,500
Billed charges of claims received during the period	$ 46,211	$ 30,316	$ 21,415

Commitments and Contingencies

We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 19 ,"Commitments and Contingencies."

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2015. Some of the amounts 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.

Additionally, we have a variety of other contractual agreements related to acquiring services used in our operations. However, we believe these other agreements do not contain material noncancelable commitments.

	Total (1)	2016	2017-2018	2019-2020	2021 and Beyond
			(In millions)		
Medical claims and benefits payable	$ 1,685	$ 1,685	$ —	$ —	$ —
Principal amount of senior notes (2)	1,552	—	—	550	1,002
Amounts due government agencies	729	729	—	—	—
Interest on long-term debt	424	49	97	91	187
Lease financing obligations	403	15	32	33	323
Operating leases	232	49	88	56	39
Purchase commitments	15	11	4	—	—
	$ 5,040	$ 2,538	$ 221	$ 730	$ 1,551

(1) As of December 31, 2015, we have recorded approximately $9 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 14, "Income Taxes."

(2) Represents the principal amounts due on our 5.375% Senior Notes due 2022, 1.125% Cash Convertible Senior Notes due 2020, and our 1.625% Convertible Senior Notes due 2044 (1.625% Notes). The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 12, "Debt."

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Quantitative and Qualitative Disclosures About Market Risk

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

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. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. 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.

Compliance Costs

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. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 8. Financial Statements and Supplementary Data

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2015. 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, 2015 and 2014, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, 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, 2015, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 26, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2016

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2015	2014
	(Amounts in millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,329	$ 1,539
Investments	1,801	1,019
Receivables	597	596
Income taxes refundable	13	—
Prepaid expenses and other current assets	192	49
Derivative asset	374	—
Total current assets	5,306	3,203
Property, equipment, and capitalized software, net	393	341
Deferred contract costs	81	54
Intangible assets, net	122	89
Goodwill	519	272
Restricted investments	109	102
Derivative asset	—	329
Deferred income taxes	18	15
Other assets	28	30
	$ 6,576	$ 4,435
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,685	$ 1,201
Amounts due government agencies	729	527
Accounts payable and accrued liabilities	362	242
Deferred revenue	223	196
Income taxes payable	—	9
Current maturities of long-term debt	449	—
Derivative liability	374	—
Total current liabilities	3,822	2,175
Senior notes	962	690
Lease financing obligations	198	157
Lease financing obligations - related party	—	40
Derivative liability	—	329
Other long-term liabilities	37	34
Total liabilities	5,019	3,425
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 56 shares at December 31, 2015 and 50 shares at December 31, 2014	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	803	396
Accumulated other comprehensive loss	(4)	(1)
Retained earnings	758	615
Total stockholders' equity	1,557	1,010
	$ 6,576	$ 4,435

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2015	2014	2013
	(In millions, except per-share data)		
Revenue:			
Premium revenue	$ 13,241	$ 9,023	$ 6,179
Service revenue	253	210	205
Premium tax revenue	397	294	172
Health insurer fee revenue	264	120	—
Investment income	18	8	7
Other revenue	5	12	26
Total revenue	14,178	9,667	6,589
Operating expenses:			
Medical care costs	11,794	8,076	5,380
Cost of service revenue	193	157	161
General and administrative expenses	1,146	765	666
Premium tax expenses	397	294	172
Health insurer fee expenses	157	89	—
Depreciation and amortization	104	93	73
Total operating expenses	13,791	9,474	6,452
Operating income	387	193	137
Other expenses, net:			
Interest expense	66	57	52
Other (income) expense, net	(1)	1	4
Total other expenses, net	65	58	56
Income from continuing operations before income tax expense	322	135	81
Income tax expense	179	73	36
Income from continuing operations	143	62	45
Income from discontinued operations, net of tax expense (benefit) of $0, $0, and $(10), respectively	—	—	8
Net income	$ 143	$ 62	$ 53
Basic net income per share:			
Income from continuing operations	$ 2.75	$ 1.34	$ 0.98
(Loss) income from discontinued operations	—	(0.01)	0.18
Basic net income per share	$ 2.75	$ 1.33	$ 1.16
Diluted net income per share:			
Income from continuing operations	$ 2.58	$ 1.30	$ 0.96
(Loss) income from discontinued operations	—	(0.01)	0.17
Diluted net income per share	$ 2.58	$ 1.29	$ 1.13
Weighted average shares outstanding:			
Basic	52	47	46
Diluted	56	48	47

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Net income	$ 143	$ 62	$ 53
Other comprehensive income (loss):			
Unrealized investment loss	(5)	—	(1)
Effect of income tax benefit	2	—	—
Other comprehensive loss, net of tax	(3)	—	(1)
Comprehensive income	$ 140	$ 62	$ 52

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
				(In millions)			
Balance at January 1, 2013	47	$ —	$ 285	$ —	$ 500	$ (3)	$ 782
Net income	—	—	—	—	53	—	53
Other comprehensive loss, net	—	—	—	(1)	—	—	(1)
Purchase of treasury stock	(2)	—	—	—	—	(53)	(53)
Retirement of treasury stock	—	—	(56)	—	—	56	—
Issuance of warrants	—	—	79	—	—	—	79
Share-based compensation	1	—	31	—	—	—	31
Tax benefit from share-based compensation	—	—	2	—	—	—	2
Balance at December 31, 2013	46	—	341	(1)	553	—	893
Net income	—	—	—	—	62	—	62
Convertible senior notes transactions, including issuance costs	2	—	22	—	—	—	22
Share-based compensation	2	—	30	—	—	—	30
Tax benefit from share-based compensation	—	—	3	—	—	—	3
Balance at December 31, 2014	50	—	396	(1)	615	—	1,010
Net income	—	—	—	—	143	—	143
Other comprehensive loss, net	—	—	—	(3)	—	—	(3)
Common stock offering, including issuance costs	6	—	373	—	—	—	373
Share-based compensation	—	—	26	—	—	—	26
Tax benefit from share-based compensation	—	—	8	—	—	—	8
Balance at December 31, 2015	56	$ —	$ 803	$ (4)	$ 758	$ —	$ 1,557

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Operating activities:			
Net income	$ 143	$ 62	$ 53
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	126	134	94
Deferred income taxes	(7)	(2)	(32)
Share-based compensation	23	22	29
Amortization of convertible senior notes and lease financing obligations	30	27	23
Other, net	19	7	18
Changes in operating assets and liabilities, net of effects from acquisitions:			
Receivables	56	(298)	(149)
Prepaid expenses and other current assets	(35)	(20)	(23)
Medical claims and benefits payable	482	531	175
Amounts due government agencies	202	470	28
Accounts payable and accrued liabilities	84	11	33
Deferred revenue	24	74	(20)
Income taxes	(22)	42	(39)
Net cash provided by operating activities	1,125	1,060	190
Investing activities:			
Purchases of investments	(1,923)	(953)	(770)
Proceeds from sales and maturities of investments	1,126	633	400
Purchases of equipment	(132)	(115)	(98)
Increase in restricted investments	(6)	(34)	(19)
Net cash paid in business combinations	(450)	(44)	(62)
Other, net	(35)	(23)	6
Net cash used in investing activities	(1,420)	(536)	(543)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	689	123	538
Proceeds from common stock offering, net of issuance costs	373	—	—
Proceeds from sale-leaseback transactions	—	—	159
Purchase of call option	—	—	(149)
Proceeds from issuance of warrants	—	—	75
Contingent consideration liabilities settled	—	(50)	—
Treasury stock purchases	—	—	(53)
Principal payments on term loan	—	—	(48)
Repayment of amount borrowed under credit facility	—	—	(40)
Proceeds from employee stock plans	18	14	9
Principal payments on convertible senior notes	—	(10)	—
Other, net	5	2	2
Net cash provided by financing activities	1,085	79	493
Net increase in cash and cash equivalents	790	603	140
Cash and cash equivalents at beginning of period	1,539	936	796
Cash and cash equivalents at end of period	$ 2,329	$ 1,539	$ 936

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(continued)

	Year Ended December 31,		
	2015	2014	2013
	(Amounts in millions)		
Supplemental cash flow information:			
Cash paid during the period for:			
Income taxes	$ 197	$ 30	$ 95
Interest	$ 38	$ 29	$ 35
Schedule of non-cash investing and financing activities:			
Senior notes exchange transaction	$ —	$ 177	$ —
Retirement of treasury stock	$ —	$ —	$ 56
Increase in non-cash lease financing obligation - related party	$ —	$ 14	$ 27
Common stock used for stock-based compensation	$ (15)	$ (9)	$ (8)
Details of business combinations:			
Fair value of assets acquired	$ (389)	$ (52)	$ (122)
Fair value of liabilities assumed	41	—	—
Fair value of contingent consideration liabilities incurred	—	—	60
Payable to seller	—	8	—
Amounts advanced for acquisitions	(102)	—	—
Net cash paid in business combinations	$ (450)	$ (44)	$ (62)
Details of change in fair value of derivatives, net:			
Gain on 1.125% Notes Call Option	$ 45	$ 143	$ 37
Loss on 1.125% Notes Conversion Option	(45)	(143)	(37)
Loss on 1.125% Warrants	—	—	(4)
Change in fair value of derivatives, net	$ —	$ —	$ (4)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other. See Note 20, "Segment Information," for further details.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of December 31, 2015, these health plans served over 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open 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.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Market Update—Other

Pathways. On November 1, 2015, we acquired all of the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia. See Note 4, "Business Combinations," for further information.

Market Updates—Health Plans

Medicare-Medicaid Plans. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered coverage beginning in the second quarter of 2015. At December 31, 2015, our membership included approximately 51,000 integrated MMP members.

Florida. On November 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to operation of the Medicaid business, of Integral Health Plan, Inc. See Note 4, "Business Combinations," for further information.

On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc. See Note 4, "Business Combinations," for further information.

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. We assumed approximately 58,000 Medicaid members in this acquisition.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. We assumed approximately 21,000 Medicaid members in this acquisition.

On November 30, 2015, we announced that our Illinois health plan entered into an agreement to assume the membership and certain Medicaid assets of Better Health Network, LLC (Better Health). As of November 30, 2015, Better Health served approximately 40,000 members in the Medicaid Family Health program in Cook County. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the first half of 2016.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. We assumed approximately 81,000 Medicaid and MIChild members in this acquisition.

In October 2015, the Michigan Department of Health and Human Services announced that Molina Healthcare of Michigan was recommended to serve the state's Medicaid members under Michigan's Comprehensive Health Plan, which commenced on January 1, 2016. The new contract has a five-year term with three one-year extensions, and covers Regions 2 through 6, and 8 through 10 of the state, representing an expansion into 18 additional counties compared with the previous Michigan Medicaid contract.

On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc. See Note 4, "Business Combinations," for further information.

Puerto Rico. Effective April 1, 2015, our Puerto Rico health plan served its first members. As of December 31, 2015, our Puerto Rico plan enrollment amounted to approximately 348,000 members.

Washington. In November 2015, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to negotiate and enter into managed care contracts for the Southwest region of the state's Apple Health Fully Integrated Managed Care Program. Molina Healthcare of Washington was selected by HCA pursuant to the request for proposal HCA issued in August 2015. The start date for the new contract is scheduled for April 1, 2016.

On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid membership and certain Medicaid assets of Columbia United Providers, Inc. We assumed approximately 57,000 Medicaid members in this acquisition.

Market Update—Molina Medicaid Solutions

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate that state's new Medicaid management information system (MMIS). The new contract was effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's incumbent MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 18, "Variable Interest Entities (VIEs)," for more information regarding these variable interest entities. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

Presentation and Reclassifications

Beginning in 2013, after our Medicaid contract with the state of Missouri expired, we have reported the results relating to the Missouri health plan as discontinued operations for all periods presented. Additionally, we abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of $10 million, which is also included in discontinued operations in the consolidated statements of income. The Missouri health plan's premium revenues were insignificant for all periods presented.

We have reclassified certain amounts in the 2014 consolidated balance sheet to conform to the 2015 presentation relating to the presentation of deferred taxes and debt issuance costs. Both reclassifications are a result of recently adopted accounting pronouncements. See Note 2, "Significant Accounting Policies," for further information.

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. 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 of our Health Plans segment;
- Health plan contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Molina Medicaid Solutions segment revenue and cost recognition;
- 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.

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.

Our investment policy requires that all of our investments have final maturities of 10 years or less (excluding variable rate securities where interest rates may be periodically reset), and that the average maturity be three 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. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our current and non-current investments, see Note 5, "Fair Value Measurements," Note 6, "Investments," and Note 10, "Restricted Investments."

Receivables

Receivables are readily determinable and because 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, Equipment, and Capitalized Software

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 to 40 years. See Note 8, "Property, Equipment, and Capitalized Software."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software 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.

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 headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Amortization of capitalized software is recorded within the heading "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.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Depreciation, and amortization of capitalized software, continuing operations	$ 87	$ 75	$ 55
Amortization of intangible assets, continuing operations	17	18	18
Depreciation and amortization, continuing operations	104	93	73
Amortization recorded as reduction of service revenue	1	3	3
Amortization of capitalized software recorded as cost of service revenue	21	38	18
Depreciation and amortization reported in the statement of cash flows	$ 126	$ 134	$ 94

Long-Lived Assets, including Intangible Assets

Long-lived assets consist primarily of property, equipment, capitalized software and intangible assets. Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at fair value and are then amortized on a straight-line basis over their expected useful lives, generally between two and 15 years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. 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.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2015, 2014, and 2013.

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount.

To determine whether goodwill is impaired, we measure the fair values of our reporting units and compare them to the carrying values of the respective units, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared with the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows. To determine fair values, we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

No impairment charges relating to goodwill were recorded in the years ended December 31, 2015, 2014, and 2013.

Business Combinations

Accounting for acquisitions requires us to recognize separately from goodwill the assets acquired and the liabilities assumed at their acquisition date fair values. Goodwill as of the acquisition date is measured as the excess of consideration transferred over the net of the acquisition date fair values of the assets acquired and the liabilities assumed. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Upon the conclusion of the measurement period or final determination of the values of assets acquired or liabilities assumed, whichever comes first, any subsequent adjustments are recorded to our consolidated statements of income. Refer to Note 4, "Business Combinations," for further details regarding our 2015 acquisitions.

Restricted Investments

Restricted investments, which consist of certificates of deposit and U.S. treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates fair value. The use of these funds is limited to specific purposes as required by regulation in the various states in which we operate, 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."

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk 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, 2015 and 2014.

Premium Revenue - Health Plans

Premium revenue is generated primarily from our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. Premium revenue is generally received based on per member per month (PMPM) rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. The state Medicaid programs and the federal Medicare program periodically adjust premium. Additionally, many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is

earned under such provisions.

The following table summarizes premium revenue from continuing operations for the periods indicated:

	Year Ended December 31,					
	2015		2014		2013	
	Amount	% of Total	Amount	% of Total	Amount	% of Total
	(Dollars in millions)					
California	$ 2,200	16.6%	$ 1,523	16.9%	$ 750	12.1%
Florida	1,199	9.0	439	4.9	265	4.3
Illinois	397	3.0	153	1.7	8	0.1
Michigan	1,067	8.1	781	8.7	676	11.0
New Mexico	1,237	9.3	1,076	11.9	447	7.2
Ohio	2,034	15.4	1,553	17.2	1,099	17.8
Puerto Rico	567	4.3	—	—	—	—
South Carolina	348	2.6	381	4.2	—	—
Texas	1,961	14.8	1,318	14.6	1,291	20.9
Utah	331	2.5	310	3.4	311	5.0
Washington	1,602	12.1	1,305	14.5	1,168	18.9
Wisconsin	261	2.0	156	1.7	143	2.3
Direct delivery	37	0.3	28	0.3	21	0.4
	$ 13,241	100.0%	$ 9,023	100.0%	$ 6,179	100.0%

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $224 million and $392 million at December 31, 2015 and December 31, 2014, respectively, to amounts due government agencies. Approximately $208 million of the liability accrued at December 31, 2015 relates to our participation in Medicaid expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. We had $3 million recorded at December 31, 2015 relating to such provisions. No such receivables were recorded at December 31, 2014.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to retain, we recorded a liability of $10 million at December 31, 2015. The amount recorded at December 31, 2014 was insignificant.

Retroactive Premium Adjustments: In New Mexico, when members are retroactively enrolled into our health plan we earn revenue only to the extent of the actual medical costs incurred by us for services provided during those retroactive periods, plus a small percentage of that medical cost for administration and profit. This cost plus arrangement for members retroactively enrolled in our health plan first became effective July 1, 2014 (retroactive to January 1, 2014). We are paid normal monthly capitation rates for the retroactive eligibility periods, and the difference between those capitation rates and the amounts due us on a cost plus basis are periodically settled with the state. To date, no such settlement has been made with the state. Our New Mexico contract is not specific as to the definition of retroactive membership, and the amount we owe the state (or that the state owes us) for the difference between capitation received and amounts due us under the cost plus arrangement varies widely depending upon the definition of retroactive membership.

In August 2015 the state provided us with a request for payment under the terms of this contract provision for the period January 1, 2014 through December 31, 2014. That request was based upon definitions of retroactive membership that were at odds with our interpretations of that term. The New Mexico health plan reduced revenue by approximately $24 million in 2015

as a result of aligning more closely our definition of retroactive membership with the state's definition. Using the state's definition of retroactive membership, however, we estimate that the state will ultimately seek repayment of an amount that ranges from $15 million to $20 million higher than what we have accrued. We do not believe that any reasonable definition of retroactive membership supports the state's position, and expect to resolve this matter with payment of the amount we have accrued at December 31, 2015. We are currently engaged in discussions with the state regarding the appropriate amount, if any, owed to the state under this contract term.

Medicare

Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive increase or decrease based upon member medical conditions for up to two years after the original year of service. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses, we have recorded a net payable of $4 million and a net receivable of $8 million for anticipated Medicare risk adjustment premiums at December 31, 2015 and December 31, 2014, respectively.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program.

- Permanent risk adjustment program: Under this permanent program, our health plans' risk scores are compared to the overall average risk score for the relevant state and market pool. Generally, our health plans will pay into the pool if their risk scores are below the average risk score, and will receive funds from the pool if their risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income.
- Transitional reinsurance program: This program is designed to provide reimbursement to insurers for high cost members. Our health plans pay an annual contribution on a per-member basis, and are eligible for recoveries if claims for individual members exceed a specified threshold, up to a maximum amount. This three-year program will end on December 31, 2016. We recognize the assessments to fund the transitional reinsurance program as a reduction to premium revenue in our consolidated statements of income. We recognize recoveries under the reinsurance program as a reduction to medical care costs in our consolidated statements of income.
- Temporary risk corridor program: This program is intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by the U.S. Department of Health and Human Services (HHS). Variances from the target amount exceeding certain thresholds may result in amounts due to or receivables due from HHS. This three-year program will end on December 31, 2016. Due to uncertainties as to the amount of federal funding available to support the risk corridor program, we do not recognize amounts receivable under this program. All liabilities are recognized as incurred. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk corridor program as an adjustment to premium revenue in our consolidated statements of income.

Additionally, the ACA established a minimum annual medical loss ratio (Minimum MLR) of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. What constitutes medical costs and premium revenue are specifically defined by federal regulations. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described above, and, for receivables, collection is reasonably assured.

Our receivables (payables) for each of these programs, as of the dates indicated, were as follows (in millions):

	December 31, 2015	December 31, 2014
Risk adjustment	$ (214)	$ (5)
Reinsurance	36	5
Risk corridor	(10)	—
Minimum MLR	(3)	—

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2015 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2015.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Maximum available quality incentive premium - current period	$ 118	$ 90	$ 63
Amount of quality incentive premium revenue recognized in current period:			
Earned current period	$ 66	$ 40	$ 46
Earned prior periods	13	4	9
Total	$ 79	$ 44	$ 55
Total premium revenue recognized for state health plans with quality incentive premiums	$ 11,107	$ 7,084	$ 2,980

Medical Care Costs - Health Plans

Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses 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 manager are included in fee-for-service costs.
- *Pharmacy expenses:* All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. 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.
- *Capitation expenses:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. 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.
- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.
- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management,

and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2015, 2014, and 2013, medically related administrative costs were $398 million, $263 million, and $153 million, respectively.

The following table provides the details of our consolidated medical care costs from continuing operations for the periods indicated (dollars in millions, except PMPM amounts):

	Year Ended December 31,								
	2015			2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 8,572	$ 218.35	72.7%	$ 5,673	$ 202.87	70.2%	$ 3,612	$ 160.43	67.1%
Pharmacy	1,610	41.01	13.7	1,273	45.54	15.8	935	41.54	17.4
Capitation	982	25.02	8.3	748	26.77	9.3	604	26.83	11.2
Direct delivery	128	3.26	1.1	96	3.44	1.2	48	2.14	0.9
Other	502	12.79	4.2	286	10.22	3.5	181	8.05	3.4
Total	$ 11,794	$ 300.43	100.0%	$ 8,076	$ 288.84	100.0%	$ 5,380	$ 238.99	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 (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. For further information, see Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. Such reinsurance coverage does not relieve us of our primary obligation to our policyholders. 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

Health Insurer Fee. The federal government under the ACA imposes an annual fee, or excise tax, on health insurers for each calendar year. The HIF is based on a company's share of the industry's net premiums written during the preceding calendar year, and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Because we primarily serve individuals in government-sponsored programs, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment or payment from a state to reimburse us for the HIF; such HIF revenue is recognized ratably throughout the year.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expense in the consolidated statements of income.

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, 2015 or 2014.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element, and are therefore multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. If the deliverable has standalone value, the arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence 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 services. While all contracts support the system of record for state MMIS, the actual services 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).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. Therefore, absent any contingencies as discussed in the following paragraph, or contract extensions, we would recognize all revenue associated with those contracts over the initial contract period. When a contract is extended, we generally consider the extension to be a continuation of the single unit of accounting; therefore, the deferred revenue as of the extension date is recognized prospectively over the new remaining term of the contract. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

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 contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts, for example. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;

- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

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.

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 and Puerto Rico taxes, nondeductible expenses under the Affordable Care Act Health Insurer Fee (HIF), nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also 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 the reversal of the recognition 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 14, "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 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, 2015 and 2014, our investments with PFM amounted to approximately $605 million and $321 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. 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 because our payors consist 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.

We operate health plans primarily as a direct contractor with the states (or Commonwealth), 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 Not Yet Adopted

Leases. In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) ASU 2016-02, *Leases*. ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The ASU is effective for us beginning in the first quarter of 2019, and requires a modified retrospective transition approach. Early adoption is permitted; we are currently evaluating the potential effects of the adoption to our financial statements.

Financial Instruments. In January 2016, the FASB issued ASU 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*, which will require public business entities to use the exit price notion when measuring the fair value of financial instruments for disclosure purposes. Also, entities will have to assess the realizability of a deferred tax asset related to an available for sale debt security in combination with the entity's other deferred tax assets. Effective for us in the first quarter of 2018, ASU 2016-01 is applied prospectively with a cumulative-effect adjustment to beginning retained earnings as of the beginning of the first reporting period in which the guidance is adopted. Early adoption is permitted in regards to certain provisions of the standard; we are evaluating the potential effects of the adoption to our financial statements.

Revenue Recognition. In July 2015, the FASB affirmed its proposal to defer the effective date of ASU 2014-09, *Revenue from Contracts with Customers,* for all entities by one year. As a result, public business entities will apply the new revenue standard to annual reporting periods beginning after December 15, 2017, and for interim reporting periods within annual reporting periods beginning after December 15, 2017. We intend to adopt this standard on January 1, 2018. We are currently evaluating our plan for adoption and its impact to our revenue recognition policies, procedures and control framework, and the resulting impact to our consolidated financial position, results of operations and cash flows.

Short-Duration Contracts. In May 2015, the FASB issued ASU 2015-09, *Disclosures about Short-Duration Contracts*, which will require additional disclosure on the liability for unpaid claims and claim adjustment expenses. We intend to adopt this standard effective for our annual report for the year ending December 31, 2016, and for interim periods thereafter. It requires additional disclosure only and will not have a significant impact to our consolidated financial statements.

Software Licenses. In April 2015, the FASB issued ASU 2015-05, *Customer's Accounting for Fees Paid in a Cloud Computing Arrangement*, which will require customers to determine whether a cloud computing arrangement includes the license of software by applying the same guidance cloud service providers use to make this determination. The ASU also eliminates the existing requirement for customers to account for software licenses they acquire by analogizing to the guidance on leases. This ASU will be effective for us in the first quarter of 2016, and is applied either prospectively or retrospectively. We are evaluating the potential effects of adoption to our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the SEC did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

Recent Accounting Pronouncements Adopted

Income Taxes. In the fourth quarter of 2015, we early adopted ASU 2015-17, *Balance Sheet Classification of Deferred Taxes*, which requires deferred tax assets and liabilities to be classified as non-current, in a classified statement of financial position. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption had an insignificant impact to our consolidated balance sheets, and had no impact to our consolidated statements of income, stockholders' equity, and cash flows.

Business Combinations. In the fourth quarter of 2015, we early adopted ASU 2015-16, *Simplifying the Accounting for Measurement-Period Adjustments*, which requires acquirers to recognize adjustments to provisional amounts identified during the measurement period (a reasonable time period after the acquisition date) in the reporting period in which such adjustment amounts are determined. For the year ended December 31, 2015, there was no impact to our consolidated financial statements.

Debt Issuance Costs. In the fourth quarter of 2015, we early adopted ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*, which requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of such debt liability, consistent with debt discounts. In a subsequent Staff Announcement, the SEC announced that it would not object to the deferral and presentation of debt issuance costs relating to line-of-credit arrangements as an asset. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption had an insignificant impact to our consolidated balance sheets, and had no impact to our consolidated statements of income, stockholders' equity, and cash flows.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	December 31,		
	2015	2014	2013
	(In millions)		
Shares outstanding at the beginning of the period	49	46	47
Weighted-average number of shares:			
Issued:			
Common stock offering	3	—	—
Convertible senior notes	—	1	—
Repurchased	—	—	(1)
Denominator for basic net income per share	52	47	46
Effect of dilutive securities:			
Share-based compensation	1	—	1
Convertible senior notes (1)	1	1	—
1.125% Warrants (1)	2	—	—
Denominator for diluted net income per share	56	48	47
Potentially dilutive common shares excluded from calculations (2):			
1.125% Warrants	—	13	12

(1) For more information regarding the convertible senior notes, including the 1.625% Notes, 3.75% Notes, and 3.75% Exchange, refer to Note 12, "Debt." For more information regarding the 1.125% Warrants, refer to Note 13, "Derivatives."

(2) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the years ended December 31, 2014 and 2013, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

4. Business Combinations

During 2015, we closed on business combinations in both the Health Plans and Other segments. For all of these transactions we applied the acquisition method of accounting, where the total purchase price was allocated, or preliminarily allocated, to tangible and intangible assets acquired, and liabilities assumed based on their respective fair values. For Health Plans acquisitions, in general, only intangible assets are acquired. All of the 2015 acquisitions were funded using available cash.

Health Plans

Consistent with our strategy to grow in our existing markets, we closed the following Health Plans acquisitions in 2015:

Florida. On November 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to operation of the Medicaid business, of Integral Health Plan, Inc. The final purchase price was $67 million, and the Florida health plan added approximately 101,000 members in the Northwest and Southwest regions of Florida as a result of this transaction. On the closing date, we withheld 10%, or approximately $7 million, of the purchase price to establish an indemnification amount held as security for the seller's indemnification obligations under the purchase agreement. We have recorded the indemnification amount to restricted assets, which will be settled in November 2016. If we do not have any claims against the seller on or before the settlement date, we will pay the full withhold amount to the seller. As of December 31, 2015, we had not made any claims against the withhold amount.

On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc. The final purchase price was $8 million, and the Florida health plan added approximately 23,000 members as a result of this transaction.

Michigan. On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc. The purchase price was $47 million, and the Michigan health plan added approximately 68,000 members as a result of this transaction.

For the Health Plans acquisitions closed in 2015, we recorded goodwill amounting to $90 million in the aggregate, which relates to future economic benefits arising from expected synergies to be achieved. Such synergies include use of our existing infrastructure to support the added membership. The amount recorded as goodwill represents intangible assets that do not qualify for separate recognition as identifiable intangible assets. The entire amount recorded as goodwill is deductible for income tax purposes. Refer to the table below for a summary of the intangible assets identified, and their economic lives.

Announced Acquisitions. As described in Note 1, "Basis of Presentation," we announced several Health Plans acquisitions in 2015 that did not close until January 1, 2016. Because the closing dates for these acquisitions fell on January 1, 2016, a holiday, approximately $101 million was recorded to prepaid expenses and other assets as of December 31, 2015, for purchase price amounts funded in December 2015. Such amounts are reported in investing activities in the accompanying consolidated statements of cash flows. The total aggregate purchase price for these acquisitions amounted to approximately $115 million, which will be allocated among goodwill and intangible assets. The initial accounting for these transactions is incomplete.

Transaction costs associated with the Health Plans acquisitions were insignificant.

Other

Pathways. Consistent with our strategy to acquire and develop new products and capabilities, on November 1, 2015, we acquired all of the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia.

The following table summarizes the preliminary values of the assets acquired and liabilities assumed at the date of acquisition.

	November 1, 2015 (In millions)
Assets:	
Cash and cash equivalents	$ 20
Receivables	52
Prepaid expenses and other current assets	4
Property and equipment	14
Intangible assets	19
Goodwill	155
Other assets	1
Liabilities:	
Medical claims and benefits payable	(2)
Accounts payable and accrued liabilities	(23)
Deferred revenue	(2)
Other long-term liabilities	(7)
Total purchase price	$ 231

As of December 31, 2015, the purchase price allocation for the acquisition was preliminary and subject to completion. Adjustments to the current fair value estimates in the above table may occur as the process conducted for various valuations and assessments is finalized, including tax assets and liabilities. Goodwill is calculated as the excess of the consideration transferred over the net assets recognized and represents the estimated future economic benefits arising from other assets acquired that could not be individually identified and separately recognized, including expected medical cost synergies to be achieved, and the workforce acquired. Such synergies include the achievement of better outcomes for our members through more effective care coordination and integration, and our retention of the net profit margin captured by the mental health provider. The workforce acquired is a significant component of goodwill because it represents primarily the patient-facing employees, now employed by us, who provide the behavioral/mental health and social services. Approximately 10% of the goodwill recorded at December 31, 2015, is deductible for income tax purposes. This percentage may increase if certain tax elections are completed in 2016.

The gross contractual amount of receivables, at the acquisition date, was approximately $61 million. At the acquisition date, the best estimate of contractual cash flows not expected to be collected was approximately $9 million.

In connection with this acquisition, we incurred approximately $3 million in transaction costs, which are recorded in general and administrative expenses.

The following table presents the intangible assets identified, by segment. The weighted-average amortization period for the Health Plans identified intangible assets, in the aggregate, is 6.4 years. The weighted-average amortization period for the Other identified intangible assets, in the aggregate, is 4.2 years.

	Fair Value	Life (years)
	(In millions)	
Intangible asset type		
Health Plans:		
Contract rights - member list	$ 23	5
Provider network	9	10
Other:		
Contract licenses	5	2
Contract rights - member list	14	5
	$ 51	

5. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include the following:

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2015 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 13, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated. The changes in Level 3 instruments for the year ended December 31, 2015 were insignificant.

Our financial instruments measured at fair value on a recurring basis at December 31, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,184	$ —	$ 1,184	$ —
Government-sponsored enterprise securities (GSEs)	211	211	—	—
Municipal securities	185	—	185	—
Certificates of deposit	80	—	80	—
U.S. treasury notes	78	78	—	—
Asset-backed securities	63	—	63	—
Subtotal - current investments	1,801	289	1,512	—
1.125% Call Option derivative asset	374	—	—	374
Total assets measured at fair value on a recurring basis	$ 2,175	$ 289	$ 1,512	$ 374
1.125% Conversion Option derivative liability	$ 374	$ —	$ —	$ 374
Total liabilities measured at fair value on a recurring basis	$ 374	$ —	$ —	$ 374

Our financial instruments measured at fair value on a recurring basis at December 31, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 641	$ —	$ 641	$ —
GSEs	122	122	—	—
Municipal securities	127	—	127	—
Certificates of deposit	69	—	69	—
U.S. treasury notes	60	60	—	—
Subtotal - current investments	1,019	182	837	—
1.125% Call Option derivative asset	329	—	—	329
Total assets measured at fair value on a recurring basis	$ 1,348	$ 182	$ 837	$ 329
1.125% Conversion Option derivative liability	$ 329	$ —	$ —	$ 329
Total liabilities measured at fair value on a recurring basis	$ 329	$ —	$ —	$ 329

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. As described in Note 2, "Significant Accounting Policies," the carrying amount of debt has been reduced by deferred issuance costs for all periods presented.

	December 31, 2015		December 31, 2014	
	Carrying Amount	Total Fair Value	Carrying Amount	Total Fair Value
		(In millions)		
5.375% Notes	$ 689	$ 700	$ —	$ —
1.125% Convertible Notes	448	865	426	767
1.625% Convertible Notes	273	365	264	337
	$ 1,410	$ 1,930	$ 690	$ 1,104

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,189	$ —	$ 5	$ 1,184
GSEs	212	—	1	211
Municipal securities	186	—	1	185
Certificates of deposit	80	—	—	80
U.S. treasury notes	78	—	—	78
Asset-backed securities	63	—	—	63
	$ 1,808	$ —	$ 7	$ 1,801

	December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 643	$ —	$ 2	$ 641
GSEs	122	—	—	122
Municipal securities	127	—	—	127
Certificates of deposit	69	—	—	69
U.S. treasury notes	60	—	—	60
	$ 1,021	$ —	$ 2	$ 1,019

The contractual maturities of our investments as of December 31, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 830	$ 829
Due after one year through five years	967	962
Due after five years through ten years	11	10
	$ 1,808	$ 1,801

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the years ended December 31, 2015, 2014 and 2013 were insignificant.

We have determined that unrealized gains and losses at December 31, 2015 and 2014 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.

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, 2015.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 825	$ 4	588	$ 119	$ 1	87
GSEs	182	1	77	—	—	—
Municipal securities	128	1	181	5	—	12
Certificates of deposit	53	—	218	—	—	—
U.S. treasury notes	53	—	32	—	—	—
Asset-backed securities	55	—	47	—	—	—
	$ 1,296	$ 6	1,143	$ 124	$ 1	99

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, 2014.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 379	$ 1	265	$ 29	$ 1	10
GSEs	75	—	22	3	—	3
Municipal securities	54	—	64	11	—	13
Certificates of deposit	13	—	52	—	—	—
U.S. treasury notes	19	—	13	—	—	—
	$ 540	$ 1	416	$ 43	$ 1	26

7. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial. The information below is presented by segment.

	December 31,	
	2015	2014
	(In millions)	
California	$ 104	$ 311
Florida	22	2
Illinois	35	32
Michigan	39	20
New Mexico	51	50
Ohio	66	45
Puerto Rico	33	—
South Carolina	6	4
Texas	56	29
Utah	18	6
Washington	53	43
Wisconsin	22	8
Direct delivery and other	6	11
Total Health Plans segment	511	561
Molina Medicaid Solutions segment	37	35
Other segment	49	—
	$ 597	$ 596

8. Property, Equipment, and Capitalized Software

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2015	2014
	(In millions)	
Land	$ 16	$ 15
Building and improvements	153	195
Furniture and equipment	250	141
Capitalized software	336	267
	755	618
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(167)	(129)
Less: accumulated amortization for capitalized software	(195)	(148)
	(362)	(277)
Property, equipment, and capitalized software, net	$ 393	$ 341

Depreciation recognized for building and improvements, and furniture and equipment was $49 million, $35 million, and $27 million for the years ended December 31, 2015, 2014 and 2013, respectively. Amortization of capitalized software was $52 million, $59 million, and $46 million for the years ended December 31, 2015, 2014 and 2013, respectively.

Molina Center. We acquired the Molina Center in December 2011. Subsequently, in June 2013 we entered into a sale-leaseback transaction for the Molina Center. Due to our continuing involvement with the leased property, the sale did not qualify for sales recognition and we remain the "accounting owner" of the property. See Note 12, "Debt."

Future minimum rental income on noncancelable leases from third party tenants of the Molina Center is sublease rental income, and is reported in other revenue in our consolidated statements of income. The future minimum rental income is as follows:

	2016	2017	2018	2019	2020	Thereafter	Total
	(In millions)						
Future minimum rentals	$ 4	4	4	2	2	1	$ 17

9. Goodwill and Intangible Assets

The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
	(In millions)		
Intangible assets:			
Contract rights and licenses	$ 224	$ 120	$ 104
Customer relationships	25	23	2
Contract backlog	24	24	—
Provider networks	27	11	16
Balance at December 31, 2015	$ 300	$ 178	$ 122
Intangible assets:			
Contract rights and licenses	$ 182	$ 105	$ 77
Customer relationships	25	23	2
Contract backlog	24	23	1
Provider networks	18	9	9
Balance at December 31, 2014	$ 249	$ 160	$ 89

Based on the balances of our identifiable intangible assets as of December 31, 2015, we estimate that our intangible asset amortization will be $25 million in 2016, $25 million in 2017, $22 million in 2018, $18 million in 2019, and $13 million in 2020. For a presentation of our goodwill and intangible assets by reportable segment, refer to Note 20, "Segment Information."

The following table presents the balances of goodwill as of December 31, 2015 and 2014:

		Acquisitions by Segment		
	December 31, 2014	Health Plans	Other	December 31, 2015
	(In millions)			
Goodwill, gross	$ 330	$ 90	$ 157	$ 577
Accumulated impairment losses	(58)	—	—	(58)
Goodwill, net	$ 272	$ 90	$ 157	$ 519

The changes in the carrying amounts of goodwill and intangible assets, at cost, in 2015 were due to the acquisitions described in Note 4, "Business Combinations."

10. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. In connection with a Molina Medicaid Solutions segment state contract, we maintained restricted investments as collateral for a letter of credit as of December 31, 2014. The following table presents the balances of restricted investments:

	December 31,	
	2015	2014
	(In millions)	
Florida	$ 34	$ 29
Michigan	1	1
New Mexico	43	35
Ohio	12	13
Puerto Rico	10	5
South Carolina	—	6
Texas	4	3
Utah	4	4
Wisconsin	1	—
Other	—	1
Total Health Plans segment	109	97
Molina Medicaid Solutions segment	—	5
	$ 109	$ 102

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2015 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 100	$ 100
Due one year through five years	9	9
	$ 109	$ 109

11. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	December 31,		
	2015	2014	2013
	(In millions)		
Fee-for-service claims incurred but not paid (IBNP)	$ 1,191	$ 871	$ 424
Pharmacy payable	88	71	45
Capitation payable	140	28	20
Other	266	231	181
	$ 1,685	$ 1,201	$ 670

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $167 million, $119 million and $151 million, as of December 31, 2015, 2014 and 2013, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for "Components of medical care costs

related to: Prior periods" represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than 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,		
	2015	2014	2013
	(Dollars in millions)		
Balances at beginning of period	$ 1,201	$ 670	$ 495
Components of medical care costs related to:			
Current period	11,935	8,123	5,434
Prior periods	(141)	(46)	(53)
Total medical care costs	11,794	8,077	5,381
Change in non-risk provider payables	48	(32)	111
Payments for medical care costs related to:			
Current period	10,448	7,064	4,932
Prior periods	910	450	385
Total paid	11,358	7,514	5,317
Balances at end of period	$ 1,685	$ 1,201	$ 670

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). Our IBNP, as included in medical claims and benefits payable, 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.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and 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. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. 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.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2015, 2014, and 2013 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

2015

We believe that the most significant factors that will determine the accuracy of our IBNP estimates at December 31, 2015 are:

- A new version of diagnosis codes was required for all claims with dates of service October 1, 2015 and later. As a result, payment was delayed for a significant number of claims due to the use of diagnosis codes that were no longer valid. Due to the resulting variability in the ratio of paid to billed amounts, the reserves are subject to more than the usual amount of uncertainty.

- At our Illinois, Puerto Rico and Wisconsin health plans, we overpaid certain provider and outpatient facility claims due to a system configuration error. For this reason, the reserves are subject to more than the usual amount of uncertainty.
- Our Michigan health plan added approximately 68,000 new members under an acquisition in the third quarter of 2015. Because these new members may have different utilization patterns than our legacy members, the reserves are subject to more than the usual amount of uncertainty.
- Our Puerto Rico health plan started operations on April 1, 2015. Because we lack sufficient historical claims data, our reserves as of December 31, 2015 are based on a combination of claims payment experience and the expected claims in the pricing assumptions. For this reason, the reserves are subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $141 million for the year ended December 31, 2015. This amount represents our estimate as of December 31, 2015, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio and California health plans, approximately 61,000 and 100,000 members, respectively, were enrolled in the new Medicaid expansion program during 2014. Also in Ohio, approximately 17,000 members were enrolled in the new MMP program in 2014. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.
- At our New Mexico health plan, the state implemented a retroactive increase to the provider fee schedules in mid-2014. As a result, many claims that were previously settled were reopened, and subject to, additional payment. Because our reserving methodology is most accurate when claims payment patterns are consistent and predictable, the payment of additional amounts on claims that in some cases had been settled more than six months before added a substantial degree of complexity to our liability estimation process. Due to the difficulties in addressing that added complexity, liabilities recorded as of December 31, 2014, were in excess of amounts ultimately paid.
- At our Washington health plan, in 2015 we collected amounts related to certain claims paid in 2013. Such collections were not anticipated in our reserves as of December 31, 2014.

2014

We recognized favorable prior period claims development in the amount of $46 million for the year ended December 31, 2014. This amount represented our estimate as of December 31, 2014, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2013 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio health plan, we entered new regions in the state, and a new product, ABD Kids, in July 2013. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.
- At our Michigan health plan, we overestimated the impact of certain unpaid potentially high-dollar claims. In addition, we overestimated the impact of the flu season on the outpatient claims for November and December 2013, which caused an overestimation in our outpatient reserve liability as of December 31, 2013.

2013

We recognized favorable prior period claims development in the amount of $53 million for the year ended December 31, 2013. This amount represented our estimate as of December 31, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Washington health plan certain high-cost newborns, as well as other high-cost disabled members, were covered by the health plan effective July 1, 2012. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors. Our actual costs were ultimately less than expected.
- At our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.

- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to our ABD members.

12. Debt

As of December 31, 2015, contractual maturities of debt for the years ending December 31 are as follows (in millions):

	Total	2016	2017	2018	2019	2020	Thereafter
5.375% Notes	$ 700	$ —	$ —	$ —	$ —	$ —	$ 700
1.125% Convertible Notes	550	—	—	—	—	550	—
1.625% Convertible Notes (1)	302	—	—	—	—	—	302
Other	1	1	—	—	—	—	—
	$ 1,553	$ 1	$ —	$ —	$ —	$ 550	$ 1,002

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The principal amounts, unamortized discount (net of premium related to 1.625% Notes), unamortized issuance costs, and net carrying amounts of debt were as follows:

	Principal Balance	Unamortized Discount	Unamortized Issuance Costs	Net Carrying Amount
	(In millions)			
December 31, 2015:				
5.375% Notes	$ 700	$ —	$ 11	$ 689
1.125% Convertible Notes	550	95	7	448
1.625% Convertible Notes	302	25	4	273
Other	1	—	—	1
	$ 1,553	$ 120	$ 22	$ 1,411
December 31, 2014:				
1.125% Convertible Notes	$ 550	$ 115	$ 9	$ 426
1.625% Convertible Notes	302	33	5	264
	$ 852	$ 148	$ 14	$ 690

	Years Ended December 31,		
	2015	2014	2013
	(In millions)		
Interest cost recognized for the period relating to:			
Contractual interest coupon rate	$ 17	$ 13	$ 13
Amortization of the discount	29	26	22
	$ 46	$ 39	$ 35

5.375% Senior Notes due 2022. On November 10, 2015, we completed the private offering of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest is payable semiannually in arrears on May 15 and November 15, beginning on May 15, 2016. The 5.375% Notes are not convertible into our common stock or any other securities.

The 5.375% Notes are guaranteed by certain of our wholly owned subsidiaries. The 5.375% Notes and the guarantees are effectively subordinated to all existing and future secured debt of us and our guarantors to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock of our subsidiaries that do not guarantee the 5.375% Notes.

We may redeem some or all of the 5.375% Notes at any time, and prior to August 15, 2022, at a price equal to 100% of the principal amount redeemed plus accrued and unpaid interest thereon, plus a "make-whole" premium. Thereafter, we may redeem some or all of the 5.375% Notes at a price equal to 100% of the principal amount redeemed plus accrued and unpaid

interest thereon. The 5.375% Notes contain customary non-financial covenants and change of control provisions.

In connection with the issuance and sale of the 5.375% Notes, we entered into a registration rights agreement. Under this agreement, we will use commercially reasonable efforts to register substantially identical notes (the Exchange Notes) with the SEC in 2016. We will then offer such freely tradable Exchange Notes in exchange for the 5.375% Notes. We will pay additional interest on the 5.375% Notes if the Exchange Notes offering is not completed timely.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. As of December 31, 2015, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Although the Credit Facility is not secured by any of our assets, certain of our wholly owned subsidiaries have jointly and severally guaranteed our obligations under the Credit Facility.

The Credit Facility contains customary non-financial and financial covenants, including a minimum fixed charge coverage ratio, a maximum debt-to-EBITDA ratio and minimum statutory net worth. At December 31, 2015, we were in compliance with all financial covenants under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes (1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest is payable semiannually in arrears on January 15 and July 15.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date. Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;

- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;

- upon the occurrence of specified corporate events; or

- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes met the stock price trigger in the quarter ended December 31, 2015, and are convertible into cash through at least March 31, 2016. Because the 1.125% Notes may be converted to cash within 12 months, the $448 million carrying amount is reported in current portion of long-term debt as of December 31, 2015.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount).

This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of December 31, 2015, the 1.125% Notes have a remaining amortization period of 4.0 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $332 million and $93 million as of December 31, 2015 and December 31, 2014, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $125 million principal amount of 1.625% convertible senior notes (1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Combined with the 1.625% Notes issued in connection with the 3.75% Exchange described below, the aggregate principal amount issued under the 1.625% Notes was $302 million.

Interest is payable semiannually in arrears on February 15 and August 15. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of December 31, 2015, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and

ending on the first date we may redeem the notes in August 2018. As of December 31, 2015, the 1.625% Notes have a remaining amortization period of 2.6 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value exceeded their principal amount by approximately $10 million as of December 31, 2015, and did not exceed their principal amount as of December 31, 2014. At December 31, 2015 and December 31, 2014, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $23 million.

3.75% Exchange. In August 2014, we entered into separate, privately negotiated, exchange agreements (the 3.75% Exchange) with certain holders of our outstanding 3.75% convertible senior notes due 2014 (the 3.75% Notes). In this transaction, we exchanged $177 million aggregate principal amount of the 3.75% Notes for $177 million principal amount of 1.625% convertible senior notes due 2044, approximately 2 million shares of our common stock, and payment of accrued interest on the exchanged 3.75% Notes; additionally, we issued approximately 81,000 shares of common stock for services rendered in connection with the 3.75% Exchange. We did not receive any proceeds from the 3.75% Exchange.

3.75% Notes. As described above, we entered into the 3.75% Exchange transaction in August 2014, under which we exchanged $177 million of the outstanding principal amount of the 3.75% Notes for the 1.625% Notes. The remaining $10 million principal amount was repaid in full in October 2014.

Lease Financing Obligations. In 2013, we entered into a sale-leaseback transaction for the Molina Center located in Long Beach, California, and our Ohio health plan office building located in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sales recognition and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Rent will increase 3% per year through the initial term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest amounted to $13 million for both years ended December 31, 2015 and 2014.

As described and defined in further detail in Note 17, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings. We have concluded that we are the accounting owner of the buildings due to our continuing involvement with the properties. We have recorded $36 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of December 31, 2015, which represents the total cost incurred by the Landlord for the construction of the buildings, net of accumulated depreciation. As of December 31, 2015 and December 31, 2014, the aggregate amount recorded to lease financing obligations, including the current portion, amounted to $40 million and $41 million, respectively. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense was $4 million and $3 million for the year ended December 31, 2015 and 2014, respectively. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was $1 million for both years ended December 31, 2015 and 2014. For information regarding the future minimum lease obligation, refer to Note 19, "Commitments and Contingencies."

13. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

		December 31,	
	Balance Sheet Location	2015	2014
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 374	$ —
	Non-current assets: Derivative asset	$ —	$ 329
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 374	$ —
	Non-current liabilities: Derivative liability	$ —	$ 329

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the notes due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 5, "Fair Value Measurements."

As of December 31, 2015, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of December 31, 2015, as described in Note 12, "Debt."

14. Income Taxes

The provision for income taxes for continuing operations consisted of the following:

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Current:			
Federal	$ 172	$ 72	$ 67
State	8	3	—
Foreign	6	—	—
Total current	186	75	67
Deferred:			
Federal	(10)	—	(25)
State	4	(2)	(6)
Foreign	(1)	—	—
Total deferred	(7)	(2)	(31)
	$ 179	$ 73	$ 36

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate for continuing operations is as follows:

	Year Ended December 31,		
	2015	2014	2013
Statutory federal tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	2.4	0.4	(0.5)
Change in unrecognized tax benefits	0.9	(0.1)	(3.7)
Nondeductible health insurer fee (HIF)	17.0	22.9	—
Nondeductible compensation	0.6	(4.1)	9.6
Nondeductible fair value of 1.125% Warrants	—	—	2.4
Other	(0.4)	(0.3)	2.0
Effective tax rate	55.5 %	53.8 %	44.8 %

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, foreign, and local tax laws.

During 2014, the Internal Revenue Service (IRS) issued final regulations related to compensation deduction limitations applicable to certain health insurance issuers. Pursuant to these final regulations, we reversed amounts treated as nondeductible in 2013 and recognized a tax benefit during 2014.

During 2015, 2014, and 2013, excess tax benefits from share-based compensation amounted to $8 million, $3 million, and $2 million, respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital.

Deferred tax assets and liabilities are classified as non-current. Significant components of our deferred tax assets and liabilities as of December 31, 2015 and 2014 were as follows:

	December 31,	
	2015	2014
	(In millions)	
Accrued expenses	$ 37	$ 13
Reserve liabilities	14	4
Other accrued medical costs	5	4
Net operating losses	7	3
Unrealized losses	2	1
Unearned premiums	21	22
Lease financing obligation	35	34
Deferred compensation	8	10
Tax credit carryover	8	8
Valuation allowance	(9)	(6)
Total deferred income tax assets, net of valuation allowance	128	93
Prepaid expenses	(9)	(6)
Depreciation and amortization	(83)	(57)
Basis in debt	(18)	(15)
Total deferred income tax liabilities	(110)	(78)
Net deferred income tax asset - long term	$ 18	$ 15

At December 31, 2015, we had state net operating loss carryforwards of $180 million, which begin expiring in 2016.

At December 31, 2015, we had California enterprise zone tax credit carryovers of $11 million, which will begin to expire in 2024, and foreign tax credit carryovers of $1 million, which expire in 2025.

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, 2015, $9 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 and foreign tax credit carryforwards. Therefore, we increased our valuation allowance by $3 million, from $6 million at December 31, 2014, to $9 million as of December 31, 2015.

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 United States, Puerto Rico, 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,		
	2015	2014	2013
	(In millions)		
Gross unrecognized tax benefits at beginning of period	$ (3)	$ (8)	$ (11)
Increases in tax positions for current year	(1)	—	—
Increases in tax positions for prior years	(5)	(1)	(2)
Decreases in tax positions for prior years	—	—	5
Settlements	—	6	—
Gross unrecognized tax benefits at end of period	$ (9)	$ (3)	$ (8)

The total amount of unrecognized tax benefits at December 31, 2015, 2014 and 2013 that, if recognized, would affect the effective tax rates is $7 million, $2 million and $6 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $1 million due to the normal expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2015, and 2014 were insignificant.

We are under examination by the IRS for calendar year 2011 and may be subject to examination for calendar years 2012 through 2014. We are under examination, or may be subject to examination, in Puerto Rico and certain state and local jurisdictions, with the major state jurisdictions being California, Utah, and Michigan, for the years 2010 through 2014.

15. Stockholders' Equity

Stockholders' equity increased $547 million during the year ended December 31, 2015. The increase was primarily due to the common stock offering described below, net income of $143 million, and $34 million related to share-based compensation transactions.

Common Stock Offering. In June 2015, we completed an underwritten public offering of 5,750,000 shares of our common stock, including the over-allotment option. Net of issuance costs, proceeds from the offering amounted to $373 million, or $64.90 per share, resulting in an increase to additional paid-in capital. We are using the proceeds to finance working capital needs, acquisitions, capital expenditures, and other general corporate activities.

1.125% Warrants. In connection with the 1.125% Notes Call Spread Overlay transaction described in Note 13, "Derivatives," in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Programs. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This newly authorized repurchase program extends through December 31, 2016.

In February 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. We did not repurchase any shares under this program, which expired December 31, 2015.

Stock Incentive Plans. At December 31, 2015, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan (2011 Plan); and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

The 2011 Plan provides for the award of restricted shares and units, performance shares and units, stock options and stock bonuses to the company’s officers, employees, directors, consultants, advisers, and other service providers. The 2011 Plan provides for the issuance of up to 4.5 million shares of common stock.

Restricted share 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.

In connection with our stock plans, we issued approximately 830,000 shares of common stock, net of shares used to settle employees' income tax obligations, in the year ended December 31, 2015.

The following table illustrates the components of our share-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2015		2014		2013	
	(In millions)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock and performance awards	$ 19	$ 13	$ 19	$ 12	$ 26	$ 23
Employee stock purchase plan and stock options	4	3	3	2	3	2
	$ 23	$ 16	$ 22	$ 14	$ 29	$ 25

As of December 31, 2015, there was $25 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.6 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 6.5% for non-executive employees as of December 31, 2015. As of December 31, 2015, the unrecognized compensation expense related to unvested stock options was insignificant.

Restricted stock. Restricted and performance stock activity for the year ended December 31, 2015 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2014	1,282,072	$ 33.55
Granted - restricted shares	273,710	64.56
Granted - performance shares	162,827	63.90
Vested - restricted shares	(371,489)	34.58
Vested - performance shares	(264,604)	30.80
Forfeited	(47,759)	37.51
Unvested balance as of December 31, 2015	1,034,757	46.68

The total fair value of restricted and performance share awards granted during the years ended December 31, 2015, 2014, and 2013 was $28 million, $25 million, and $33 million, respectively. The total fair value of restricted share awards, including those with performance or market conditions which vested during the years ended December 31, 2015, 2014, and 2013 was $39 million, $24 million, and $22 million, respectively.

In 2015, our named executive officers were granted approximately 163,000 restricted shares with performance and market conditions. The grant date fair value for the awards with market conditions were determined based on a Monte Carlo Simulation which projected Total Stockholder Return (TSR) over the performance period using correlations and volatilities of our ISS peer groups. The weighted-average grant date fair value per share of the 2015 performance awards based on three-year TSR was $49.43, determined using additional inputs as follows: risk-free interest rate of 0.8%, dividend yield of 0%, and expected life of 2.8 years.

As of December 31, 2015, there were approximately 377,000 unvested restricted shares outstanding which contained one or more performance measures. In the event the vesting conditions are not achieved, the awards will lapse. Based on our assessment as of December 31, 2015, we expect the performance conditions relating to approximately 199,000 of these outstanding restricted share awards to be met in full.

In 2015, we reversed approximately $3 million in share-based compensation expense recognized from grant date through March 31, 2015, related to 178,000 of the awards granted in 2014, due to management's determination in the second quarter of 2015 that the achievement of the underlying performance conditions was not probable.

In December 2015, approximately 229,000 restricted stock awards with performance conditions, granted in 2013, vested due to achievement of the total revenue metric as defined in the terms of the grant.

Employee Stock Purchase Plan. Under our employee stock purchase plan (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. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2015, 2014, and 2013, the inputs to this model were as follows: risk-free interest rates of approximately 0.1%; expected volatilities ranging from approximately 30% to 50%, dividend yields of 0%, and an average expected life of 0.5 years. We issued approximately 301,900, 327,200 and 299,600 shares of our common stock under the ESPP during the years ended December 31, 2015, 2014, and 2013, respectively. The 2011 ESPP provides for the issuance of up to three million shares of common stock.

Stock Options. No stock options were granted in 2015 and 2014, and stock options outstanding as of December 31, 2015 were insignificant. The grant date fair value per share of the stock options awarded to the new members of our board of directors during 2013 was $14.67. We estimated the fair value of each stock option award using the Black-Scholes option pricing model, with the following inputs: risk-free interest rate of 1.4%, expected volatility of 41.3%, dividend yield of 0%, and expected life of 7 years. The total intrinsic value of options exercised during the years ended December 31, 2015, 2014, and 2013 was $6 million, $2 million, and $1 million, respectively.

16. Employee Benefits

We sponsor defined contribution 401(k) plans that cover 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) plans totaled $27 million, $21 million and $13 million in the years ended December 31, 2015, 2014, and 2013, 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.

17. Related Party Transactions

Prior to December 22, 2015, we were the lessee under a lease with 6th & Pine Development, LLC (the Landlord) for two office buildings. The principal members of the Landlord were John C. Molina, our chief financial officer and a director of Molina Healthcare, Inc., and his wife. In addition, in connection with the development of the buildings being leased, John C. Molina pledged certain of his common stock holdings in Molina Healthcare, Inc. Dr. J. Mario Molina, our chief executive officer, president and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary. On December 22, 2015, the Landlord assigned the lease to an unrelated third party. There were no significant changes to the lease other than the assignment to the new owner. As a result of the assignment, as of December 31, 2015, amounts previously reported as lease financing obligations - related party were reported in lease financing obligations on the accompanying consolidated balance sheets. For information regarding the lease financing obligation associated with this lease, refer to Note 12, "Debt."

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina and John C. Molina. Under the terms of this provider agreement, the California health plan paid Pacific approximately $1 million in each of 2015 and 2014 for medical care provided to health plan members. Payments in 2013 were insignificant.

Refer to Note 18, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

18. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. Beginning in 2014, JMMPC also provided certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2015, JMMPC had total assets of $17 million, and total liabilities of $17 million. As of December 31, 2014, JMMPC had total assets of $31 million, and total liabilities of $31 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

New Markets Tax Credit

In 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC (Wells Fargo), its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC (Investment Fund), and certain of Wells Fargo's affiliated Community Development Entities (CDEs), in connection with our participation in the federal government's New Markets Tax Credit Program (NMTC). The NMTC was established by Congress to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $6 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $16 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $21 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $6 million. Additionally, financing costs incurred in structuring the arrangement amounting to $1 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE—collecting and remitting interest and fees and NMTC compliance—were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $6 million is included in cash at December 31, 2015 and December 31, 2014 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

19. Commitments and Contingencies

Certain Leasing Transactions. As described in Note 12, "Debt," we entered into certain leasing transactions that have been classified as lease financing obligations. Such leases have initial terms that range from 16.5 years to 25 years. Additionally, the leases provide for renewal options ranging from 10 years to 25 years in aggregate.

Operating Leases. We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2025. Facility lease terms generally range from five to 10 years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under all operating leases and lease financing obligations consist of the following approximate amounts:

	Lease Financing Obligations	Operating Leases	Total
		(In millions)	
2016	$ 15	$ 49	$ 64
2017	16	47	63
2018	16	41	57
2019	16	32	48
2020	17	24	41
Thereafter	323	39	362
	$ 403	$ 232	$ 635

Rental expense related to operating leases amounted to $44 million, $32 million, and $25 million for the years ended December 31, 2015, 2014, and 2013, respectively. The amounts reported in "Lease Financing Obligations" above represent our contractual lease commitments for the properties described in Note 12, "Debt" under the subheading "Lease Financing Obligations." Payments under these leases adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income.

Employment Agreements. In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which were amended and restated in 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 equity compensation, and a cash payment for health and welfare benefits.

In 2013 we entered into employment agreements with our Chief Operating Officer, Chief Accounting Officer, and Chief Legal Officer. These agreements continue until terminated by us, or the executive resigns. If the executive's employment is terminated by us without cause or the executive resigns for good reason, the executive will be entitled to receive one year's base salary and termination bonus, as defined, full vesting of time-based equity compensation, and a cash payment for health and welfare benefits.

Payment of the severance benefits described above is contingent upon the executive's signing a release agreement waiving claims against us. If the executives are terminated for cause, no further payments are due under the contracts.

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. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. The District Court dismissed this action as to Molina without leave to amend as to some allegations and with leave to amend as to other allegations. On October 22, 2015, the Relator filed a third amended complaint. We believe that we have several meritorious defenses to the claims of the Relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Hospital Management Contract. During the fourth quarter of 2015, we recorded a contract settlement charge of approximately $15 million as a result of our termination of a hospital management agreement.

Professional Liability Insurance. We carry medical professional liability insurance for health care services rendered in the primary care institutions that we manage. In addition, we also carry errors and omissions insurance for all Molina entities.

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 have led certain 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 business, consolidated financial position, results of operations, or cash flows.

States' Budgets. From time to time the states in which our health plans operate may delay premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of December 31, 2015, our Illinois health plan served approximately 98,000 members, and recognized premium revenue of approximately $397 million for the year ended December 31, 2015. As of February 23, 2016, Illinois is current with its premium payments.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs including health care-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. Our Puerto Rico health plan became operational on April 1, 2015. As of December 31, 2015, the plan served approximately 348,000 members and recognized premium revenue of approximately $192 million in the fourth quarter of 2015, or approximately $64 million per month. As of February 23, 2016, the Commonwealth continues to pay us weekly for current membership.

It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility. Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter.

It has been our practice in the past, and will remain so in the future, to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, 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 approximately $1,229 million at December 31, 2015, and $859 million at December 31, 2014. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $612 million and $203 million as of December 31, 2015, and 2014, respectively.

The National Association of Insurance Commissioners (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 which may vary from state to state. All of the states in which our health plans operate, except California and Florida, have adopted these rules. California and Florida have not 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, 2015, our health plans had aggregate statutory capital and surplus of approximately $1,350 million compared with the required minimum aggregate statutory capital and surplus of approximately $776 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2015. 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.

20. Segment Information

We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other.

Our reportable segments are consistent with how we currently manage the business and view the markets we serve. The Health Plans segment consists of our health plans and our direct delivery business. Our health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides MMIS design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies. Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a

reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

The following table presents gross margin as the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the actual dollars earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. One of the key metrics used to assess the performance of the Health Plans segment is the medical care ratio; therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue. We previously reported our segment results to the operating income level, where we reported the cost of all centralized services within our most significant segment, the Health Plans segment.

The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies."

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
2015				
Total revenue (1)	$ 13,917	$ 195	$ 66	$ 14,178
Gross margin	1,447	55	5	1,507
Depreciation and amortization (2)	95	25	6	126
Goodwill, and intangible assets, net	393	73	175	641
Total assets	4,707	213	1,656	6,576
2014				
Total revenue (1)	9,449	210	8	9,667
Gross margin	947	53	—	1,000
Depreciation and amortization (2)	83	46	5	134
Goodwill, and intangible assets, net	286	75	—	361
Total assets	3,355	185	895	4,435
2013				
Total revenue (1)	6,376	205	8	6,589
Gross margin	799	44	—	843
Depreciation and amortization (2)	60	28	6	94
Goodwill, and intangible assets, net	249	81	—	330
Total assets	1,921	176	891	2,988

(1) Total revenues consists primarily of premium revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments.

(2) Depreciation and amortization reported in accompanying consolidated statements of cash flows.

The following table reconciles gross margin by segment to consolidated income from continuing operations before income tax expense:

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Gross margin:			
Health Plans	$ 1,447	$ 947	$ 799
Molina Medicaid Solutions	55	53	44
Other	5	—	—
Other operating revenues (1)	684	434	205
Other operating expenses (2)	1,804	1,241	911
Operating income	387	193	137
Other expenses, net	65	58	56
Income from continuing operations before income tax expense	$ 322	$ 135	$ 81

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

21. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2015 and 2014.

	For The Quarter Ended			
	March 31, 2015	June 30, 2015	September 30, 2015	December 31, 2015
	(In millions, except per-share data)			
Premium revenue	$ 2,971	$ 3,304	$ 3,377	$ 3,589
Service revenue	52	47	47	107
Operating income	82	116	113	76
Income from continuing operations	28	39	46	30
Net income	28	39	46	30
Net income per share (1):				
Basic	$ 0.58	$ 0.78	$ 0.84	$ 0.54
Diluted	$ 0.56	$ 0.72	$ 0.77	$ 0.52

	For The Quarter Ended			
	March 31, 2014	June 30, 2014	September 30, 2014	December 31, 2014
	(In millions, except per-share data)			
Premium revenue	$ 1,940	$ 2,167	$ 2,317	$ 2,599
Service revenue	54	50	52	54
Operating income	24	32	40	97
Income from continuing operations	4	8	16	34
Net income	4	8	16	34
Net income per share (1):				
Basic	$ 0.10	$ 0.17	$ 0.34	$ 0.70
Diluted	$ 0.09	$ 0.16	$ 0.33	$ 0.69

(1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the year ended December 31, 2014, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

22. Condensed Financial Information of Registrant

The condensed balance sheets as of December 31, 2015 and 2014, and the related condensed statements of income, comprehensive income and cash flows for each of the three years in the period ended December 31, 2015 for our parent company Molina Healthcare, Inc. (the Registrant), are presented below.

Condensed Balance Sheets

	December 31,	
	2015	2014
	(Amounts in millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 360	$ 75
Investments	252	126
Income taxes refundable	7	13
Due from affiliates	86	18
Prepaid expenses and other current assets	46	33
Derivative asset	374	—
Total current assets	1,125	265
Property, equipment, and capitalized software, net	267	265
Goodwill and intangible assets, net	61	65
Investments in subsidiaries	2,205	1,377
Deferred income taxes	23	11
Derivative asset	—	329
Advances to related parties and other assets	36	43
	$ 3,717	$ 2,355
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 157	$ 107
Current portion of long-term debt	449	—
Derivative liability	374	—
Total current liabilities	980	107
Senior notes	962	690
Lease financing obligations	198	157
Lease financing obligations - related party	—	40
Derivative liability	—	329
Other long-term liabilities	20	22
Total liabilities	2,160	1,345
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding:		
56 shares at December 31, 2015 and 50 shares at December 31, 2014	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	803	396
Accumulated other comprehensive loss	(4)	(1)
Retained earnings	758	615
Total stockholders' equity	1,557	1,010
	$ 3,717	$ 2,355

Condensed Statements of Income

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Revenue:			
Management fees and other operating revenue	$ 928	$ 704	$ 599
Investment income	3	2	3
Total revenue	931	706	602
Expenses:			
Medical care costs	55	46	38
General and administrative expenses	797	583	504
Depreciation and amortization	82	73	51
Total operating expenses	934	702	593
Operating (loss) income	(3)	4	9
Interest expense	66	57	51
Other expense	—	1	4
Loss before income taxes and equity in net income of subsidiaries	(69)	(54)	(46)
Income tax benefit	(21)	(27)	(16)
Net loss before equity in net income of subsidiaries	(48)	(27)	(30)
Equity in net income of subsidiaries	191	89	83
Net income	$ 143	$ 62	$ 53

Condensed Statements of Comprehensive Income

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Net income	$ 143	$ 62	$ 53
Other comprehensive income (loss):			
Unrealized investment loss	(5)	—	(1)
Effect of income tax benefit	2	—	—
Other comprehensive loss, net of tax	(3)	—	(1)
Comprehensive income	$ 140	$ 62	$ 52

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Operating activities:			
Net cash provided by operating activities	$ 113	$ 74	$ 63
Investing activities:			
Capital contributions to subsidiaries	(770)	(292)	(166)
Dividends received from subsidiaries	142	—	24
Purchases of investments	(244)	(129)	(363)
Proceeds from sales and maturities of investments	118	263	98
Purchases of equipment	(91)	(94)	(77)
Change in amounts due to/from affiliates	(68)	16	(6)
Other, net	—	8	(6)
Net cash used in investing activities	(913)	(228)	(496)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	689	123	538
Proceeds from common stock offering, net of issuance costs	373	—	—
Proceeds from sale-leaseback transactions	—	—	159
Purchase of call option	—	—	(149)
Proceeds from issuance of warrants	—	—	75
Treasury stock repurchases	—	—	(53)
Principal payment on term loan of subsidiary	—	—	(47)
Repayment of amount borrowed under credit facility	—	—	(40)
Proceeds from employee stock plans	18	14	9
Principal payments on convertible senior notes	—	(11)	—
Other, net	5	3	2
Net cash provided by financing activities	1,085	129	494
Net increase (decrease) in cash and cash equivalents	285	(25)	61
Cash and cash equivalents at beginning of year	75	100	39
Cash and cash equivalents at end of year	$ 360	$ 75	$ 100

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

The Registrant was incorporated in 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 three other state health plans. 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 accompanying condensed financial information of the Registrant 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 2015, 2014, and 2013 for these services amounted to $914 million, $692 million, and $592 million, respectively, and are included in operating revenue.

During 2013, the Registrant used a portion of the proceeds from the sale of the Molina Center, described in Note 12, "Debt," to repay the remaining principal balance of the related term loan, on behalf of a subsidiary of the Registrant.

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 - Dividends and Capital Contributions

When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries.

For all periods presented, the Registrant made capital contributions to certain subsidiaries 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, net of insignificant returns of capital.

Note D - Related Party Transactions

The Registrant's related party transactions are described in Note 17, "Related Party Transactions."

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.

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, 2015. 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* (2013 framework).

Our management's evaluation did not include an assessment of the effectiveness of internal control over financial reporting at Pathways Health and Community Support LLC (Pathways), which was acquired on November 1, 2015. The total assets and net assets of Pathways included in our consolidated balance sheets at December 31, 2015, were $276 million and $231 million, respectively. Total revenue and net loss of Pathways included in our consolidated results of operations for the year ended December 31, 2015, were $57 million and $4 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, 2015, based on the 2013 framework criteria.

Ernst & Young, LLP, the independent registered public accounting firm who audited the Company's Consolidated Financial Statements included in this Form 10-K, has issued a report on the Company's internal control over financial reporting, which is included herein.

Changes in Internal Control over Financial Reporting. There were no changes in the Company's internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2015, that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

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, 2015, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (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 Pathways Health and Community Support LLC (Pathways), which is included in the 2015 consolidated financial statements of Molina Healthcare, Inc. and constituted $276 million and $231 million of total and net assets, respectively, as of December 31, 2015, and $57 million and $4 million of revenues and net loss, 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 Pathways.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, 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, 2015 and 2014, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2015 and our report dated February 26, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2016

PART III

Item 10. Directors, Executive Officers, and Corporate Governance

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 1 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 definitive proxy statement for our 2016 Annual Meeting of Stockholders. The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Election of Directors," "Corporate Governance," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 11. Executive Compensation

The information required by Items 402, 407(e)(4), and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2015)

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	121,711	(1)	$ 25.40	4,058,668	(2)

(1) Options to purchase shares of our common stock issued under the 2002 Equity Incentive Plan and 2011 Equity Incentive Plan. Further grants under the 2002 Equity Incentive Plan have been suspended.

(2) Includes shares remaining available to issue under the 2011 Equity Incentive Plan, and the 2011 Employee Stock Purchase Plan.

The remaining information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Related Party Transactions," "Corporate Governance," and "Director Independence" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Additionally, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 17, "Related Party Transactions," and Note 18, "Variable Interest Entities (VIEs)," under the subheading "Joseph M. Molina M.D., Professional Corporations."

Item 14. Principal Accountant Fees and Services

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Auditor Fees" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information 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 financial statements included in Item 8 of this Form 10-K, Financial Statements and Supplementary Data, above are filed as part of this annual report.

(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 26th day of February, 2016.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina

Joseph M. Molina, M.D. (Dr. J. Mario Molina)
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)	February 26, 2016
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	February 26, 2016
/s/ Joseph W. White **Joseph W. White**	Chief Accounting Officer (Principal Accounting Officer)	February 26, 2016
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	February 26, 2016
/s/ Daniel Cooperman **Daniel Cooperman**	Director	February 26, 2016
/s/ Charles Z. Fedak **Charles Z. Fedak**	Director	February 26, 2016
/s/ Steven G. James **Steven G. James**	Director	February 26, 2016
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	February 26, 2016
/s/ Steven J. Orlando **Steven J. Orlando**	Director	February 26, 2016
/s/ Ronna E. Romney **Ronna E. Romney**	Director	February 26, 2016
/s/ Richard M. Schapiro **Richard M. Schapiro**	Director	February 26, 2016
/s/ Dale B. Wolf **Dale B. Wolf**	Director	February 26, 2016

INDEX TO EXHIBITS

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 may 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.

Number	Description	Method of Filing
2.1	Membership Interest Purchase Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Healthcare, Inc.	Filed as Exhibit 2.1 to registrant's Form 8-K filed September 8, 2015.
2.2	Amendment to Membership Interest Purchase Agreement, dated as of October 30, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Pathways, LLC, as assignee of all rights and obligations of Molina Healthcare, Inc.	Filed herewith.
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	Certificate of Amendment to Certificate of Incorporation	Filed as Exhibit 3.1 to registrant’s Form 8-K filed July 24, 2013.
3.3	Third Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 10-Q filed July 30, 2014.
4.1	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.2	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.3	Indenture, dated as of September 5, 2014, by and between Molina Healthcare, Inc. and U.S. Bank National Association	Filed as Exhibit 4.1 to registrant’s Form 8-K filed September 8, 2014.
4.4	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant’s Form 8-K filed September 8, 2014.
4.5	Form of 1.625% Convertible Senior Notes Due 2044 Note Purchase Agreement, dated as of September 11, 2014, by and between Molina Healthcare, Inc. and certain institutional investors	Filed as Exhibit 10.1 to registrant’s Form 8-K filed September 12, 2014.
4.6	First Supplemental Indenture, dated as of September 16, 2014, by and between Molina Healthcare, Inc. and the U.S. Bank National Association	Filed as Exhibit 4.1 to registrant’s Form 8-K filed September 17, 2014.
4.7	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant’s Form 8-K filed September 17, 2014.
4.8	Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee.	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.9	Form of 5.375% Senior Notes due 2022.	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.10	Form of Guarantee pursuant to Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee.	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.

Number	Description	Method of Filing
4.11	Registration Rights Agreement dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and SunTrust Robinson Humphrey, Inc., as representative of the Initial Purchasers (as defined therein).	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.12	First Supplemental Indenture, dated February 18, 2016, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as trustee.	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 18, 2016.
*10.1	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
*10.2	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.5 to registrant's Form 10-K filed February 26, 2014.
*10.3	Amendment No. 1 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2014.
*10.4	Amendment No. 2 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.4 to registrant's Form 10-K filed February 26, 2015.
*10.5	2011 Equity Incentive Plan	Filed as Exhibit 10.8 to registrant's Form 10-K filed February 26, 2014.
*10.6	2011 Employee Stock Purchase Plan	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2015.
*10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. 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. 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. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
*10.10	Form of Stock Option Agreement under Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
*10.11	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.
*10.12	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.
*10.13	Employment Agreement with Terry Bayer dated June 14, 2013	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 14, 2013.
*10.14	Employment Agreement with Joseph White dated June 14, 2013	Filed as Exhibit 10.2 to registrant's Form 8-K filed June 14, 2013.
*10.15	Employment Agreement with Jeff Barlow, dated June 14, 2013	Filed as Exhibit 10.3 to registrant's Form 8-K filed June 14, 2013.
*10.16	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.
*10.17	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.
*10.18	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed as Exhibit 10.16 to registrant's Form 10-K filed February 28, 2013.
10.19	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.20	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
10.21	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.
10.22	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.

Number	Description	Method of Filing
10.23	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.24	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.25	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.26	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.27	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.
10.28	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013.
10.29	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013.
10.30	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013.
10.31	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013.
10.32	Lease Agreement, dated as of February 27, 2013, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.32 to registrant's Form 10-K filed February 28, 2013.
10.33	First Amendment to Office Building Lease, effective as of October 31, 2014, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed November 5, 2014.
10.34	Second Amendment to Office Building Lease, effective as of November 2, 2015, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed November 6, 2015.
10.35	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013.
10.36	Agreement of Purchase and Sale, dated as of June 12, 2013, by and between Molina Healthcare, Inc. and Molina Center, LLC, and AG Net Lease Acquisition Corp.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed July 25, 2013.
10.37	Lease Agreement, dated as of June 13, 2013, by and between AGNL Clinic, L.P., and Molina Healthcare, Inc.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed July 25, 2013.
10.38	Form of Exchange Agreement, dated August 11, 2014, by and between Molina Healthcare, Inc. and certain beneficial owners of Molina Healthcare, Inc.'s 3.75% Convertible Senior Notes due 2014	Filed as Exhibit 10.1 to registrant's Form 8-K filed August 12, 2014.
10.39	Credit Agreement, dated as of June 12, 2015, by and among Molina Healthcare, Inc., Molina Information Systems, LLC, Molina Medical Management, Inc., certain lenders named on the signature pages thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2015.
10.40	Guarantor Joinder Agreement, dated February 18, 2016, by and among the guarantor parties thereto and SunTrust Bank, as Administrative Agent.	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 18, 2016.

Number	Description	Method of Filing
10.41	Purchase Agreement, dated as of February 11, 2013, among Molina Healthcare, Inc. and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Representatives of the Initial Purchasers	Filed as Exhibit 1.1 to registrant's Form 8-K filed February 15, 2013.
10.42	Capitated Medical Group/IPA Provider Services Agreement, effective May 1, 2013, by and between Molina Healthcare of California and Pacific Healthcare IPA.	Filed herewith.
10.43	Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to Molina Healthcare of California Group/IPA Provider Services Agreement(s), effective September 26, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed herewith.
10.44	Capitated Financial Alignment Demonstration Amendment to Molina Healthcare of California Group/IPA Provider Services Agreement, effective as of July 1, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	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.
101.INS	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

Exhibit 2.2
Execution Copy

AMENDMENT TO MEMBERSHIP INTEREST PURCHASE AGREEMENT

This Amendment to Membership Interest Purchase Agreement (this "Amendment") is made and entered into as of October 30, 2015, by and among The Providence Service Corporation, a Delaware corporation ("PSC"), Ross Innovative Employment Solutions Corp., a Delaware Corporation ("Ross", and together with PSC, each a "Seller" and together, the "Sellers"), and Molina Pathways, LLC, a Delaware limited liability company ("Buyer") as assignee of all rights and obligations of Molina Healthcare, Inc., a Delaware corporation ("Molina").

WHEREAS, the Sellers and Molina entered into that certain Membership Interest Purchase Agreement (the "Purchase Agreement"), dated as of September 3, 2015;

WHEREAS, pursuant to that certain Assignment and Assumption Agreement, dated as of October 29, 2015, by and between Molina and Buyer, Molina assigned all of its rights and obligations under the Purchase Agreement to Buyer;

WHEREAS, the Sellers and Buyer have agreed, pursuant to Section 10.5 of the Purchase Agreement, to amend the Purchase Agreement as provided in this Amendment; and

WHEREAS, all capitalized terms used but not otherwise defined herein shall have the meanings ascribed to them in the Purchase Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged and incorporating the recitals set forth above, the parties hereto hereby agree as follows:

1. Certain Intercompany Obligations. Notwithstanding anything to the contrary in the Purchase Agreement, no Intercompanies between or among the Acquired Companies arising in the ordinary course of business consistent with past practice on or after October 15, 2015 through the Closing will be taken into account when determining Indebtedness of the Acquired Companies, the Estimated Purchase Price, Purchase Price or Final Purchase Price.

2. Defined Terms: Any reference to the defined term "Real Property Representations" in the Purchase Agreement is hereby amended and restated to read in its entirety as "Real Estate Representations".

3. No Other Amendments: Except as otherwise expressly amended or modified hereby, all of the terms and conditions of the Purchase Agreement shall continue in full force and effect.

4. Entire Agreement: This letter agreement and the Purchase Agreement together superseded any and all oral or written agreements and understandings heretofore made relating to the subject matter hereof and thereof and contain the entire agreement of the parties hereto relating to the subject matter hereof and thereof.

5. Incorporation of Miscellaneous Provisions: This letter agreement shall be subject to the miscellaneous provisions contained in Article 10 of the Purchase Agreement, which are hereby incorporated by reference herein, *mutatis mutandis*.

6. Counterparts: This letter agreement may be executed in two or more counterparts (including by means of facsimile or .pdf signature pages), each of which shall be deemed to constitute an original, but all of which together shall constitute one and the same document.

[*Remainder of Page Intentionally Blank*]

IN WITNESS WHEREOF, each of the parties hereto has caused this Amendment to be duly executed on its behalf as of the day and year first above written.

THE PROVIDENCE SERVICE CORPORATION

By:/s/James M. Lindstrom
Name: James M. Lindstrom
Title: CEO

ROSS INNOVATIVE EMPLOYMENT SOLUTIONS CORP.

By:/s/David Shackelton
Name: David Shackelton
Title: CFO

MOLINA PATHWAYS, LLC

By:/s/Terry Bayer
Name: Terry Bayer
Title: Manager

[Signature Page to Amendment to Membership Interest Purchase Agreement]

MOLINA HEALTHCARE OF CALIFORNIA

CAPITATED MEDICAL GROUP / IPA

PROVIDER SERVICES AGREEMENT

This Capitated Medical Group / IPA ("Agreement") is entered by and between Molina Healthcare of California, a California corporation ("Health Plan"), and **Pacific Healthcare IPA** ("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 certain Health Care 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:

 Provider or authorized representative's initials: FB

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 serve on Health Plan's panel of providers for the products specified 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. Practice Information includes, but is not limited to, name, address, telephone number, hours of operation, type of practice, and ability to accept new patients. 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 business and practice, 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

 Provider or authorized representative's initials: FB

Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. Prior Authorization. If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, 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. Upon and following such referral, Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care.

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. Member Eligibility Verification. Provider shall verify eligibility of Members prior to rendering services.

g. Admissions. Provider shall cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

h. Emergency Room Referral. If Provider refers a Member to an emergency room for Covered Services, Provider shall provide notification to Health Plan within twenty-four (24) hours of the referral.

i. 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.

 Provider or authorized representative's initials: FB

j. Subcontract Arrangements. Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors 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.

k. Availability of Services. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

l. Treatment Alternatives. Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of Covered Services limitations. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.

2.3 **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.

2.4 **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. 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 Records. 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 and/or as required to 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. If Provider is a medical group or IPA, Provider shall accept delegation of utilization management responsibilities from Health Plan at Health Plan's request. If delegation of utilization management responsibilities is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider by the Utilization Payment Reduction Amount specified in Attachment D.

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 reassign Members to another provider. If Provider is a medical group or IPA, Provider shall accept delegation of credentialing responsibilities at Health Plan's request and shall cooperate with Health Plan in establishing and maintaining appropriate credentialing mechanisms within Provider's organization. If delegation of credentialing responsibilities to a group or IPA is revoked, Health Plan shall reduce any otherwise applicable payments owing to group or IPA by the Credentialing Reduction Amount specified in Attachment D.

 Provider or authorized representative's initials: FB

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 ensure that Provider promptly delivers to Provider's constituent providers, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Licensure and Standing.**

a. Licensure. Provider warrants and represents that it is appropriately licensed to render health care services within the scope of Provider's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. 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. **Staffing Privileges for Providers.** Consistent with community standards, every physician Provider shall have staff privileges with at least one Health Plan contracted Hospital as necessary to provide services to members under this Agreement, and shall authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of his/her hospital privileges.

e. **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. Every physician Provider shall maintain, at a minimum, professional liability insurance with limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate for the policy year and for each physician comprising Provider. 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.

2.8 **Claims Payment.**

a. **Submitting Claims.** If applicable**,** 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. When applicable, 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. 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.

f. 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.

g. 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 another provider contracted with Health Plan; who receives capitation from Health Plan and is responsible for arranging for Covered Services through subcontract arrangements ("Capitated Provider"), 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.

2.9 **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 and all applicable sub-attachments to 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 and all applicable sub-attachments to 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.

2.10 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another medical group, IPA, or provider 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.

2.11 **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 Medi-Cal 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.

2.12 **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.

2.13 **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.

2.14 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider shall forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Plan's or the Member's request to transfer the records.

2.15 **Notification of Network Change.** Where Provider constitutes specialists, is a medical group, IPA, or any other similar entity/organization, Provider shall provide Health Plan and Member with timely written notification in the event a constituent specialty provider terminates its contract with Provider. Said written notification shall be in compliance with all state and federal laws or government sponsored program requirements.

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 the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of the Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing 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 (1) 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 fifty (150) 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. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation

methodology;

f. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

g. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise terminated as a provider by any state or federal health care program;

h. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

i. 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.

4.5 **Notice to Members of Termination.** In the event one of the parties to this Agreement provides notification of termination of this Agreement, Health Plan shall provide affected Members with timely written notification, of such termination, prior to the effective date of specialist termination, as required for compliance with any state and federal laws, government sponsored program requirement, or accreditation requirement. Notification to affected members shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f).

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 Los Angeles County; 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 E-1 – Financial Solvency Provisions
Attachment E-2 – Provider Claims Processing Provisions
Attachment F – Medicaid Program Provisions
Attachment F-1 – Emergency Services Provisions
Attachment G – Acknowledgment of Receipt of Provider Manual
Attachment H – Medicare Program Provisions
Attachment I – Disclosure Form
Attachment J – Certificate of Ownership
Attachment K – Matrix of Financial Responsibility
Attachment L – Business Associate Addendum

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 Healthcare IPA Associates, Inc.

5000 Airport Plaza Drive, Suite 150,Long Beach, CA 90815
Attention: Kathy Hegstrom

The parties may change the names and addresses noted above through written

notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

***** THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK *****

SIGNATURE AUTHORIZATION

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth by Health Plan below. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

Pacific Healthcare IPA **Molina Healthcare of California**

Provider Signature:	/s/ Faustino Bernadett	Molina Signature:	/s/ Teri Lauenstein
Signatory Name (Printed):	Faustino Bernadett, M.D.	Signatory Name (Printed):	Teri Lauenstein
Signatory Title (Printed):	President	Signatory Title (Printed):	Vice President, Network Management & Operations
Signature Date:	3/12/2013	Signature Date:	3/28/13
		Effective Date:	(To be completed by Health Plan) May 1, 2013

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.

Y Group/IPA (a list of constituent members with their License No., UPIN and DEA numbers is attached and incorporated herein)

Please enter "N/A" for the following if not applicable or not available:

Provider Name	Pacific Healthcare IPA	Billing Address: 5000 Airport Plaza Drive #150, Long Beach, CA 90815
Telephone No.	(562) 766-2000	
Facsimile No.	(562) 766-2008	
Tax I.D. No. (TIN)	20-4396324	
License No.		
NPI	1265785323	Physical Address (if different than above): 5000 Airport Plaza Drive #150, Long Beach, CA 90815
NPI Taxonomy		
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.

/s/ Faustino Bernadett_____
Provider Signature

Faustino Bernadett MD_____
Signatory Name (Printed)

President _____
Signatory Title (Printed)

3/12/2013_____
Signature Date

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. **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.

9. **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.

10. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.

11. **Health Plan** means Molina Healthcare of California.

12. **HEDIS Studies** means Health Employer Data and Information Set.

13. **IPA** means Independent Practice Association.

14. **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.

15. **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.

16. **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.

17. **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.

18. **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.

19. **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.

20. **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.

21. **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.

22. **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.

23. **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.

N Medi-Cal Geographic Managed Care

N Medi-Cal Two-Plan Model

Y MA-SNP (Molina Medicare Options Plus)

Y CFAD (Medicare Capitated Financial Alignment Demonstration and successor(s))

N Molina Health Benefit Exchange Product

N 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

Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the reimbursement terms set forth in this Attachment and any applicable sub-attachments referenced hereto and incorporated herein.

ARTICLE ONE – COMPENSATION TERMS

6.1 **Definitions.** The following terms shall have the meanings attributed below for purposes of this attachment. Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Agreement.

a. Capitation Payments are the monthly payments made to Provider on a prepaid basis for Covered Services provided or arranged by Provider under this Agreement. Capitation Payments to Provider shall be made to the Provider by the fifteenth (15th) day of each month. In the event the fifteenth (15th) day of the month is not a business day, the Capitation Payment shall be due and payable on the next business day following the fifteenth (15th) day of the month.

b. Medicare Program Members are the Members enrolled in the following Medicare program(s) as specified in Attachment C and checked below:

Y MA-SNP (Molina Medicare Options Plus))
Y CFAD (Capitated Financial Alignment Demonstration and successor(s)

c. Medicare Program Revenue is the Part A and B Monthly CMS Payment that Health Plan receives from CMS for Medicare Program Members assigned to Provider.

6.2 **Capitation Payment Terms.**

a. Matrix of Financial Responsibility. For each Health Plan program or set of programs (ie. Medicaid Programs, Medicare Programs, etc) that Provider is reimbursed on a Capitation Payment basis, there is an attached Matrix of Financial Responsibility at Attachment K specifying the financial responsibility for Covered Services between Health Plan and Provider.

b. Capitation Payments for Medicare Program Members assigned to Provider shall be made based upon a per Member per month capitation rate.

For Medicare Program Members, Health Plan shall pay provider at thirty-eight percent (38%) of the Medicare Program Revenue per Medicare Program Member per month. Health Plan may amend this Agreement, in accordance with the applicable Amendment section of this Agreement, to modify these Capitation Payments in order to account for any revenue reduction in the applicable government-sponsored program(s) and benefits, if any.

c. **Collection of Copayments.** Provider shall be responsible for the collection of copayments and deductibles (if any) upon rendering Covered Services to Members. Any copayments or deductibles which are stated as a percentage shall be calculated utilizing the fee-for-service rates set forth in the "Non-Capitated Services Submission of Claims/Claims Payment" provisions in this Attachment, applicable to Member's Health Plan program, for such Covered Services. Provider shall not refuse to provide Covered Services in the event a Member is unable to pay their copayment or deductible except as may be specifically permitted in the Provider Manual or as approved in advance by Health Plan.

d. **Coordination of Benefits for Capitated Providers.** Notwithstanding any other provisions of this Agreement, if Provider is reimbursed on a capitated basis and a coordination of benefits occurs, Provider shall not be eligible for additional compensation from Health Plan beyond the applicable Capitation Payments or Non-Capitated Services Submission of Claims/Claims Payments.

e. **Retroactive Adjustments.** Capitation Payments shall be subject to retroactive adjustments due to retroactive changes in the following; (i) for those programs based on a percent of premium capitation payment method, the amounts related to such premium adjustments for each program as demographic (ie. age, gender, hospice, ESRD, part A/B coverage, institutionalized, working aged, Medicaid, etc) and/or risk adjustments (ie. CMS Hierarchical Condition Category "HCC" adjustments), if any, which Health Plan receives in government funding sources for each Member assigned to Provider, and/or (ii) for all capitation payment methods, whether on a per Member per month or percent of premium basis, the retroactive changes in the number of Members assigned to Provider for each program.

f. **Character of Payments.** Capitation Payments to Provider pursuant to this Agreement are for the primary purpose of compensating Provider for the value of Covered Services provided pursuant to this Agreement. Provider shall assure that claims and compensation for Covered Services provided or arranged pursuant to this Agreement are paid from the Capitation Payments from Health Plan to Provider as may be necessary for Provider to satisfy its financial obligations under this Agreement. Health Plan shall have the right, but not the obligation, to pay claims which Provider fails to pay for Covered Services provided to Members. Provider specifically agrees that Health Plan may recover such owed amounts by way of offset or recoupment in accordance with the Offset provisions of this Agreement.

g. **Legislation Regulating Provider Risk.** Provider recognizes that the compensation terms set forth in this Attachment are established in exchange for Provider's provision of Covered Services that are the financial responsibility of Provider, as outlined in the applicable Matrix of Financial Responsibility. In the event that any state or federal law, policy, directive, or government sponsored program requirement requires Health Plan to assume financial risk for certain Covered Services previously assigned to Provider, Health Plan may, without Provider's consent, amend this Agreement to comply. Health Plan will provide Provider with forty-five (45) business days' notice of the change unless a shorter timeframe is necessary for compliance.

   Health Plan will present Provider with its actuarial valuation of the services that will no longer be the financial risk of Provider. Provider will have the opportunity to either present Health Plan with its expense data or an independent actuarial valuation of the same services. If Provider chooses to retain an independent actuary at its expense, the selection of the actuary must be mutually agreeable to both parties. If the independent actuary's findings indicate that the value of the services is less than Health Plan's valuation and if Health Plan and Provider reach mutual agreement on a lower valuation, then an adjustment corresponding to the mutually agreed upon valuation shall be made to the Health Plan's compensation as of the effective date of Health Plan's implementation of the legislation. The negotiated rate will be documented via an amendment of the Agreement by the parties.

h. **Non-Capitated Services Submission of Claims/Claims Payment.** For Clean Claims for Covered Services rendered to Members which are provided

or arranged by Provider, but are (i) Health Plan's financial responsibility under the applicable Matrix of Financial Responsibility, and (ii) are not covered by Capitation Payments (collectively the "Non-Capitated Services"), 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. Health Plan shall then reimburse Provider for such Non-Capitated Services on a fee-for-service basis in accordance with the applicable Claims Payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable fee-for-service rates set forth below less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

(1) Non-Capitated Services Payment Rate for Medicare Program Members. An amount equivalent to one hundred percent (100%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service program payment rates as of the date(s) of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service program as of the date(s) of service, payment shall be at thirty percent (30%) of Provider's billed charges.

(2) Non-Capitated Services Payment Rate for all other Members not otherwise designated above. An amount equivalent to sixty-five percent percent (65%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service program payment rates as of the date(s) of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service program as of the date(s) of service, payment shall be at thirty percent (30%) of Provider's billed charges.

i. Adequacy of Compensation. Provider shall accept payments as provided herein, along with any applicable co-payments, deductibles, and coordination of benefits collections as payment in full for providing or arranging Covered Services under this Agreement. Provider shall not balance bill Members for

any Covered Services.

ARTICLE TWO – REVOCATION OF DELEGATED RESPONSIBILITIES

7.1 **Revocation of Delegated Responsibilities.** If applicable, Health Plan shall reduce any otherwise applicable payments owing to Provider by the amounts specified below in the event delegation of the responsibilities set forth in the applicable Program Participation sections in this Agreement are revoked.

a. Utilization Management Payment Reduction Amount. If delegation of utilization management responsibilities is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider by sixty-five cents ($0.65) per Member per month.

b. Credentialing Payment Reduction Amount. If delegation of credentialing responsibilities is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider by sixty-five cents ($0.65) per Member per month.

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 Services, Provider shall make such Emergency 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))

 Provider or authorized representative's initials: FB

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

 Provider or authorized representative's initials: FB

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, whichever is applicable, and the California Code of Regulations.

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" identify regulatory citations in Title 28 of the California Code of Regulations.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

I. DEFINITIONS

1.1 **"Cash-to-Claims Ratio"** is Provider's cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by Provider's unpaid claims liability. Unpaid claims liability is claims payable plus incurred but not reported claims ("IBNR").

1.2 **"Contracted Plans"** means all full-service health care service plans as defined in Section 1345(f) of the California Health & Safety Code with which Provider has contracts involving a Risk Arrangement.

1.3 **"Corrective Action Plan" ("CAP")** means a plan reflected in a document containing requirements for correcting and monitoring Provider's efforts to correct any financial solvency deficiencies in the Grading Criteria, financial deficiencies or other claims payment deficiencies, determined through the DMHC's review or audit process, indicating that Provider may lack the capacity to meets its contractual obligations consistent with the requirements of Rule 1300.70(b)(2)(H)(1).

 Provider or authorized representative's initials: FB

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.

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.

(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.

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:

(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 claims 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.

(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).

(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.

 Provider or authorized representative's initials: FB

(b) The quarterly financial survey report shall include the following if Provider has fewer than 10,000 covered lives under all Risk Arrangements as of December 31 of the preceding calendar year:

(i) The disclosure statements set forth in sections 3.2(a)(ii),(iii), (iv) and (v) above.

(ii) In the event Provider serves fewer than 10,000 covered lives under all Risk Arrangements and it: (i) fails to satisfactorily demonstrate its compliance with the Grading Criteria; (ii) experiences an event that materially alters its ability to remain compliant with the Grading Criteria; (iii) is found, by the DMHC's (or the DMHC's designee's) review or audit activities, to potentially lack sufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of Rule 1300.70(b)(2)(H)(1); or (iv) is found, through the DMHC's HMO Help Center, medical audits and surveys, or any other source, to be delaying referrals, authorizations, or access to basic health care services based on financial considerations, Provider shall, within thirty (30) calendar days of the DMHC's written request, begin submitting all quarterly financial survey reports set forth in sections 3.2(a) above.

3.3 Annual Financial Survey. Provider agrees to submit to the DMHC on a yearly basis, not more than one hundred fifty (150) calendar days after the close of Provider's fiscal year beginning on or after January 1, 2005, annual financial survey reports, in an electronic format determined by the DMHC as required by Rule 1300.41.8, based upon Provider's annual audited financial statement prepared in accordance with generally accepted auditing standards and containing all of the following:

(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.

(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.

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

 Provider or authorized representative's initials: FB

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;

(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.

(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;

(ii) 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;

(ii) 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;

(iv) Describes the specific actions Provider has taken or will take to correct the identified deficiencies, including any written representations made by Health Plan and/or other Contracted Plans to assist Provider in the implementation of its CAP. The actions shall be appropriate and reasonable in scope and breadth depending upon the nature and degree of the deficiency, and acceptable to the DMHC;

(v) Describes the timeframe for completing the corrective action and specifies a schedule for submitting progress reports to the DMHC, Health Plan and all other Contracted Plans. All corrective actions must be completed within the following timeframes, unless an extension is approved in writing by the DMHC:

(A) Timeframes for correcting working capital deficiencies shall not exceed 12 months;

(B) Timeframes for correcting TNE deficiencies shall not exceed 12 months;

(C) Timeframes for correcting IBNR deficiencies shall not exceed three (3) months;

(D) Timeframes for correcting claims timeliness deficiencies shall not exceed six (6) months;

(E) Timeframes for correcting cash-to-claims ratio deficiencies shall not exceed twelve (12) months.

(vi) Identifies the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at Provider for ensuring compliance with the CAP;

(vii) Describes:

(A) Provider's patient record retention and storage policies;

(B) The procedures and the steps Provider will take to ensure that patient medical records are appropriately stored and maintained;

(C) The procedures and the steps Provider will take to ensure that patient medical records will be readily available and transferable to patients in the event Provider ceases operations or Provider fails to meet its obligations set forth in the CAP. At a minimum, Provider's patient medical records policies and procedures shall be consistent with existing laws relating to the responsibilities for the preservation and maintenance of medical records and the protection of the confidentiality of medical information.

(b) Notwithstanding section 4.1(a) above, Provider shall not be required to submit a CAP if Provider proactively demonstrates to the DMHC's written satisfaction that necessary and prudent capital investments have or may cause a temporary deficiency in Provider's TNE, working capital or Cash-to-Claims Ratios and that Provider has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in its claim payment timeliness.

(c) To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of Health Plan and all other Contracted Plans.

(d) The self-initiated CAP shall be considered a final CAP, subject to the DMHC's approval process as set forth in section 4.1(j) below, unless, within fifteen (15) calendar days of the receipt of Provider's self-initiated CAP proposal, Health Plan or another Contracted Plan provides written notice to the DMHC and Provider stating the reason for its objections and recommendations for revisions,

(e) In the event that Health Plan or another Contracted Plan files a written objection with the DMHC and Provider, Provider shall within twenty (20) calendar days: (1) implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by Health Plan or another Contracted Plan; and (2) submit to Health Plan, all other Contracted Plans and the DMHC a revised CAP proposal that addresses the concerns raised by the objecting Contracted Plan(s), including Health Plan. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of Health Plan and all other Contracted Plans.

(f) Health Plan shall have ten (10) calendar days to submit to Provider and the DMHC its objections and recommended revisions, in an electronic format determined by the DMHC, to the self-initiated revised CAP proposal.

(g) Within fifteen (15) calendar days of receipt of Health Plan's or any other Contracted Plan's objections and recommended revisions to the revised CAP proposal, the DMHC shall schedule a meeting ("CAP Settlement Conference") with Provider, Health Plan and all other Contracted Plans to discuss and reconcile the differences.

(h) Within seven (7) calendar days of the CAP Settlement Conference, Provider shall submit a final self-initiated CAP proposal to Health Plan and the DMHC.

(i) Within ten (10) calendar days of receipt of Provider's final self-initiated CAP proposal, the External Party shall submit its recommendation to the DMHC to approve, disapprove or modify Provider's final self-initiated CAP proposal.

(j) Within ten (10) calendar days of receipt of the External Party's recommendation, the DMHC shall approve, disapprove or modify Provider's final self-initiated CAP proposal, which shall then become the final CAP. If the DMHC does not act upon the recommendations of the External Party within ten (10) calendar days, the External Party's recommendation shall be deemed approved.

(k) A final CAP shall remain in effect until Provider demonstrates compliance with the requirements of the CAP, or the CAP expires in accordance with its own terms.

(l) In addition to the CAP requirements specified in section 4.1(a) above, the DMHC may direct Provider to initiate a CAP whenever it determines that Provider has experienced an event that materially alters its ability to remain compliant with the Grading Criteria or when the DMHC's review process indicates that Provider may lack sufficient financial capacity to meet its contractual obligations consistent with the requirements of Rule 1300.70(b)(2)(11)(1).

(m) Provider shall submit to the DMHC and Health Plan each periodic progress report prepared pursuant to a final CAP, and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of Provider, as defined by Rule 1300.45(o) of Title 28 California Code of Regulations.

(n) Provider shall advise Health Plan and the DMHC in writing within five (5) calendar days if Provider experiences an event that materially alters Provider's ability to remain compliant with the requirements of a final CAP.

(o) Upon request from the DMHC, Provider shall provide additional documentation to the DMHC and Health Plan to demonstrate Provider's progress towards fulfilling the requirements of a CAP.

(p) All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the DMHC shall be received and maintained on a confidential basis by Health Plan and shall not be disclosed, except as allowed or required under this Amendment.

ATTACHMENT E-2

DMHC Provider Claims Processing Provisions

This Attachment is required to comply with the claims payment and processing requirements. In processing claims, Provider shall comply with Title 42 U.S.C. Section 1396u-2(f) and Health and Safety Code Sections 1371 through 1371.8. Unless otherwise stated, references to the term “Rule” identify 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:

(1) Provider shall accept and adjudicate claims for health care services provided to plan enrollees in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and Rules 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

(2) Provider shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and Rules 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

(3) Provider shall submit a Quarterly Claims Payment Performance Report (“Quarterly Claims Report") to Health Plan within thirty (30) days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Provider's compliance status with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and Rules 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

Provider shall include in its Quarterly Claims Report a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition, and working days to resolution, as to each provider dispute received. Each individual dispute contained in a Provider's bundled notice of provider dispute shall be reported separately to the Heath Plan

The Quarterly Claims Report be signed by and include the written verification of a principal officer, as defined by Rule 1300.45(o), of Provider, stating that the report is true and correct to the best knowledge and belief of the principal officer.

(4) Provider shall make available to Health Plan and the DMHC all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.

(5) Any provider that submits a claim dispute to Provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to Health Plan's dispute resolution process for a de novo review and resolution for a period of 60 working days from Provider's Date of Determination, pursuant to the provisions of Rule 1300.71.38(a)(4).

(6) In the event Provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties), Health Plan and Provider shall attempt to establish an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code. Health Plan shall have the authority to assume processing and timely reimbursement of Provider’s claims while the parties are attempting to establish a corrective action plan. In the event Health Plan and Provider fail to agree upon an approved corrective action plan or if Provider fails to comply with the corrective action plan, Health Plan shall have the authority to assume responsibility for the processing and timely reimbursement of Provider’s claims. Health Plan shall recover any such amounts paid by way of offset or recoupment from current or future amounts due Provider.

(7) In the event Provider fails to timely resolve its provider disputes including the issuance of a written decision, Health Plan and Provider shall attempt to establish an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code. Health Plan shall have the authority to assume responsibility for the administration of the Provider's dispute resolution mechanism(s) and for the timely resolution of provider disputes while the parties are attempting to establish a corrective action plan. In the event Health Plan and Provider fail to agree upon an approved corrective action plan or if Provider fails to comply with the corrective action plan, Health Plan shall have the authority to assume responsibility for the administration of the Provider's dispute resolution mechanism(s) and for the timely resolution of provider disputes.

ATTACHMENT F [Not Applicable]

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 debt 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.

a. 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.

b. Provider shall permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

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 Care Services.

18. Provider shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, California Code of Regulations, Division 1, Chapter 9, commencing with Section 37000. Provider shall document and appropriately follow up on blood lead screening test results.

Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's Medical Record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent(s) or guardian shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Members Medical Record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement.

19. Provider shall provide Health Plan with the Disclosure Statement set forth in Title 22, California Code of Regulations Section 51000.35 prior to commencing services under this Agreement

20. 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 F-1 [Not Applicable]

DHCS Provisions

The following provisions apply exclusively to Covered Services provided and activities engaged in pursuant to Medicaid Program, and those Providers that have assumed financial obligations for certain Emergency Services:

Non-Contracting Emergency Service Providers

Provider shall cover Emergency Services in accordance with the requirements of Title 22, CCR, Section 53855 and 53912.5 including the following:

A. Provider shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary services rendered to a Member until the Member's condition has stabilized sufficiently to permit discharge, or referral and transfer in accordance with instructions from Health Plan. Emergency Services shall not be subject to Prior Authorization by Provider or Health Plan. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. Emergency Services shall not be subject to Prior Authorization by Provider.

B. At a minimum, Provider must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

C. For all other non-contracting providers, reimbursement by Provider for properly documented claims for services rendered by a non-contracting provider pursuant to this provision shall be the lower of the following rates applicable at the time the services were rendered by the non-contracting provider:

1) The usual charges made to the general public by the non-contracting provider.

2) The maximum Fee-For-Service rates for similar services under the Medi-Cal program.

3) The rate agreed to by Provider and the non-contracting provider.

D. Provider shall not refuse to cover reimbursement for Emergency Services rendered by a non-contracting provider based on the emergency room provider, hospital, or fiscal agent not notifying the Member's Primary Care Physician or Provider of the Member's screening and treatment within 10 calendar days of presentation for emergency. Provider shall not limit what constitutes an emergency medical condition solely on the basis of lists of diagnoses or symptoms.

E. In accordance with California Code of Regulations, Title 28, Section 1300.71.4, Provider shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a Member within 30 minutes of the request. If Provider fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approve. Provider is financially responsible for post-stabilization service payment as provided by subprovision C above.

F. Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California 95814 for resolution under the provisions of Welfare and Institutions Code Section 14454 and California Code of Regulations, Title 22, Section

53620et. eq., except Section 53698. Provider agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Provider is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof or reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and California Code of Regulations, Title 22, section 53702.

ATTACHMENT G

Acknowledgement of Receipt of Provider Manual

Provider hereby acknowledges receipt of Health Plan's Provider Manual.

Date of receipt: 3/8/2013_____

Initials of authorized
representative of Provider: KH

 Provider or authorized
representative's initials: FB

ATTACHMENT H

MEDICARE PROGRAM REQUIREMENTS---HEALTH CARE SERVICES

This Attachment H sets forth Medicare program requirements that are hereby incorporated into contracts and/or agreements with Providers covering the provision of health care services. The Agreement and this attachment shall be automatically modified to conform to subsequent amendments to Medicare program requirements. In the event of any inconsistency between the terms of this attachment and the Agreement, the terms of this attachment shall control.

1. **Downstream Compliance**. Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare enrollees to agree in writing to all of the terms provided herein.

2. **Right to Audit**. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii)).

3. **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)).

4. **Hold Harmless/Cost Sharing.** Provider agrees it may not under any circumstances, including nonpayment of moneys due the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the

Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. Members who are dually eligible for Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii)).

5. **Delegation**. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment H-1. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).

6. **Prompt Payment**. Health Plan and Provider agree that Health Plan shall pay all clean claims for services that are covered by Medicare 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 for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor. 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. (42 CFR 422.520(b)).

7. **Reporting.** Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8)).

8. **Accountability**. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment H-1. (42 CFR 422.504(i)(3)(ii)).

9. **Compliance with Medicare Laws and Regulations**. Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

10. **Benefit Continuation.** Provider agrees to provide for continuation of enrollee health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Molina for Medicare services; and (ii) for Members who are hospitalized on the date Molina's contract with CMS terminates, or, in the event of an insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 422.504(g)(2)(ii) and 422.504(g)(3).

ATTACHMENT H-1

Medicare Program Requirements---Delegated Services

This Attachment H-1 sets forth Medicare program requirements that are hereby incorporated into contracts and/or agreements that delegate to Provider responsibility for any management or administrative services. The Agreement and this attachment shall be automatically modified to conform to subsequent amendments to Medicare program requirements. In the event of any inconsistency between the terms of this attachment and the Agreement, the terms of this attachment shall control.

1. **Downstream Compliance.** Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare enrollees to agree in writing to all of the terms provided herein.

2. **Medicare Compliance**. Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

3. **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)).

4. **Right to Audit**. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii)).

5. **Responsibilities and Reporting Arrangements.** The Agreement specifies the delegated activities and reporting responsibilities. To the extent applicable, Provider shall support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data . (42 CFR 504(a)(8)).

6. **Revocation of Delegated Activities**. 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. (42 CFR 422.504(i)(4)(ii)).

7. **Accountability** Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 422.504(i)(3)(iii)).

8. **Credentialing.** If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (422.504(i)(4) and 422.504(i)(5)).

9. **Monitoring.** Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contractual obligations. Health Plan shall monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 422.504(i)(4)).

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10. **Further Requirements.** Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5)).

ATTACHMENT I

DISCLOSURE FORM

(Welfare and Institutions Code Section 14452 (a))

Name of Subcontractor: **Pacific Healthcare IPA**

The undersigned hereby certifies that the following information regarding **Pacific Healthcare IPA** (the "Organization") is true and correct as of the date set forth below.

---

1. Officers/Directors General Partners:
Faustino Bernadett, Jr. MD, Robert Lugliani, MD

---

2. Co-Owner(s):
See #1

---

3. Stockholders owning more than ten percent (10%) of the stock of the Organization:
See #1

---

4. Major creditors holding more than five percent (5%) of Organization's debt:
N/A

---

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:

Date: 3/12/2013 By: Faustino Bernadett

Print Name: Faustino Bernadett, MD

Title: President

ATTACHMENT J

CERTIFICATE OF OWNERSHIP

I, Faustino Bernadett, MD, an authorized representative of Pacific Healthcare, IPA, 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
Faustino Bernadett, MD		
Robert Lugliani, MD		

- 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.

Faustino Bernadett_____ 3/12/2013_____
Signature of Authorized Representative and Title Date

ATTACHMENT K

Matrix of Financial Responsibility

The following matrices outlines the division of financial responsibility between Health Plan and Provider ("Matrix of Financial Responsibility"), the intent being to clarify Covered Services categories in order to provide for accurate administration of this Agreement. For services not specifically listed, each matrix serves as a model under which broad service categories suggest the appropriate financial responsibility. The applicable provisions and attachments of this Agreement, including Health Plan's Provider Manual, should be consulted for an accurate and complete description of Covered Services. Member benefit information and eligibility shall be verified by Provider prior to the provision of any services. The following matrices are included in this Agreement, referenced hereto and incorporated herein:

Attachment K-1 (MA-SNP & CFAD)

ATTACHMENT K-1

Matrix of Financial Responsibility

MA-SNP (Molina Medicare Options Plus) Program

CFAD (Capitated Financial Alignment Demonstration and successor(s))

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Abortion			X
Acupuncture	Not covered under Medicare or Medi-Cal		
Allergy Testing (including serum)	X		
Alpha-fetoprotein Test			X
Ambulance, Air or Ground (Emergency Services) In Area Out-of-Area	 X X		
Ambulance, Air or Ground (Non-Emergency, Facility to Facility) In Area Out-of-Area		 X X	
Amniocentesis Facility Component Professional Component	 X X		
Anesthetics, Administration of Inpatient Outpatient	 X X		
Blood and Blood Products		X	
Blood Donations		X	
Blood Donations, Autologous (when Medically Necessary)		X	

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Cancer Drugs and Administration of the Drug		X	
Inpatient Facility Component and Drugs	X X		
Inpatient Professional Component	X		
Physician's office	X		
Outpatient Facility Component		X	
Outpatient Professional Component			
Oral taken by patient			
Caregiver Relief: Assist with Member bathing, feeding, dressing and other needs		X	
Chemical Dependency (Acute Inpatient Overdose Treatment)			
Inpatient Facility Component		X	
Inpatient Professional Component		X	
Chemical Dependency – Detoxification & Rehabilitation (Outpatient Treatment			
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Child Health and Disability Prevention Services (CHDP)			X
California Children Services (CCS)			X
Chiropractic Care	X		
Clinical Trials 3 (when a Medicare covered benefit)		X	
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component			

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CPSP – Comprehensive Perinatal Services Program			X
Dental Services (routine)			X
Dental Services (including treatment of TMJ) (when medically necessary related to accidental injury or trauma to sound natural teeth, and for dental work necessary to construct non-dental structures) Professional Component Anesthesia (only when medically indicated) Facility Component	X X	X	
Diabetic Supplies (includes glucose monitors, test strips, lancets, screening tests)		X	
Dialysis Inpatient Facility Component Outpatient Facility Component Professional Component Out-of-Area Routine	 X X X	X	
Disease Management		X	
Drugs/Medications Inpatient Outpatient Prescriptions (Oral Medications) Injectable Medications Administered by Home Health Provider Depo Provera, Lupron, Growth Hormones (administered in	 X X	 X X X X X	

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Physician's Office)			
Administered in the Physician's		X	
Office (excluding Depo Provera,		X	
Lupron, Growth hormones)		X	
Infusion Therapy (i.e. TPN)		X	
Self Administered			
Self Administered Insulin			
Vaccinations (except in conjunction with CHDP)			
Durable Medical Equipment (DME)			
Inpatient		X	
Outpatient Dispensing	X		
Emergency Room Visits, In-Area			
Facility Component		X	
Professional Component –	X		
Anesthesiology, ER Physicians,			
Pathology, Radiology	X		
Professional Component Other			
Emergency Room Visits, Out-of-Area			
Facility Component		X	
Professional Component –		X	
Anesthesiology, ER Physicians,			
Pathology, Radiology		X	
Professional Component Other			
Emergency Medical Response – In home emergency response unit allowing Member to communicate with a central monitoring station in an emergency.		X	
Endoscopic Studies			
Professional	X		
Outpatient Facility Component	X		

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Family Planning Services			
Inpatient Facility Component			X
Inpatient Professional Component			X
Outpatient Facility			X
Outpatient Professional Component			X
Fetal Monitoring			
Inpatient Facility Component			X
Outpatient Facility and Professional Component			X
Genetic Testing (when medically necessary)	X		
Outpatient Facility Component	X		
Outpatient Professional Component			
Health Education	X		
Hearing Aid			X
Hearing Aid Replacement Batteries		X	
Hearing Screening			
Routine Hearing Exam			X
Diagnostic Hearing Exams	X		
Home Health Care (Including home hospice, MSW, OT, PT, RT, SN, injections, IV infusion supplies and injected substances, etc.)		X	
Hospice Care			
Inpatient Facility 3		X	
Professional Component	X		
Hospitalization – In-Area			
Facility Component		X	
Professional Component	X		
Hospitalization – Out-of-Area			
Facility Component		X	

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Professional Component		X	
Professional Component (where Member is stable for transfer and group/provider refuses to transfer Member)	X		
Implantable Lenses (following cataract surgery)	X		
Infertility Services	Not covered by Medicare or Medi-Cal		
Investigational/Experimental Procedures (when a Medicare covered benefit)			
Inpatient Professional		X	
Outpatient Professional		X	
Inpatient Facility		X	
Outpatient Facility		X	
Immunizations (Flu Vaccine, Hep B, Pneumonia Vaccine)		X	
Professional Component	X		
Laboratory Tests (except when related to ER Pathology)			
Inpatient Facility Component		X	
Outpatient Facility and Professional Component (including Pathology)	X		
Medical/Surgical Supplies (including ostomy supplies)		X	
Inpatient	X		
Outpatient & Office			
Mental Health			
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component		X	

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Nutrition/Diet Counseling	X		
Nutritional Supplements/Enteral Feeding Therapy (when Medically Necessary)	X		
Nurse Advice Line – Twenty-four (24) hour unlimited telephone access to live registered nurse to answer medical questions.		X	
Obstetrical Care Inpatient Facility Component Outpatient Diagnostic Services (including but not limited to fetal monitoring, ultrasound, & observation) Total OB Care (Professional Component)	 X X	X	
Office Visit Supplies (i.e. Splints, bandages, casting, etc.)	X		
Organ Transplant (when a covered benefit i.e. Kidney and Cornea) (also refer to CCS) Inpatient Facility Component Inpatient Professional Component Investigational/Experimental Transplants are not covered.	 X	X	
Organ Transplant Work Up Facility Component Professional Component	 X	X	
Ostomy Supplies Inpatient Outpatient	 X	X	
Outpatient Diagnostic Services	X		

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
(including but not limited to…) Angiograms, Colonoscopy, Echocardiograms, EDG, EEG, EKG, EMG/NCV, Sleep Studies, Treadmill, Drug			
Outpatient Surgery (excluding abortion) Facility Component Professional Component	 X	X	
Pathology Services (except when related to ER visit) Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	X	
Physical Therapy / Occupational Therapy / Respiratory Therapy / Speech Therapy, Rehabilitation Inpatient Outpatient	 X	X	
Personal Patient Navigator		X	
Preventative Care – Colorectal Services, TB Screening, Bone Density, Mammograms, Prostate Screening In office Outpatient Professional Outpatient Facility	 X X X		
Primary and Specialty Care Physician Services – Inpatient, Outpatient, SNF, Office, Patient's Home (see Emergency Room for exceptions)	X		
Podiatry Services			

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Includes two routine visits per calendar year	X		
Medically necessary foot care	X		
Pre-Admission Diagnostic Testing Facility and Professional Component	X		
Prosthetics/Orthotics Inpatient and Surgically Implanted Outpatient Dispensing		X X	
Radiation Therapy Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	X	
Radiology Services Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	X	
Reconstructive Surgery (Non-cosmetic) Facility Component Professional Component	 X	X	
Routine Physical Examinations (when a Medicare covered benefit)	X		
Skilled Nursing Facility (SNF) Facility Component Professional Component	 X	X	
Sterilization			X
Transportation – Ambulatory, Van, Wheelchair, Gurney			X
Urgent Care Services	X		
Vision Care Eye exams for the diagnosis and	X		

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
treatment for diseases and conditions of the eye.			X
One routine eye exam per calendar year.			X
Eyeglass frames and lenses or contact lenses every two years		X	
Following cataract surgery, one pair of eye glasses or contact lenses			
Well Baby Exams			X

ATTACHMENT L

Business Associate Addendum

With respect to the creation, receipt, maintenance, or transmission of Protected Health Information in the performance of certain delegated functions on behalf of Health Plan ("Molina Healthcare") in accordance with the term and conditions set forth in this Agreement, Provider agrees that it is Health Plan's business associate ("Business Associate") with all the rights and obligations set forth in this Attachment.

RECITALS

WHEREAS, Business Associate may create, receive, maintain, or transmit protected health information on behalf of Molina Healthcare in conjunction with the services described in the Agreement;

WHEREAS, such protected health information may be used or disclosed only in accordance with the Privacy Rule issued by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

WHEREAS, Business Associate must safeguard any electronic protected health information that it creates, receives, maintains, or transmits on behalf of Molina Healthcare as required by the Security Rule issued by the U.S. Department of Health and Human Services under HIPAA and;

WHEREAS, Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") provisions in the American Recovery and Reinvestment Act of 2009 ("ARRA") amended HIPAA and its implementing regulations.

NOW THEREFORE, the parties agree as follows:

1. **DEFINITIONS**

Unless otherwise provided for in this Addendum, terms used in this Attachment shall have the same meanings as set forth in HIPPA, ARRA, the Privacy Rule and the Security Rule.

“ARRA” means Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§17921-17954, and any and all references in this Addendum to sections of ARRA shall be deemed to include all associated existing and future implementing regulations, when and as each is effective.

"Availability" means the property that data or information is accessible and useable upon demand by an authorized person.

“Breach” shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

"Business Associate" means an entity or a person that performs a function on behalf of, or provides a service to, Molina Healthcare that involves the creation, receipt, use or disclosure of PHI.

“Compliance Date” shall mean, in each case, the date by which compliance is required under the referenced provision of ARRA and/or its implementing regulations, as applicable; provided that, in any case for which that date occurs prior to the effective date of this Addendum, the Compliance Date shall mean the effective date of this Addendum.

Confidentiality means the property that data or information is not made available or disclosed to unauthorized persons or processes.

Electronic Protected Health Information (“Electronic PHI”) means Protected Health Information that is transmitted by, or maintained in, electronic media.

Integrity means the property that data or information have not been altered or destroyed in an unauthorized manner.

Protected Health Information (“PHI”) means individually identifiable information, transmitted or maintained in any form or medium, relating to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care

provided to an individual, as more fully defined in 45 CFR § 160.103, and any amendments thereto.

Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Security Rule means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to Molina Healthcare under the Agreement, including those set forth in this Addendum, as amended by written agreement of the parties from time to time.

"Unsecured PHI" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services (HHS) in guidance issued pursuant to ARRA.

2. **GENERAL PROVISIONS**

2.1 Effect. This Addendum supersedes any agreements between the parties involving the disclosure of PHI by Molina Healthcare to Business Associate. To the extent any conflict or inconsistency between this Addendum and the terms and conditions of any agreement exists, the terms of this Addendum shall prevail.

2.2 Amendment. The parties agree to amend this Addendum as necessary to comply with the Privacy Rule, the Security Rule, and such other regulations promulgated by the Secretary of Health and Human Services pursuant to HIPAA.

3. **SCOPE OF USE AND DISCLOSURE**

3.1 Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under this Agreement, if such use or disclosure of PHI would not violate the Privacy Rule. Unless otherwise limited herein, Business Associate may use or disclose PHI:

a. for Business Associate's proper management and administrative services;

b. to carry out the legal responsibilities of Business Associate; and

c. to provide data aggregation services relating to the health care operations of Molina Healthcare if required under the Agreement.

3.2 Business Associate shall not request, use or release more than the minimum amount of PHI necessary to accomplish the purpose of the use or disclosure and comply with 42 U.S.C. § 17935(b) as of its Compliance Date.. Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Molina Healthcare is the sole property of Molina Healthcare.

3.3 Business Associate. or its agents or subcontractors shall not perform any work outside the United States of America that involves access to, or the disclosure of, PHI without the prior written consent of Molina Healthcare.

3.4 As of the Compliance Date, Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.

3.5 As of the Compliance Date, Business Associate shall not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

3.6 As of the Compliance Date, Business Associate shall not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

4. **OBLIGATIONS OF BUSINESS ASSOCIATE.**

4.1 Use or disclose PHI only as permitted or required by this Addendum or as required by law.

4.2 Establish and use appropriate safeguards to prevent unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of Health Plan.

4.4 Promptly report to Molina Healthcare any unauthorized use or disclosure of PHI, or security incident, with no more than three (3) days after Business Associate becomes aware of the unauthorized use of disclosure of PHI or security Incident..

Business Associate shall take all reasonable steps to mitigate any harmful effects of such breach or security incident. Business Associate shall indemnify Molina Healthcare against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of Business Associate's or its agent's or subcontractor's unauthorized use or disclosure of PHI or Breach of Unsecured PHI including but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI.

4.5 Business Associate shall, following discovery of a Breach of Unsecured PHI that is caused by Business Associate or its agents or subcontractors, notify Molina Healthcare of such Breach, without unreasonably delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to Molina Healthcare shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Molina Healthcare is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach;

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 Ensure that all of its subcontractors and agents are bound by the same restrictions and obligations contained herein, whenever PHI is made accessible to such subcontractors or agents.

4.7 Within ten (10) days of receiving a request, make all PHI and related information in its possession available as follows:

a. To the individual or Molina Healthcare to the extent necessary to permit Molina Healthcare to respond to an individual's request for access to their PHI for inspection and copying in accordance with 45 CFR § 164.524, to the extent the PHI is maintained in a Designated Record Set;

b. To the individual or Molina Healthcare to the extent necessary to permit Molina Healthcare to make an accounting of disclosures of PHI about the individual, in accordance with 45 CFR § 164.528. At a minimum, Business Associate shall provide Health Plan with the following information: (i) the date of the disclosure, (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person, (iii) a brief

description of the PHI disclosed, and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

c. In the event that Business Associate in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an individual, then Business Associate shall provide an accounting of disclosures of PHI, within ten (10) days, to Molina Healthcare, or when and as directed by Molina Healthcare, directly to an individual in accordance with the requirements for accounting for disclosures made through an Electronic Health Record in 42 U.S.C. 17935(c), as of its Compliance Date.

4.8 Within fifteen (15) days of receiving a request from Molina Healthcare, incorporate any amendment or correction to the PHI in accordance with the Privacy Rule, to the extent the PHI is maintained in a Designated Record Set.

4.9 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Molina Healthcare available to Molina Healthcare or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the Privacy Rule.

4.10 Upon termination of the Agreement, Business Associate shall, at the option of Molina Healthcare, return or destroy all PHI created or received from, or on behalf of, Molina Healthcare. Business Associate shall not retain any copies of PHI except as required by law. If PHI is destroyed, Business Associate agrees to provide Molina Healthcare with certification of such destruction. If return or destruction of all PHI, and all copies of PHI, is not feasible, Business Associate shall extend the protections of this Attachment to such information for as long as it is maintained. Termination of this Agreement attached hereto shall not affect any of its provisions that, by wording or nature, are intended to remain effective and to continue in operation.

4.11 Standard Transactions. To the extent Business Associate conducts Standard Transaction(s) on behalf of Molina Healthcare, Business Associate shall comply with the HIPAA Regulations, "Administrative Requirements," 45 C.F.R. § 162.100 et seq., by the applicable compliance date(s) and shall not: (a) Change the definition, data condition or use of a data element or segment in a standard; (b) Add any data elements or segments to the maximum defined data set; (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) Change the meaning or intent of the standard's implementation specifications.

5. **INDEMNIFICATION**

Each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation contained herein by such party, its employees, agents, subcontractors or other representatives.

6. **TERMINATION OF AGREEMENT**

Notwithstanding any other provision of this Addendum or the Agreement, Molina Healthcare may terminate this Addendum and the Agreement upon five (5) days written notice to Business Associate if Molina Healthcare determines, in its sole discretion, that Business Associate has violated a material term of this Addendum and such breach is not cured within such five (5) day period.

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Exhibit 10.43

REGULATORY AMENDMENT FOR THE CAPITATED FINANCIAL ALIGNMENT DEMONSTRATION PRODUCT TO MOLINA HEAL TH CARE OF CALIFORNIA GROUP/IPA PROVIDER SERVICES AGREEMENT(S)

This Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to the Group/IPA Provider Services Agreement(s}, or other health care service contract applicable to Provider (the "Amendment") is made and entered into by and between Molina Healthcare of California ("Health Plan") and Pacific Healthcare IPA Associates, Inc. ("Provider").

A. **Whereas,** Health Plan and Provider have previously entered into a Group/IPA Provider Services Agreement, or other corresponding health care services agreement or contract as may have been amended from time to time ("Agreement"); and

B. Whereas, Health Plan desires to amend the Agreement to add regulatory provisions that Provider and Health Plan must remain in compliance with for the Capitated Financial Alignment Demonstration Product as governed by the 3-way agreement between DHCS, CMS and Health Plan and applicable regulations.

NOW, THEREFORE, in consideration of the promises, covenants and warranties stated herein, both parties agree as follows:

1. Section 5.11 **Attachments (**or equivalent section of the Agreement) is amended to add the following to the list of Attachments which are part of the Agreement:

   Attachment M -Capitated Financial Alignment Demonstration Program Requirements
   Attachment M-1- Capitated Financial Alignment Demonstration Program Requirements Delegated Services

2. Attachment M-Capitated Financial Alignment Demonstration Program Requirements, attached hereto, is hereby added to the Agreement.

3. Attachment M-1- Capitated Financial Alignment Demonstration Program Requirements-Delegated Services, attached hereto, is hereby added to the Agreement.

4. Health Plan and Provider acknowledge that Attachment H, Medicare Program Requirements Healthcare Services, and Attachment H-1, Medicare Program Requirements-Delegated Services, are applicable only to Health Plan's Medicare Advantage (Molina Medicare Options) and Medicare Advantage Special Needs Plan (Molina Medicare Options Plus) programs, and nothing in this Amendment or Agreement shall be construed to apply such requirements to the Medicare-Medicaid Program, otherwise known as the Capitated Financial Alignment Demonstration.

5. Health Plan and Provider acknowledge that the Capitated Financial Alignment product is part of the Medicare-Medicaid Program and is not a sub-product under the Medicare or Medicaid Products. In the event that the Capitated Financial Alignment Demonstration was categorized as a sub-productunder the Medicare or Medicaid Program in the Agreement or previous Amendments, they will now be treated as a separate product under the Capitated Financial Alignment Demonstration Program.

6. Compliance with Applicable Law, section 2.9 (or equivalent section of the Agreement), is modified to add the following subsection, which reads:

Provider acknowledges that all Covered Services rendered pursuant to the Medicare-Medicaid Program are subject to the additional provisions set forth in Attachment M.

7. Pursuant to Section 5.6, Amendment, or equivalent section of the Agreement, Health Plan may amend this Agreement to maintain compliance with any state or federal law, policy, directive or government sponsored program by providing forty-five (45) business days' notice, unless a shorter time is necessary for compliance.

8. Effective Date. This Amendment shall become effective immediately upon receipt.

9. Use of Defined Terms. Unless otherwise defined in this Amendment, capitalized terms utilized in this Amendment will have the same meaning(s) ascribed to such terms in the Agreement.

10. No Other Modifications. Except as provided herein, the terms and conditions of the Agreement shall remain the same, in full force and effect.

ATTACHMENT M

Capitated Financial Alignment Demonstration Program Requirements

This attachment sets forth the applicable Capitated Financial Alignment Demonstration Program requirements, which is otherwise known as the Medicare-Medicaid Program, covering the provision of health care services that are required by CMS and the State of California to be included in contracts and/or agreements between; (i) health plans I health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS and the State of California requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare-Medicaid Program Members to agree in writing to all of the terms provided herein.

2. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, computer or other electronic systems, including medical records. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare-Medicaid Program Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later.

3 . Confidentiality. Provider will comply with the confidentiality and Medicare-Medicaid Program Member record accuracy requirements set forth in 42 CFR 422.118.

4. Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Medicare-Medicaid Program Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. In addition, Medicare-Medicaid Program Members will not be held liable for any Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services will be provided at zero-cost share to the Medicare-Medicaid Program Member.5. Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment M-lof this Agreement.

6. Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS and DHCS.

7. Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for Covered Services, which are determined by Health Plan to be payable, 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.

8. Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.

9. Compliance with Medicare Laws and Regulations. Provider will comply with all federal and state laws, regulations, and CMS instructions.

10. Benefit Continuation. Provider agrees to provide for continuation of Medicare-Medicaid Program Member health care benefits (i) for all Medicare-Medicaid Program Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Medicare-Medicaid Program Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge.

11. Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all Medicare-Medicaid Program Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

12. Provider will render all services in accordance with Health Plan's contractual obligations to CMS and DHCS.

13. Provider will render all services associated with the Medicare-Medicaid Program, which is otherwise known as the Capitated Financial Alignment Demonstration, in compliance with 42 C.F.R. § § 422.504, 423.505, and 438.6(1).

14. Provider must maintain Medicare-Medicaid Program Member records and information in an accurate and timely manner.

15. Provider must comply with the Federal Emergency Medical Treatment and Labor Act (EMT ALA) and all requirements outlined in 42 U.S. Code § 1395dd and Health Plan will not create any policies that conflict with the Provider's obligations under EMTALA.

16. Provider may not close or otherwise limit its acceptance of Medicare-Medicaid Program Members as patients unless the same limitations apply to all commercially insured Medicare-Medicaid Program Members.

17. Health Plan may not refuse to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:

a. Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Health Plan's health benefit plans as they relate to the needs of such provider's patients; or

b. Communicated with one or more of his or her prospective, current, or former patients with respect to the method by which such provider is compensated by the Health Plan for services provided to the patient.

18. Provider is not required to indemnify Health Plan for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Health Plan based on the Health Plan's management decisions, utilization review provisions or other policies, guidelines or actions.

19. Prior written approval must be obtained from DHCS before this Agreement is assigned or delegated.

20. Provider is required to provider interpreter services to Members.

21. Provider must timely gather, preserve and provide to DHCS, any records in the Provider's possession.

22. Provider must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003.

23. Health Plan shall make no payment to Provider for a provider preventable condition as defined by law.

ATTACHMENT M-1

Capitated Financial Alignment Demonstration Program Requirements - Delegated Services

This attachment sets forth the applicable Capitated Financial Alignment Demonstration Program requirements, which is otherwise known as the Medicare-Medicaid Program, covering the delegation to Provider of any management responsibilities or administrative services, if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans I health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS or DHCS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare-Medicaid Program Members to agree in writing to all of the terms provided herein.

2. Medicare Compliance. Provider will comply with all federal and state laws, regulations, and CMS instructions.

3. Confidentiality. Provider will comply with the confidentiality and Medicare-Medicaid Program Member record accuracy requirements set forth in 42 CFR 422.118.

4. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare-Medicaid Program Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later.

5. Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities, if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data.

6. Revocation of Delegated Activities. In the event CMS, DHCS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked.

7. Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS.

8. Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement.

9. Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities.

10. Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement.

Exhibit 10.44

CAPITATED FINANCIAL ALIGNMENT DEMONSTRATION AMENDMENT TO
MOLINA HEALTHCARE OF CALIFORNIA
GROUP/IPA PROVIDER SERVICES AGREEMENT

This Capitated Financial Alignment Demonstration Amendment to the Group/IPA Provider Services Agreement (the "Amendment") is made and entered into by and between Molina Healthcare of California ("Health Plan") **and Pacific Healthcare IPA Associates, Inc.** ("Provider").

A. **Whereas**, Health Plan and Provider have previously entered into Group/IPA Provider Services Agreement, as may have been amended from time to time ("Agreement"); and

B. **Whereas,** Health Plan desires to amend the Agreement in regards to Provider's compensation for the Capitated Financial Alignment Demonstration product.

NOW, THEREFORE, in consideration of the promises, covenants and warranties stated herein, both parties agree as follows:

1. Attachment B, Definitions, is amended to add the following definition:

   Capitated Financial Alignment Demonstration (CFAD) Product, or Medicare and Medicaid Program, means the managed care program established by the Centers for Medicare and Medicaid Services (CMS) through the capitated financial alignment demonstration in which the state, CMS and Health Plan will enter into a three-way contract that will allow the health plan to provide care to beneficiaries eligible for both Medicaid and Medicare.

2. Attachment K-2 - CFAD Matrix of Financial Responsibility is hereby added to the Agreement and attached hereto.

3. Attachment D-1 - Compensation Schedule for CFAD Members, is hereby added to the Agreement and attached hereto.

4. All references in the Agreement which treat the CFAD product as a Medicare product are null and void. The CFAD product is its own separate and distinct product.

5. Any reference to additional payments for incentive programs or the preventive care compensation programs shall not be applicable to the CFAD product. If the CFAD product will be eligible for additional compensation, a separate amendment will be issued at a future date.

6. Attachment H, Medicare Program Provisions, shall also apply to the Capitated Financial Alignment Demonstration Product for all Medicare services provided under the Capitated Financial Alignment Demonstration Product.

7. Use of Defined Terms. Unless otherwise defined in this Amendment, capitalized terms utilized in this Amendment will have the same meaning(s) ascribed to such terms in the Agreement.

8. No Other Modifications. Except as provided herein, the terms and conditions of the Agreement shall remain the same, in full force and effect.

9. Counterparts. This Amendment may be executed in one or more counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers thereunto duly authorized.

Pacific Healthcare IPA Associates, Inc.		**Molina Healthcare of California**	
By:	/s/ F. Bernadett	By:	/s/ Michelle Espinoza
			Michelle Espinoza
Its:	President	Its:	Vice President, Provider Network Management
Date:	6/13/2014	Date:	7/3/14

Effective date (to be entered by Health Plan): 7/1/14

ATTACHMENT K-2

CFAD MATRIX OF FINANCIAL RESPONSIBILITY

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Abortion			
Facility Component			X
Office/Outpatient Setting Component			X
Professional Component			X
Acupuncture	Not a Covered Service		
Allergy Testing (including serum)	X		
Alpha-fetoprotein Test			X
Ambulance, Air or Ground (Emergency Services)			
In Area		X	
Out-of-Area		X	
Amniocentesis			
Facility Component	X		
Professional Component	X		
Anesthetics, Administration of			
Inpatient	X		
Outpatient	X		
Blood and Blood Products		X	
Blood Donations		X	
Blood Donations, Autologous (when Medically Necessary)		X	
Cancer Drugs (including infusion) and Administration of the Drug in the following settings:			
Inpatient Facility Component		X	
Inpatient Professional Component			
Cancer Drugs administered in Physician's Office	X		
Outpatient Facility Component	X		
Outpatient Professional Component	X		
Oral taken By Patient	X	X	
Caregiver Relief: Assist with Member bathing, feeding, dressing and other needs		X	
Chemical Dependency (Acute Inpatient Overdose Treatment)			
Inpatient Facility		X	
Inpatient Professional Component		X	
Chemical Dependency - Detoxification & Rehabilitation (Outpatient Treatment)			
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Chiropractic Care	X		

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Clinical Trials			
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Custodial Care (In a Skilled Nursing Facility)		X	
Dental Services (Routine)		X	
Dental Services (including treatment of TMJ, when Medically Necessary related to accidental injury or trauma to sound natural teeth and for dental work necessary to construct non-dental structures)			
Professional Component			
Anesthesia (only when medically indicated)	X		
Facility Component	X	X	
Diabetic Supplies (includes glucose monitors, test strips, lancets, screening tests)		X	
Dialysis (inclusive of injectables)			
Inpatient Facility Component			
Outpatient Facility Component	X		
Professional Component	X		
Out-of-Area Routine	X	X	
Disease Management		X	
Drugs/Medications			
Inpatient			
Outpatient		X	
Prescriptions (Oral Medications)			
Injectable Medications		X	
Administered by Home Health Provider		X	
Depo Provera, Lupron, Growth Hormones (administered by Physician's Office)		X X	
Administered in the Physician's Office - (excluding Depo Provera, Lupron, Growth Hormones)			
Infusion Therapy (i.e. TPN. For cancer related drugs or infusion, refer to Cancer Drugs and Administration of Cancer Drugs section in Matrix)		X	
Self Administered		X	
Self Administered Insulin		X	
Vaccinations	X	X	
Durable Medical Equipment (DME)			
Inpatient			
Outpatient Dispensing	X	X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Emergency Room Visits, In-Area Facility Component Professional Component (Anesthesiology, ER Physicians, Pathology, Radiology) Professional Component Other than above	 X	 X X	
Emergency Room Visits, Out-of-Area Facility Component Professional Component (Anesthesiology, ER Physicians, Pathology, Radiology) Professional Component Other than above		 X X X	
Emergency Medical Response - In home emergency response unit allowing Member to communicate with a central monitoring station in an Emergency.		X	
Endoscopic Studies Professional Outpatient Facility Component	 X X		
Family Planning Services Inpatient Facility Component Inpatient Professional Component Outpatient Facility Outpatient Professional Component		 X	 X X X
Fetal Monitoring Inpatient Facility Component Outpatient Facility and Professional Component		 X	 X
Genetic Testing (when Medically Necessary Outpatient Facility Component Outpatient Professional Component	 X X		
Health Education	X		
Hearing Aid Hearing Aid Replacement Batteries		X X	
Hearing Screening Routine Hearing Exam Diagnostic Hearing Exams	 X	 X	
Home Health Care (Including home hospice, MSW, OT, PT, RT, SN, injections, IV infusion, supplies and injected substances, etc.)		X	
Hospice Care Inpatient Facility Professional Component		X X	
Hospitalization In-Area Facility Component Professional Component	 X	 X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Hospitalization Out-of-Area			
Facility Component			
Professional Component			
Professional Component (where Member is stable for transfer and group/provider refuses to transfer Member)	X	X X	
Implantable Lenses (following cataract surgery)		X	
Incontinence Supplies			X
Infertility Services	Not a Covered Service		
Investigational/Experimental Procedures (when a Medicare Covered Benefit)			
Inpatient Professional		X	
Outpatient Professional		X	
Inpatient Facility		X	
Outpatient Facility		X	
Immunizations (Flu Vaccine, Hep B, Pneumonia Vaccine)			
Professional Component	X		
Laboratory Tests (except when related to ER Pathology)			
Inpatient Facility Component			
Outpatient Facility and Professional Component (including Pathology)	X	X	
Medical/Surgical Supplies (including ostomy supplies)			
Inpatient			
Outpatient & Office	X	X	
Mental Health			
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Nutrition/Diet Counseling	X		
Nutritional Supplements/Enteral Feeding Therapy (when Medically Necessary)		X	
Nurse Advice Line - Twenty-Four (24) hour unlimited telephone access to live registered nurse to answer medical questions.		X	
Obstetrical Care			
Inpatient Facility Component			
Outpatient Diagnostic Services (including but not limited to fetal monitoring, ultrasound and observation)	X		
Total OB Care (Professional Component)	X	X	
Office Visit Supplies (i.e. Splints, Bandages, Casting, etc.)	X		
Organ Transplant (when a Covered Benefit*)			
Inpatient Facility Component			
Inpatient Professional Component		X	
**Investigational/Experimental Transplants are not covered.*		X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Organ Transplant Work Up Facility Component Professional Component	 X	 X	
Ostomy Supplies Inpatient Outpatient	 X	 X	
Outpatient Diagnostic Services, including but not limited to: Angiograms, Colonoscopy, Echocardiograms, EDG, EEG, EKG, EMG/NCV, Sleep Studies, Treadmill, Drug	 X		
Outpatient Surgery Facility Component Professional Component	 X	 X	
Pathology Services (except when related to ER visit) Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	 X	
Physical Therapy , Occupational Therapy, Respiratory Therapy, Speech Therapy, Rehabilitation Inpatient Outpatient	 X	 X	
Personal Patient Navigator		X	
Preventive Care - Colorectal Services, TB Screening, Bone Density, Mammograms, Prostate Screening In Office Outpatient Professional Outpatient Facility	 X X X		
Primary and Specialty Care Physician Services* Inpatient Outpatient SNF Office Patient's Home **See Emergency Room for exceptions*	 X X X X	 X	
Podiatry Services (includes two (2) routine visits per calendar year) Medically Necessary podiatry/foot care	X X		
Pre-Admission Diagnostic Testing Professional Component Facility Component	 X X		
Prosthetics/Orthotics Inpatient and Surgically Implanted Outpatient Dispensing		 X X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Radiation Therapy			
Inpatient Facility Component			
Outpatient Facility Component	X		
Professional Component	X	X	
Radiology Services			
Inpatient Facility Component			
Outpatient Facility Component	X		
Professional Component	X	X	
Reconstructive Surgery (Non-Cosmetic)			
Facility Component			
Professional Component	X	X	
Routine Physical Examinations	X		
Skilled Nursing Facility			
Facility Component		X	
Professional Component		X	
Sterilization			X
Transportation - Ambulatory, Van, Wheelchair, Gurney		X	
Urgent Care Services	X		
Vision Care			
Eye exams for the diagnosis and treatment for diseases and conditions of the eye.			
One routine eye exam per calendar year.		X	
Eyeglass frames and lenses or contact lenses every two (2) years.		X	
Following cataract surgery, one pair of eye glasses or contact lenses.	X	X	

Long Term Services and Support (LTSS):

Health Plan shall be responsible for providing and/or coordinating Covered Services that are included as a part of the following programs: Long Term Care (LTC), Multipurpose Senior Services Program (MSSP), In-Home Support Services (IHSS) services, and Community-Based Adult Services (CBAS). Claims for these services should be billed directly to the Health Plan.

ATTACHMENT D-1

COMPENSATION SCHEDULE FOR CFAD MEMBERS

Capitation Payments for Capitated Financial Alignment Demonstration Members. Provider shall be compensated for all CFAD Members assigned to Provider based upon a per Member per month capitation rate. For Capitated Financial Alignment Demonstration Members, Health Plan shall pay Provider at a rate equivalent to Thirty Eight percent (38%) of the Medicare Part A and B premium it receives from CMS. Health Plan may amend the Agreement, in accordance with the applicable Amendment section of the Agreement to modify these Capitation Payments in order to account for any revenue reduction in the applicable government sponsored program(s) and benefits, if any.

Non-Capitated Services Submission of Claims/Claims Payment. For Clean Claims for Covered Services rendered to Members which are provided or arranged by Provider, but are (i) Health Plan financial responsibility or listed as Other Covered Services under the applicable Matrix of Financial Responsibility, and/or (ii) are not covered by Capitation Payments (collectively the "Non-Capitated Services"), 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. Health Plan shall reimburse Provider for such Non-Capitated Services on a fee-for service basis in accordance with the applicable Claims Payment provisions of this Agreement, at the lesser of: (i) Provider's billed charges, or (ii) pursuant to the methodology described below.

(1) **Non-Capitated Services Payment Rate for Capitated Financial Alignment Demonstration Members.** Provider will receive an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the date(s) of service, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including but not limited to co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

In the event a Covered Service is covered by Medicaid or is primary to Medicaid, but not Medicare, Health Plan agrees to compensate Provider for such Covered Services rendered to Members, that are submitted on a Clean Claim and determined by Health Plan to be payable, on a fee-for-service basis, at the lesser of; (i) Provider's billed charges, or (ii) at an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of California in effect on the date(s) of service, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

Provider acknowledges that CMS and the State of California have not released final joint-capitation rate to be paid to Health Plan for this product/program. If, after the final capitation rate is released, Health Plan determines that the above compensation for this product/program is unsustainable, Provider agrees to negotiate a new compensation rate for this product/program with Health Plan in good faith. If Health Plan and Provider cannot agree to a new rate before this product/program begins, Health Plan or Provider may immediately terminate this product/program from this Agreement, in compliance with applicable laws.

EXHIBIT 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2015	**2014**	**2013**	**2012**	**2011**
	(Dollars in Millions)				
Earnings:					
Income before income taxes, continuing operations	$ 322	$ 135	$ 81	$ 23	$ 120
Add fixed charges:					
Interest expense, including amortization of debt discount and expense	66	57	52	17	16
Estimated interest portion of rental expense	8	5	4	3	2
Total fixed charges	74	62	56	20	18
Total earnings available for fixed charges	$ 396	$ 197	$ 137	$ 43	$ 138
Fixed charges from above:	$ 74	$ 62	$ 56	$ 20	$ 18
Ratio of Earnings to Fixed Charges	5.4	3.2	2.4	2.2	7.7
Total rent expense	$ 44	$ 32	$ 25	$ 20	$ 23
Interest factor	18%	16%	16%	14%	11%
Interest component of rental expense	$ 8	$ 5	$ 4	$ 3	$ 2

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Iowa, Inc. *	Iowa
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Mississippi, Inc.*	Mississippi
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of New York, Inc.*	New York
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Oklahoma, Inc.*	Oklahoma
Molina Healthcare of Pennsylvania, Inc.*	Pennsylvania
Molina Healthcare of Puerto Rico, Inc.	Puerto Rico/Nevada
Molina Healthcare of South Carolina, LLC	South Carolina
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company^	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Health Plan Management, Inc.*	New York
Molina Hospital Management, Inc.	California
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Youth Academy	California
Molina Medical Management, Inc.	California
Easy Care MSO, LLC~	California
Molina Pathways, LLC	Delaware
Molina Pathways of Ohio, LLC+*	Ohio
Molina Pathways of Texas, Inc.+	Texas
Molina Personal Care of Texas, Inc.+ *	Texas
Molina Personal Care of South Carolina, Inc.+*	South Carolina
Synergy Partners, L.L.C.+	Michigan
Pathways Health and Community Support LLC+	Delaware
AmericanWork, Inc.-	Delaware
A to Z In-Home Tutoring LLC-	Nevada
Children's Behavioral Health, Inc.-	Pennsylvania
Choices Group, Inc.-	Delaware

EXHIBIT 21.1

College Community Services-	California
Dockside Services, Inc.-	Indiana
Family Builders, Inc.- *	Arizona
Family Preservation Services, Inc.-	Virginia
Family Preservation Services of Florida, Inc.-	Florida
Family Preservation Services of North Carolina, Inc.-	North Carolina
Family Preservation Services of Washington D.C., Inc.-	District of Columbia
Family Preservation Services of West Virginia, Inc.-	West Virginia
Maple Star Nevada, Inc.-	Nevada
Maple Star Oregon, Inc.-	Oregon
Pathways Community Corrections, Inc.-	Delaware
Camelot Care Centers, Inc.>	Illinois
Pathways Community Services LLC-	Delaware
Pathways Community Services LLC-	Pennsylvania
Pathways of Massachusetts LLC-	Delaware
Pathways of Washington, Inc.-	Washington
Pathways Health and Community Support of Florida, Inc.-	Florida
Pathways of Arizona, Inc.-	Arizona
Pathways of Idaho LLC-	Delaware
Pathways of Alabama, Inc.-	Alabama
Pathways of Delaware, Inc.-	Delaware
Pathways of Maine, Inc.-	Maine
Pathways of Oklahoma, Inc.-	Oklahoma
Pathways Community Support of Texas, Inc.-	Texas
The RedCo Group, Inc.-	Pennsylvania
Raystown Developmental Services, Inc./	Pennsylvania
Transitional Family Services, Inc.-	Georgia
W.D. Management, LLC-	Missouri

* Non-operational entity

^ Wholly owned subsidiary of Molina Healthcare of Texas, Inc.

\+ Wholly owned subsidiary of Molina Pathways, LLC

~ Partially owned subsidiary of Molina Medical Management, Inc.

\- Wholly owned subsidiary of Pathways Health and Community Support LLC

/ Wholly owned subsidiary of The RedCo Group, Inc.

> Wholly owned subsidiary of Pathways Community Corrections, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statements No. 333-108317, No. 333-138552, No. 333-153246, No. 333-170571, and No. 333-174912 on Form S-8 pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan; 2002 Equity Incentive Plan; 2002 Employee Stock Purchase Plan; 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and Registration Statement No. 333-204558 on Form S-3, of our reports dated February 26, 2016, 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, 2015.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2016

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the annual report on Form 10-K for the period ended December 31, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order 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 the report;

3. Based on my knowledge, the financial statements, and other financial information included in the 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 the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), 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 the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the 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 to 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 financial 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.

Dated: February 26, 2016

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed this annual report on Form 10-K for the period ended December 31, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order 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 the report;

3. Based on my knowledge, the financial statements, and other financial information included in the 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 the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), 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 the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the 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 to 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 financial 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.

Dated: February 26, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

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 report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2015 (the "Report"), I, Joseph M. 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.

Dated: February 26, 2016

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

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 report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2015 (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.

Dated: February 26, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer