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SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2009

or

o **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. o 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. o 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 o 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). o Yes o 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 o | Accelerated filer ☑ | Non-accelerated filer o | Smaller reporting company o
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). o Yes ☑ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2009, the last business day of our most recently completed second fiscal quarter, was approximately $255 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2009).

As of March 5, 2010, approximately 25,700,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2010 Annual Meeting of Stockholders to be held on May 4, 2010, are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

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Form 10-K

PART I

Item 1: ***Business***

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization. Our revenues are derived primarily from premium revenues paid to our health plans by the relevant state Medicaid authority, which revenues are jointly financed by the federal and state governments. Increasingly, we also derive revenues from the federal Centers for Medicare and Medicaid Services, or CMS, in connection with our Medicare services. As of December 31, 2009, approximately 1,455,000 members were enrolled in our health plans.

The payments made to our health plans generally represent an agreed upon amount per member per month, or a "capitation" amount, which is paid regardless of whether the member utilizes any medical services in that month or whether the member utilizes medical services in excess of the capitation amount. Each of our health plans is thus financially "at risk" for the medical care of its members. Each health plan contracts with health care providers in the relevant communities or states in which it operates, including primary care physicians, specialist physicians, physician groups, hospitals, and other medical care providers. These health care providers then provide medical care to the health plan's enrolled members. Various core administrative functions of our health plans — primarily claims processing, information systems, and finance — are centralized at our corporate parent in Long Beach, California. Our California health plan also operates 17 of its own primary care community clinics; we have a Virginia subsidiary which manages three county-owned primary care community clinics in Fairfax County, Virginia; and our Washington health plan recently began operating its own behavioral health clinic.

Dr. C. David Molina founded our Company in 1980 under the name "Molina Medical Centers" as a provider organization serving the Medicaid population in Southern California through a network of primary care clinics. Since then, we have increased our membership through the start-up development of new health plan operations, the acquisition of existing health plans, and internal or organic growth. Key milestones in our history have included the following:

Year	Milestone
1980	Molina Medical Centers founded in Los Angeles, California by Dr. C. David Molina
1985	Obtained HMO license in California
1994	Acquired minority interest in Michigan health plan
1997	Utah health plan established as start-up operation
1999	Incorporated in California as "American Family Care, Inc.," parent of the California and Utah health plan subsidiaries
	Acquired controlling interest in Michigan and Washington health plans
2000	Company name changed to Molina Healthcare, Inc., a California corporation
2003	Reincorporated in Delaware, and completed initial public offering and listing of shares for trading on the New York Stock Exchange under the symbol, MOH
2004	Acquired the New Mexico health plan
2005	Ohio health plan established as start-up operation
2006	The California, Michigan, Utah, and Washington health plans began operating Medicare Advantage Special Needs plans
	Acquired the Cape Health Plan in Michigan, merging it into the Michigan health plan
	Texas health plan established as start-up operation
2007	The California, Michigan, New Mexico, Texas, Utah, and Washington health plans began enrolling members in Medicare Advantage plans with prescription drug coverage, or MA-PD plans
	Acquired the Missouri health plan

Year	Milestone
2008	The New Mexico and Texas health plans began operating Medicare Advantage Special Needs plans
	Florida health plan established as a start-up operation
2009	The Ohio health plan began operating a Medicare Advantage Special Needs plan

On January 18, 2010, we entered into a definitive agreement to acquire the Health Information Management, or HIM, business of Unisys Corporation. The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. The acquisition is expected to close in the first half of 2010. We intend to operate the HIM business under the name, *Molina Medicaid Solutions*.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is *www.molinahealthcare.com*.

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to "Molina Healthcare," the "Company," "we," "our," and "us" herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge on our website, *www.molinahealthcare.com*, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, and Corporate Governance and Nominating Committee Charters, are also available on our website. Such information is also available in print upon the request of any stockholder to our Investor Relations Department at the address of our executive offices set forth above. In accordance with New York Stock Exchange, or NYSE, rules, on May 11, 2009, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Our Industry

The Medicaid and CHIP Programs. Established in 1965, the Medicaid program is an entitlement program funded jointly by the federal and state governments and administered by the states. The Medicaid program provides health care benefits to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced "TAN-if"). TANF is the successor to the Aid to Families with Dependent Children program, or AFDC, and most enrolled members are mothers and their children. Another common state-administered Medicaid program is for the aged, blind, or disabled, or ABD Medicaid members, who do not qualify under other Medicaid coverage categories. Although state programs must meet minimum federal standards, states have significant flexibility in determining eligibility thresholds, the amount of covered services, and payment rates for providers.

In addition, the Children's Health Insurance Program, known widely by the acronym CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage, but not enough to afford commercial health insurance. States have the option of administering CHIP through their Medicaid programs.

The federal government pays a portion of the costs that states incur to provide services to Medicaid enrollees. The proportion of states' costs that the federal government pays is based on the "federal medical assistance percentage," or FMAP. The percentage for each state is determined through a formula that assigns a higher federal reimbursement rate to states that have lower income per capita (and vice versa) relative to the national average. Prior to the implementation of the American Recovery and Reinvestment Act of 2009, or ARRA, the average matching rate that the federal government paid was 57 percent nationwide; states contributed the remaining 43 percent. The federal matching rates have both a floor

(50 percent) and a ceiling (83 percent). The matching rates for CHIP are approximately one-third higher than those under Medicaid. Generally, states have more programmatic flexibility in CHIP than in Medicaid.

As part of ARRA, enacted on February 17, 2009, states were scheduled to receive approximately $87 billion in assistance for their Medicaid programs through a temporary increase in the FMAP match rate. The funding is effective from October 1, 2008 to December 31, 2010. Under ARRA, every state has received a minimum FMAP increase of 6.2 percent. The balance of funding is based on unemployment rates in the states. In order to receive this additional FMAP increase, states may not reduce Medicaid eligibility levels below the eligibility levels that were in place on July 1, 2008. Medicaid is classified as an entitlement, and therefore there is no limit on the federal funds that may be expended. Federal payments for Medicaid are limited only by the amount states are willing and able to spend. Nevertheless, budgetary constraints at both the federal and state levels may limit the benefits paid and the number of members served by Medicaid. CHIP, however, is a capped allotment. Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 enacted on February 4, 2009, CHIP was reauthorized and expanded to cover up to a total of 11 million children by 2011. The legislation also provided an additional $32.8 billion in funding over the next four-and-a-half years, and allows states to expand coverage up to 300 percent of the federal poverty level. CHIP will continue to be funded at an enhanced match, with a minimum federal amount of 65 percent.

On March 10, 2010, the United States Senate approved legislation which would allocate $25 billion to the extension by six months of the 6.2% increase in the FMAP provided under ARRA. If this legislation is passed by the House and signed into law by President Obama, the increased FMAP paid to the states will continue through June 30, 2011.

Medicaid Managed Care. Under traditional fee-for-service Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These beneficiaries typically have minimal access to preventive care such as immunizations, and access to primary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, because providers are paid on a fee-for-service basis where additional services rendered result in additional revenues, they lack incentives to monitor utilization and control costs.

In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments for the covered health care services. The health plan, in turn, arranges for the provision of the covered health care services by contracting with a network of providers, including both physicians and hospitals, who agree to provide the covered services to the health plan's members. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore and, in many cases, to mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have mandatory Medicaid managed care programs.

Medicare Advantage Plans. During 2009, each of our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name, Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name, Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operate a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans at December 31, 2009 was approximately 12,000 members. Our 2009 premium revenues from Medicare across all health plans represented approximately 3.7% of our total premium revenues.

Other Government Programs for Low Income Individuals. In certain instances, states have elected to provide medical benefits to individuals and families who do not qualify for Medicaid. Such programs are often administered in a manner similar to Medicaid and CHIP, but without federal matching funds. At December 31, 2009, our Washington health plan served approximately 20,000 such members under one such program, that state's "Basic Health Plan."

Our Approach

We focus on serving financially vulnerable families and individuals who receive health care benefits through government-sponsored programs within a managed care model. These families and individuals generally represent diverse cultures and ethnicities. Many have had limited educational opportunities and do not speak English as their first language. Lack of adequate transportation is common. We believe we are well-positioned to capitalize on the growth opportunities in serving these members. Our approach to managed care is based on the following key attributes:

Experience. For 30 years we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. We have developed and forged strong relationships with the constituents whom we serve — members, providers, and government agencies. Our ability to deliver quality care and to establish and maintain provider networks, as well as our administrative efficiency, has allowed us to compete successfully for government contracts. We have a strong record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The successful integration of our New Mexico and Missouri health plans demonstrated our ability to expand into states in which we had not previously had any presence. The establishment of our health plans in Utah, Ohio, and Texas reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We arrange health care services through contracts with providers that include independent physicians and medical groups, hospitals, ancillary providers and, in California, our own clinics. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates, and diagnostic related groups, or DRGs. Our provider network strategy is to contract with providers that are best-suited, based on expertise, proximity, cultural sensitivity, and experience, to provide services to the members we serve.

Our California health plan operates 17 company-owned primary care clinics in California. In addition, in 2008, our unlicensed subsidiary in Virginia began to manage the Fairfax County Community Health Care Network. This network consists of three county-owned clinics, providing comprehensive medical services to over 16,000 of Fairfax County's uninsured residents. In 2010, our Washington health plan teamed with Compass Health to launch *Molina Medical at Compass Health*, a treatment center focused on integrating primary care and behavioral health services. We believe that our clinics serve a useful role in providing certain communities with access to primary care and providing us with insights into physician practice patterns, first-hand knowledge of the needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. We have 30 years of experience developing targeted health care programs for culturally diverse Medicaid members, and believe we are well-qualified to successfully serve these populations. We contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. We educate employees and providers about the differing needs among

our members. We develop member education materials in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

Medical Management. We believe that our experience as a health care provider has helped us to improve medical outcomes for our members while at the same time enhancing the cost-effectiveness of care. We monitor day-to-day medical management to provide appropriate care to our members, contain costs, and ensure an efficient delivery network. We have developed disease management and health education programs that address the particular health care needs of our members. We have established pharmacy management programs and policies that have allowed us to manage our pharmaceutical costs effectively. For example, our staff pharmacists educate our providers on the use of generic drugs rather than brand drugs.

Our Strategy

Our objective is to be an innovative health care leader while delivering competitive returns for our investors. We seek to provide quality care and accessible services in an efficient and caring manner to Medicaid, CHIP, Medicare, and other financially vulnerable members. To achieve these objectives, we intend to:

Focus on serving financially vulnerable families and individuals. We believe that the Medicaid and low-income Medicare population, which is characterized by significant ethnic diversity, requires unique services to meet its health care needs. Our 30 years of experience in serving this population has provided us significant expertise in meeting the unique needs of our members.

Increase our membership. We have grown our membership through a combination of acquisitions, start-up health plans, serving new populations, and internal or organic growth. Increasing our membership provides the opportunity to grow and diversify our revenues, increase profits, enhance economies of scale, and strengthen our relationships with providers and government agencies. We will continue to seek to grow our membership by expanding within existing markets and entering new strategic markets.

- *Expand within existing markets.* We expect to grow in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, extending our services to new populations, maintaining positive provider relationships, and integrating members from other health plans.
- *Enter new strategic markets.* We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size and, where possible, mandated Medicaid managed care enrollment.

Provide quality cost-effective care. We will use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the quality of care, these programs also facilitate the cost-effective delivery of that care. To document our commitment to quality, each Molina Healthcare health plan has adopted goals: (1) to achieve or continue accreditation by the National Committee for Quality Assurance, or NCQA, and (2) to achieve scores under the Healthcare Effectiveness Data and Information Set, or HEDIS, at the 75th percentile for Medicaid plans. It is our goal to be the health plan of choice, recognized for the quality and accessibility of our services. Financially vulnerable families and individuals covered by government programs have traditionally faced long-standing barriers to accessing care that include language, culture, and literacy. We want to be known for our ability to help others overcome these barriers. Among physicians, hospitals, and other providers, we want to be known for prompt and accurate payment of claims and sound medical decisions.

Leverage operational efficiencies. Our centralized administrative infrastructure, flexible information systems, and dedication to controlling administrative costs provide economies of scale. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and entry into new markets.

Our Health Plans

As of December 31, 2009, our health plans were located in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Additionally, we operate three county primary care clinics in Virginia. As of December 31, 2009, we ceased serving members in Nevada. An overview of our health plans and their principal governmental program contracts with the relevant state authority is provided below:

State	Expiration Date	Contract Description or Covered Program
California	3-31-12	Subcontract with Health Net for services to Medi-Cal members under Health Net's Los Angeles County Two-Plan Model Medi-Cal contract with the California Department of Health Services (DHS).
California	12-31-12	Medi-Cal contract for Sacramento Geographic Managed Care Program with DHS.
California	3-31-11	Two Plan Model Medi-Cal contract for Riverside and San Bernardino Counties (Inland Empire) with DHS.
California	6-30-10	Medi-Cal contract for San Diego Geographic Managed Care Program with DHS.
California	6-30-10	Healthy Families contract (California's CHIP program) with California Managed Risk Medical Insurance Board (MRMIB).
Florida	8-31-12	Medicaid contract with the Florida Agency for Health Care Administration.
Michigan	9-30-10	Medicaid contract with state of Michigan.
Missouri	6-30-10	Medicaid contract with the Missouri Department of Social Services.
New Mexico	6-30-11	Salud! Medicaid Managed Care Program contract (including CHIP) with New Mexico Human Services Department (HSD).
Ohio	6-30-10	Medicaid contract with Ohio Department of Job and Family Services (ODJFS).
Texas	8-31-10	Medicaid contract with Texas Health and Human Services Commission (HHSC).
Utah	6-30-10	Medicaid and CHIP contracts with Utah Department of Health.
Washington	12-31-10	Basic Health Plan and Basic Health Plus Programs contract with Washington State Health Care Authority (HCA).
Washington	6-30-10	Healthy Options Program (including Medicaid and CHIP) contract with state of Washington Department of Social and Health Services.

In addition to the foregoing, our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington have entered into a standardized form of contract with CMS with respect to their operation of a MA SNP, and our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington have also entered into a standardized form of contract with CMS with respect to their operations of a MA-PD plan. These contracts are renewed annually and were most recently renewed as of January 1, 2010.

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. We are usually paid a negotiated per member per month amount, or PMPM, with the PMPM amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also paid an additional amount for each newborn delivery in Michigan, Missouri, New Mexico, Ohio, Texas, and Washington. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. As of December 31, 2009, our California health plan served 351,000 members. Our plan serves the counties of Los Angeles, Riverside, San Bernardino, San Diego, and Sacramento. Our Medi-Cal members in

Los Angeles County are served pursuant to a subcontract we have entered into with Health Net, with Health Net in turn contracting with the state. Our California health plan also operates 17 of its own primary care community clinics.

Florida. As of December 31, 2009, our Florida plan served approximately 50,000 members, and operated in 7 of the state's 67 counties.

Michigan. As of December 31, 2009, our Michigan health plan served 223,000 members, and operated in 46 of the state's 83 counties, including the Detroit metropolitan area.

Missouri. As of December 31, 2009, our Missouri health plan served 78,000 members, and operated in 57 of the state's 114 counties.

New Mexico. As of December 31, 2009, our New Mexico health plan served 94,000 members, and operated in all of New Mexico's 33 counties.

Ohio. As of December 31, 2009, our Ohio health plan served 216,000 members, and operated in 50 of the state's 88 counties.

Texas. As of December 31, 2009, our Texas health plan served 40,000 members, serving STAR and CHIP members in 11 counties and STAR PLUS members in 13 counties. STAR stands for State of Texas Access Reform, and is Texas' Medicaid managed care program. STAR PLUS is the Texas Medicaid managed care program serving ABDs and includes a long-term care component.

Utah. As of December 31, 2009, our Utah health plan served 69,000 members including 4,000 Medicare Advantage SNP members. Our Utah health plan serves Medicaid members in 25 of the state's 29 counties, including the Salt Lake City metropolitan area, and CHIP members in all 29 counties.

Virginia. On July 1, 2008, Molina Healthcare of Virginia, Inc. began to operate the Fairfax County Community Health Care Network. This network consists of three county clinics, and, as of December 31, 2009, provided comprehensive medical services to over 16,000 of the county's uninsured residents.

Washington. As of December 31, 2009, our Washington health plan served 334,000 members, and operated in 34 of the state's 39 counties. In February 2010, our Washington health plan began operating a behavioral health clinic under the name, *Molina Medical at Compass Health*.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

The following table shows the total approximate number of primary care physicians, specialists, and hospitals participating in our network as of December 31, 2009:

	Primary Care Physicians	Specialists	Hospitals
California	3,015	7,320	72
Florida	707	931	60
Michigan	2,491	5,351	71
Missouri	2,001	6,156	96
New Mexico	1,568	6,549	63
Ohio	1,828	11,581	106
Texas	1,369	5,421	61
Utah	1,261	3,936	39
Washington	3,089	6,256	88
Total	17,329	53,501	656

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations, or IPAs. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California health plan operates 17 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a non-licensed subsidiary in Virginia which manages three health care clinics for Fairfax County, and our Washington health plan recently opened a behavioral health clinic.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert

data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*℠ 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 fifteen. *Healthy Living with Diabetes*℠ is a diabetes disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/Submit Authorizations.

- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/PCP.
- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (such as those that may be required by the Health Insurance Portability and Accountability Act of 1996, or HIPAA, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the HEDIS and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. At December 31, 2009, all of our eligible health plans were accredited by the NCQA. Our Missouri plan will begin the NCQA review and accreditation process in 2010, and our Florida plan expects to apply for NCQA review as soon as it is eligible.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 3.4 system), with the exception of our Missouri plan which we expect will be migrated to the Molina standard platform in the second quarter of 2010.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- *Medicaid HMOs* — National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- *Prepaid Health Plans* — Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- *Primary Care Case Management Programs* — Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan’s provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources.

Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules can occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Each of our health plans is required to file quarterly reports on its operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC, and are administered by the states. Our Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington health plans are subject to RBC requirements. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state governments jointly fund it, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states, such as Washington, award contracts to any applicant demonstrating that it meets the state's requirements. Other states, such as California, engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that

we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Once awarded, our contracts generally have terms of one to three years, with renewal options at the discretion of the states. Our contracts generally set forth the requirements for operating in the Medicaid sector, and include provisions relating to: eligibility; enrollment and disenrollment processes; covered services; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education and wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by the insurance department of the jurisdiction that licenses the health plan, and must submit periodic utilization reports and other information to state or county Medicaid authorities. Health plans are not permitted to enroll members directly, and are permitted to market only in accordance with strict guidelines. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by CMS. Medicare beneficiaries have the option to enroll in a Medicare Advantage plan. Under Medicare Advantage, managed care plans contract with CMS to provide benefits that are comparable to original Medicare in exchange for a fixed PMPM that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, made numerous changes to the Medicare program, including expanding the Medicare program to include a prescription drug benefit. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan. Plans are not required to offer the same benefits, but are required to provide coverage that is at least actuarially equivalent to the standard drug coverage delineated in the MMA.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, or MIPPA, became law and, in September 2008, CMS promulgated implementing regulations. MIPPA impacts a broad range of Medicare activities and impacts all types of Medicare managed care plans. MIPPA and subsequent CMS guidance place

prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. MIPPA also establishes certain restrictions on agent and broker compensation.

HIPAA. In 1996, Congress enacted HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- Afford privacy to patient health information, and
- Protect the privacy of patient health information through physical and electronic security measures.

ARRA further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state attorneys general to bring enforcement actions and increasing penalties for violations.

Fraud and Abuse Laws. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2009, we had approximately 2,800 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Item X: Executive Officers of the Registrant

J. Mario Molina, M.D., 51, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 45, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 30 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Mark L. Andrews, Esq., 52, has served as Chief Legal Officer and General Counsel since 1998. He also has served as a member of the Executive Committee of our company since 1998. Before joining our company, Mr. Andrews was a partner at Wilke, Fleury, Hoffelt, Gould & Birney of Sacramento, California, where he chaired that firm’s health care and employment law departments and represented Molina as outside counsel from 1994 through 1997. Mr. Andrews holds a Juris Doctorate degree from Hastings College of the Law.

Terry P. Bayer, 59, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has 26 years of health care management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional

responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University.

James W. Howatt, 63, has served as our Chief Medical Officer since May 2008. Dr. Howatt formerly served as the chief medical officer of Molina Healthcare of Washington. Prior to joining Molina Healthcare in February 2006, Dr. Howatt was Western Regional Medical Director for Humana, where he was responsible for the coordination and oversight of quality, utilization management, credentialing, and accreditation for Humana's activities west of Kansas City. Previously, he was Vice President and CMO of Humana Arizona, where he was responsible for leading a variety of medical management functions and worked closely with the company's sales division to develop customer-focused benefit structures. Dr. Howatt also served as CMO for Humana TRICARE, where he oversaw a $2.5 billion health care operation that served three million beneficiaries and comprised a professional network of 40,000 providers, 800 institutions, and 13 medical directors. Dr. Howatt received B.S. and M.D. degrees from the University of California, San Francisco, and also holds a Master of Business Administration degree with an emphasis in Health Management from the University of Phoenix. He interned and completed his residency program in family practice at Ventura County Hospital in Ventura, California. Dr. Howatt is a board-certified family physician and a member of the American College of Managed Care Medicine.

Item 1A: ***Risk Factors***

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This annual report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. We cannot guarantee that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to our Health Plan Business

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts or changes in member eligibility thresholds or criteria which could compress our profit margins.

With the exception of the relatively small portion of our revenues which come from Medicare, nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs are continuing to increase at the same time that state budgets are suffering from unprecedented deficits. In June 2009, 46.9 million members were enrolled in the Medicaid program throughout the nation, nearly 3.3 million more than in June 2008, representing the largest one-year increase since the inception of the Medicaid program. Because governmental health care programs account for such a large portion of state budgets, efforts to contain overall government spending and to achieve a balanced budget often result in significant political pressure being directed at the funding for these health care programs. The National Association of State Medicaid Directors estimates that state budget shortfalls in the coming fiscal year, which begins in July in most states, will total $140 billion. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it will likely be a prime target for cost-containment efforts. Thus, the sufficiency of the funding under our various state contracts, or the rates we expect to be paid during the course of a year, will be in jeopardy during 2010 while the state budget crises persist. All of the states in which we currently operate our health plans are currently facing significant budgetary pressures. Moreover, because Medicaid enrollment often lags behind unemployment, increases in Medicaid enrollment in 2010 could be even greater than it was in 2009, putting even greater pressure on state budgets.

As part of the American Recovery and Reinvestment Act of 2009, or ARRA, the federal government increased the amount of funding for federal Medicaid matching by approximately $87 billion for the period between October 1, 2008 and December 31, 2010. The actual matching percentage is computed from a formula that takes into account the average per capita income for each state relative to the national average, and a state's unemployment rate. As a result of the passage of this legislation, the share of Medicaid costs that are paid for by the federal government has gone up, and the share of costs that are paid for by the states has gone down. However, in order for states to receive these increased federal matching funds, they must first budget for and actually spend their own state dollars to cover their additional Medicaid and CHIP members. Medicaid spending will therefore be driven by states' available revenues. State governments may have insufficient funds to fully fund these programs or provide for expanded enrollment. As a result, states may seek to cut or revise health care programs, optional benefits, eligibility criteria and thresholds, or provider rates, causing the funding of one or more of our state contracts to be curtailed or cut off. In addition, the timing of payments we receive may be impacted by state budget shortfalls. In addition, the $87 billion in increased Medicaid funding provided by ARRA will expire as of December 31, 2010, in the middle of many states' fiscal years. On March 10, 2010, the United States Senate approved legislation which would allocate $25 billion to the extension by six months of the 6.2% increase in the FMAP provided under ARRA. If this legislation is passed by the House and signed into law by President Obama, the increased FMAP paid to the states will continue through June 30, 2011. Unless increased Medicaid funding similar to that provided under ARRA is renewed, the impending loss of this federal funding may cause states to curtail their health care programs or to slash membership in the middle of their fiscal year. Such an action could result in the abrupt loss of a significant number of our enrollees.

Because of their budget deficits, some of the states in which we operate may unexpectedly reduce the rates paid to our health plans or carve out certain elements of their Medicaid benefits, thereby undermining the assumptions used to generate our earnings projections. For instance, effective October 1, 2009, the state of Missouri carved out pharmacy from its Medicaid benefit package, and effective February 1, 2010 the state of Ohio did likewise with its pharmacy benefit. The provision of this benefit by our Missouri and Ohio health plans, respectively, had previously been a significant source of earnings for those health plans. Many states have moved to cut optional benefits in the face of budgetary pressures. There is a risk that cutting such benefits may drive Medicaid patients into expensive emergency rooms, further exacerbating the cost of the Medicaid program to a state. Any unexpected rate cuts or changes in benefit packages could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio for 2009 of 86.8% had been one percentage point higher, or 87.8%, our earnings for 2009 would have been $0.18 per diluted share rather than our actual 2009 earnings of $1.19 per diluted share, an 85% reduction in our earnings.

Factors that may affect our medical care costs include the level of utilization of health care services, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, unexpected patterns in the annual flu season, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. This was demonstrated in the third and fourth quarters of 2009, when our medical costs exceeded our previous estimates as a result of much higher utilization due to widespread influenza-related illness across the Company's health plans, higher medical costs associated with our rapid enrollment growth and the higher costs associated with new members, and higher emergency room costs. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our business may be negatively affected by the enactment of health care or health insurance reforms.

In response to escalating health care costs and the large and growing number of uninsured Americans, legislative proposals that would reform the health care system have been advanced by Congress and state legislatures and are currently pending at the federal and state levels. These proposals include policy changes that could fundamentally change the dynamics of the health care industry, such as having the federal government assume a larger role in the health care industry, or effecting a fundamental restructuring of the Medicare or Medicaid programs. These proposals may also affect certain aspects of our business, including our enrollment levels, our required payment of excise or premium taxes, our contracting with providers, provider reimbursement methods and payment rates, coverage determinations, mandated benefits, minimum medical expenditures, claims payment and processing, drug utilization and patient safety efforts, collection, use, disclosure, maintenance, and disposal of individually identifiable health information or personal health records. One proposal for partially financing the cost of health care reform is to assess an excise tax on the revenues of health plans based on their market share. If adopted as proposed, such an excise tax would have a significant impact on our profitability.

We cannot predict if any of these initiatives will ultimately become law, or, if enacted, what their terms or the regulations promulgated pursuant to such laws will be. But their enactment could increase our costs, expose us to expanded liability, and require us to revise the ways in which we conduct business or put us at risk for loss of business. In addition, our operating results could be adversely affected by such changes even if we correctly predict their occurrence.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves

for such “incurred but not paid,” or IBNP medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to Medicare Advantage or ABD Medicaid members, is impacted by the more limited experience we have had with those populations. Finally, with regard to the new Medicaid and CHIP members we expect to enroll in 2010 through organic growth due primarily to the recession, new members may be disproportionately costly due to high utilization in their first several months of Medicaid or CHIP membership as a result of their previously having been uninsured and therefore not seeking or deferring medical treatment.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

If our government contracts are not renewed or are terminated, or if the responsive bids of our health plans for new Medicaid contracts are not successful, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts generally run for periods of one year to four years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. There is no guarantee that any of our government contracts will be renewed or extended. Moreover, our contracts may be subject to periodic competitive bidding. In the event the responsive bids of our health plans are not successful, we will lose our Medicaid contract in the applicable state, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, they may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or had previously been the case.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. In addition, most contracts are terminable without cause. We may face increased competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the contracting process. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions or reduce our liquidity and capital resources.

To provide liquidity, we have a $200 million senior secured credit facility that matures in May 2012. As of December 31, 2009, we had no outstanding indebtedness under our credit facility. Our credit facility imposes numerous restrictions and covenants, including prescribed consolidated leverage and fixed charge coverage ratios,

net worth requirements, and acquisition limitations that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends without lender approval. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to act with complete flexibility, or our inability to use our credit facility in the manner intended. If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, we may be unable to use the credit facility in the manner intended, and our operations, liquidity, and capital resources could be materially adversely affected.

Adverse equity and credit market conditions may have a material adverse affect on our liquidity or our ability to obtain financing on acceptable terms.

The securities and credit markets have been experiencing significant volatility and disruption over the past eighteen months. The availability of credit from virtually all types of lenders has been significantly affected. Such conditions may persist throughout 2010. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, fund net worth requirements, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant.

Our access to additional financing will depend on a variety of factors such as prevailing economic and equity and credit market conditions, the general availability of credit, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case we may not be able to successfully obtain additional financing on favorable terms or at all.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from nine state health plans. If we were unable to continue to operate in any of those nine states, or if our current operations in any portion of the states we are in were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

Portions of our premium revenue are subject to accounting estimates or retroactive adjustment.

Certain elements of the premium revenue earned by our Florida, New Mexico, Ohio, Texas, and Utah health plans, and by our Medicare Advantage plans, are subject to accounting estimates. Such estimates may subsequently prove to be inaccurate or may require adjustment based upon factual developments. If our accounting estimates with respect to our anticipated premiums are inaccurate or previously recognized premiums require retroactive adjustment, the change in our revenues could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Minimum medical cost floors could limit our profitability.

Our New Mexico health plan is subject to a minimum medical expense level as a percentage of the premium revenue it receives. Our Florida health plan is subject to minimum behavioral health expense levels as a percentage of its behavioral health premium revenues. In both states, premium revenue recoupment may occur if these levels are not met. In addition, our Ohio health plan is subject to certain limits on its administrative costs, and our Texas health plan is required to pay an experience rebate to the state of Texas in the event its profits exceed certain established levels. Other states may adopt similar medical cost floors. For instance, a proposal has been made in the

state of Washington to establish a minimum medical cost floor of 86% of premiums received. These regulatory requirements or new requirements could limit our ability to increase or maintain our overall profits as a percentage of revenues. Moreover, state governments may disagree with our interpretation or application of the contract provisions governing these medical cost floor requirements, which could result in our having to adjust the amount of our obligations under these provisions. Any changes to the terms of these provisions, or the adoption of new or similar provisions, could adversely affect our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we were unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also create increased net worth requirements. In such circumstances we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have an adverse impact on our business, financial condition, cash flows, or results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets — particularly operators of large commercial health plans — have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already

operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or comply with these regulatory requirements in a timely manner, if at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

In order to close on the acquisition of the HIM business, the parties must first obtain regulatory approvals from each of the states of West Virginia, Louisiana, New Jersey, Idaho, Maine, and Florida, as well as various consents to assignment of contract by various vendors. In addition, the parties must also satisfy numerous other conditions to closing. There can be no assurances that the parties will be successful in obtaining the necessary state approvals or contract assignments. In the event the parties are unable to satisfy all of the closing conditions, the Company may be unable to close on its acquisition of the HIM business.

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

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In fiscal year 2006, we had total premium revenue of $2.0 billion. In fiscal year 2009, we had total premium revenue of $3.7 billion, an increase of 84% over a four-year span. Continued rapid growth could place a significant strain on our management and on other Company resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems, could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the country. If a major earthquake were to strike the Los Angeles and Long Beach area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

If we are unable to maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to assure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial position, cash flows, or results of operations.

The insolvency of a delegated provider could obligate us to pay their referral claims which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

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

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which the Company does not participate. These actions and the resulting negative publicity could become associated with or imputed to the Company, regardless of the Company's actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which the Company does participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. Providers at the 17 primary care clinics we operate in California are employees of our California health plan. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our California plan is subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of its employees. We maintain medical malpractice insurance for our clinics in the amount of $1 million per occurrence, and an annual aggregate limit of $3 million, errors and omissions insurance in the amount of $15 million per occurrence and in aggregate for each policy year, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, cash flows, or results of operations, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and

other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2009, 2008, and 2007 without approval of the regulatory authorities were approximately $9.0 million, $7.6 million, and $18.7 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our credit facility and/or our senior convertible notes.

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

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

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $16.12 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

- state and federal budget pressures,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- changes in government payment levels,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy, including our acquisition of the HIM business of Unisys Corporation,
- the operating and stock price performance of other comparable companies in the health care industry,
- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change, and
- general economic conditions, including unemployment rates, inflation, and interest rates.

Our stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our stock does not continue to develop, securities analysts may not maintain or initiate research coverage of our Company and our shares, and this could depress the market for our shares.

Members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate own or are entitled to receive upon certain events approximately 57% of our capital stock. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of our Company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

It may be difficult for a third party to acquire our Company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In

addition, any change in control of our state health plans would require the approvals of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our Company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

We do not anticipate paying any cash dividends in the foreseeable future.

We have not declared or paid any dividends since our initial public offering in July 2003. While we have in the past and may again use our available cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles (“GAAP”) and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, the adoption of new pronouncements or the application of existing pronouncements to our business could significantly affect our results of operations.

Our investments in auction rate securities are subject to risks that may cause losses and have a material adverse effect on our liquidity.

As of December 31, 2009, our investments in auction rate securities included amounts designated as available-for-sale securities totaling $26.9 million par value (fair value of $23.0 million). As a result of the changes in fair value of auction rate securities designated as available-for-sale, we recorded unrealized gains of $0.8 million ($0.5 million, net of tax) to accumulated other comprehensive income for the year ended December 31, 2009, and we recorded unrealized losses of $7.6 million ($4.7 million, net of tax) to other comprehensive loss for the year ended December 31, 2008. We deem the cumulative unrealized losses on these securities to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost. However, if we were to sell these investments before recovery of their cost, we would be required to record a charge to earnings for any accumulated losses, which would impact our earnings for the quarter in which such event occurred.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated primarily as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive loss as a separate component of stockholders’ equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full

cost can be recovered. Trading securities are carried at fair value and any realized gains or losses are included as a component of earnings. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may further deteriorate or provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines or losses related to our trading securities to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments or trading security losses may result in realized losses in future periods which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Another flu epidemic in 2010 or other kind of epidemic in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results during 2009 were significantly impacted by the widespread incidence of the H1N1 flu in the states in which we operate our health plans. The recurrence in 2010 of the H1N1 flu, another variant of the flu, or the outbreak and rapid spread of any other highly contagious and potentially virulent disease, could increase the utilization rates among our members, resulting in significantly increased outpatient, inpatient, emergency room, and pharmacy costs.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process, and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax

law changes. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations, or the accounting reversal of any tax benefits or revenue previously recognized by the Company, could have an adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel which could negatively impact our operations.

Risks Related to the Operation of the Health Information Management Business

The following risk factors are contingent upon the successful closing of our acquisition of the HIM business of Unisys Corporation, which is expected to close in the first half of 2010. We intend to operate the HIM business under the name, Molina Medicaid Solutions.

We have not previously operated a health information management business.

Our Company and senior management personnel have not previously operated a health information management business such as the HIM business, and there may be various aspects of the business with which we are unfamiliar. Although we expect most of the existing HIM business personnel to join our Company to continue to operate the HIM business, our lack of familiarity with the day-to-day operational issues of the HIM business, as well as our lack of experience in responding to requests for proposal to secure new HIM or MMIS business, may negatively impact the growth, future prospects, and the overall profitability of the HIM business.

We may have difficulty integrating the HIM business and its operations.

In connection with the acquisition of the HIM business, we are hiring approximately 900 new employees. These employees were not previously familiar with our operations or our corporate culture. In addition, to operate the HIM business, we will be required to develop new internal controls, accounting policies, accounting infrastructure, regulatory schemes, compliance requirements, and disclosure controls. Our inability to effectively integrate the new HIM business could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We may be unable to retain or renew the state government contracts of the HIM business on terms consistent with our expectations or at all.

The HIM business currently has management contracts in only six states. If, after the closing, we were unable to continue to operate in any of those six states, or if the HIM business' current operations in any of those six states were significantly curtailed, the revenues and cash flows of the HIM business could decrease materially, and as a result our profitability would be negatively impacted.

If we have underestimated the operating cost and capital outlay projections for the HIM business, our profitability could be adversely affected.

In negotiating the purchase price for the HIM business, we estimated the operating costs and capital outlays required to operate the business as a Molina entity. In the event we have underestimated the costs associated with the HIM business, the profitability of that business may be significantly less than expected.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of the HIM business, there are substantial risks associated with full performance under the contracts.

The state contracts of the HIM business typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or unanticipated delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our overall business, financial conditions, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business may be adversely affected.

The contracts of the HIM business with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments and the imposition of fines, and suspension from future government contracting. Further, any negative publicity related to the HIM business' state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have an adverse effect on our business, financial conditions, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results or damage our reputation.

Experienced computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

The HIM business routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to

time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

Item 1B: ***Unresolved Staff Comments***

There are no unresolved comments from the staff of the Securities and Exchange Commission which were received more than 180 days before the end of our 2009 fiscal year.

Item 2: ***Properties***

We lease a total of 51 facilities, including our corporate headquarters at 200 Oceangate in Long Beach, California. We own a 32,000 square-foot office building in Long Beach, California, our 26,000 square-foot data center in Albuquerque, New Mexico, and one of the community clinics in Pomona, California. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3: ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 4: ***Reserved***

PART II

Item 5: ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2009		
First Quarter	$ 22.74	$ 16.22
Second Quarter	$ 25.75	$ 18.11
Third Quarter	$ 25.05	$ 19.36
Fourth Quarter	$ 23.49	$ 17.05
2008		
First Quarter	$ 44.94	$ 23.46
Second Quarter	$ 30.50	$ 22.68
Third Quarter	$ 42.61	$ 24.08
Fourth Quarter	$ 32.45	$ 16.12

As of March 5, 2010, there were 116 holders of record of our common stock. We did not declare or pay any dividends in 2009, 2008, or 2007. While we have in the past and may again in the future use our cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Moreover, our ability to pay dividends to stockholders is dependent on cash dividends being paid to us by our subsidiaries. Laws of the states in which we operate or may operate our health plans, as well as requirements of the government sponsored health programs in which we participate, limit the ability of our health plan subsidiaries to pay dividends to us. In addition, the terms of our credit facility limit our ability to pay dividends.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2009)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	650,739(1)	$30.25	3,801,382(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and Incentive Plan have been suspended.

(2) Includes only shares remaining available to issue under the 2002 Equity Incentive Plan (the "2002 Incentive Plan") and the 2002 Employee Stock Purchase Plan (the "ESPP"). The 2002 Incentive Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares available for issuance under the 2002 Incentive Plan automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. The 400,000 share increase on January 1, 2010 increased the total number of shares reserved for issuance under the 2002 Incentive Plan to 4,400,000 shares. The ESPP initially allowed for the issuance of 600,000 shares of common stock. Beginning December 31, 2003, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares reserved for issuance under the ESPP automatically increased by 1% of total outstanding capital stock.

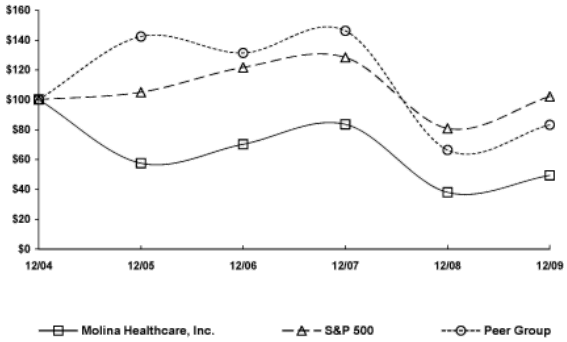
STOCK PERFORMANCE GRAPH

The following discussion shall not be deemed to be "soliciting material" or to be "filed" with the SEC nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500") and a peer group index for the five-year period from December 31, 2004 to December 31, 2009. The graph assumes an initial investment of $100 in Molina Healthcare, Inc. common stock and in each of the indices.

The peer group index consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN*
Among Molina Healthcare, Inc, The S&P 500 Index
And A Peer Group



* $100 invested on 12/31/04 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.

Item 6. ***Selected Financial Data***

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics") for the five years ended December 31, 2009 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data. The data under the caption "Operating Statistics" has not been audited.

	Year Ended December 31,				
	2009	2008(1)	2007(1)(2)	2006(3)	2005
Statements of Income Data:					
Revenue:					
Premium revenue	$ 3,660,207	$ 3,091,240	$ 2,462,369	$ 1,985,109	$ 1,639,884
Investment income	9,149	21,126	30,085	19,886	10,174
Total revenue	3,669,356	3,112,366	2,492,454	2,004,995	1,650,058
Expenses:					
Medical care costs	3,176,236	2,621,312	2,080,083	1,678,652	1,424,872
General and administrative expenses	399,149	344,761	285,295	229,057	163,342
Loss contract charge	—	—	—	—	939
Impairment charge on purchased software(4)	—	—	782	—	—
Depreciation and amortization	38,110	33,688	27,967	21,475	15,125
Total expenses	3,613,495	2,999,761	2,394,127	1,929,184	1,604,278
Gain on purchase of convertible senior notes	1,532	—	—	—	—
Operating income	57,393	112,605	98,327	75,811	45,780
Interest expense	(13,777)	(13,231)	(5,605)	(2,353)	(1,929)
Income before income taxes	43,616	99,374	92,722	73,458	43,851
Provision for income taxes	12,748	39,776	34,996	27,731	16,255
Net income	$ 30,868	$ 59,598	$ 57,726	$ 45,727	$ 27,596
Net income per share:					
Basic	$ 1.19	$ 2.15	$ 2.04	$ 1.64	$ 1.00
Diluted	$ 1.19	$ 2.15	$ 2.03	$ 1.62	$ 0.98
Weighted average number of common shares outstanding	25,843,000	27,676,000	28,275,000	27,966,000	27,711,000
Weighted average number of common shares and potential dilutive common shares outstanding	25,984,000	27,772,000	28,419,000	28,164,000	28,023,000
Operating Statistics:					
Medical care ratio(5)	86.8%	84.8%	84.5%	84.6%	86.9%
General and administrative expense ratio(6)	10.9%	11.1%	11.5%	11.4%	9.9%
General and administrative expense ratio, excluding premium taxes	7.5%	8.0%	8.2%	8.4%	7.1%
Members(7)	1,455,000	1,256,000	1,149,000	1,077,000	893,000

	As of December 31,				
	2009	2008(1)	2007(1),(2)	2006(3)	2005
Balance Sheet Data:					
Cash and cash equivalents	$ 469,501	$ 387,162	$ 459,064	$ 403,650	$ 249,203
Total assets	1,245,235	1,148,068	1,170,016	864,475	659,927
Long-term debt (including current maturities)	158,900	164,873	160,166	45,000	—
Total liabilities	702,497	616,306	655,640	444,309	297,077
Stockholders' equity	542,738	531,762	514,376	420,166	362,850

(1) The consolidated balance sheet and operating results have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options*. The cumulative adjustments to reduce retained earnings were $3.4 million as of January 1, 2009, and $604,000 as of January 1, 2008. Additionally, interest expense increased $4.5 million for the year ended December 31, 2008, and $1.0 million for the year ended December 31, 2007.

(2) The balance sheet and operating results of the Mercy CarePlus acquisition, relating to our Missouri health plan, have been included since November 1, 2007, the effective date of the acquisition.

(3) The balance sheet and operating results of the Cape Health Plan acquisition, relating to our Michigan health plan, have been included since May 15, 2006, the effective date of the acquisition.

(4) Amount represents an impairment charge related to commercial software no longer used for operations.

(5) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See *Management's Discussion and Analysis of Financial Condition and Results of Operations* for further discussion.

(6) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(7) Number of members at end of period.

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Adoption of Convertible Debt Accounting

Our 2008 and 2007 consolidated financial statements have been recast to reflect the adoption of FASB Accounting Standards Codification (ASC) 470-20, *Debt with Conversion and Other Options*. This resulted in additional interest expense of $4.5 million ($0.10 per diluted share) for the year ended December 31, 2008, and $1.0 million ($0.02 per diluted share) for the year ended December 31, 2007.

Overview

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Effective December 31, 2009, we terminated operations at our small Medicare health plan in Nevada. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On January 18, 2010, we entered into a definitive agreement to acquire the Health Information Management, or HIM, business of Unisys Corporation. The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS, a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. The acquisition is expected to close in the first half of 2010. We intend to operate the HIM business under the name, *Molina Medicaid Solutions.*

Our financial performance for 2009, 2008, and 2007 is briefly summarized below (dollars in thousands, except per-share data):

	Year Ended December 31,		
	2009	2008	2007
Earnings per diluted share	$ 1.19	$ 2.15	$ 2.03
Premium revenue	$3,660,207	$3,091,240	$2,462,369
Operating income	$ 57,393	$ 112,605	$ 98,327
Net income	$ 30,868	$ 59,598	$ 57,726
Medical care ratio	86.8%	84.8%	84.5%
G&A expenses as a percentage of total revenue	10.9%	11.1%	11.5%
Total ending membership	1,455,000	1,256,000	1,149,000

Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2009, we received approximately 92% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for CHIP members of the are generally among our lowest, with rates as low as

approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to over $240 in Ohio. Among our Medicaid ABD membership, PMPM premiums range from approximately $320 in Utah to over $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare premiums are almost $1,200 PMPM, with Medicare revenue totaling $135.9 million, $95.1 million, and $49.3 million, for the years ended December 31, 2009, 2008, and 2007, respectively.

For the year ended December 31, 2009, we received approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in California (effective October 1, 2009), Michigan, Missouri, Ohio, Texas, Utah (effective September 1, 2009), and Washington. Such payments are recognized as revenue in the month the birth occurs. Approximately 2.5% of our premium revenue for the year ended December 31, 2009 was realized under a Medicaid cost-plus reimbursement agreement with the state of Utah that ended effective August 31, 2009. Effective September 1, 2009, the Utah health plan's contract with the state of Utah became a prepaid capitation contract, under which the plan is now paid a fixed PMPM amount, as in the other states in which we operate.

Certain components of premium revenue are subject to accounting estimates. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health.* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At December 31, 2009, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.
- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2009, we had not recorded any liability under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.
- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. Through December 31, 2009, our New Mexico health plan had received $3.6 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $2.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $1.4 million for the remainder.
- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009, our Ohio health plan had received $8.8 million in at-risk revenue for state fiscal year 2009

and the first half of state fiscal year 2010 combined. We have recognized $7.5 million of that amount as revenue through December 31, 2009 and recorded a liability of approximately $1.3 million for the remainder.

- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at December 31, 2009 and 2008.
- *Texas Health Plan Premium Revenue:* The contract entered into between our Texas health plan and the state of Texas includes a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of December 31, 2009, we had an aggregate liability of approximately $2.0 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2009 and 2010 contract years (ending August 31 of each year). During 2009, we paid the state of Texas $4.9 million relating to the 2008 and 2009 contract years, and the 2008 contract year is now closed. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.
- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009, our Texas health plan had received $1.7 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $1.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $0.5 million for the remainder.
- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue. Based upon our knowledge of member health care utilization patterns we have recorded a liability of approximately $0.6 million related to the potential recoupment of Medicare premium revenue at December 31, 2009.

Historically, membership growth has been the primary reason for our increasing annual premium revenues, although more recently our revenues have also grown due to the more care-intensive benefits and related higher premiums associated with our ABD and Medicare members. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2009	2008	2007
Total Ending Membership by Health Plan:			
California	351,000	322,000	296,000
Florida(1)	50,000	—	—
Michigan	223,000	206,000	209,000
Missouri	78,000	77,000	68,000
New Mexico	94,000	84,000	73,000
Ohio	216,000	176,000	136,000
Texas	40,000	31,000	29,000
Utah	69,000	61,000	55,000
Washington	334,000	299,000	283,000
Total	1,455,000	1,256,000	1,149,000
Total Ending Membership by State for our Medicare Advantage Special Needs Plans:			
California	2,100	1,500	1,100
Michigan	3,300	1,700	1,100
New Mexico	400	300	—
Texas	500	400	—
Utah	4,000	2,400	1,900
Washington	1,300	1,000	500
Total	11,600	7,300	4,600
Total Ending Membership by State for our Aged, Blind or Disabled ("ABD") Population:			
California	13,900	12,700	11,800
Florida(1)	8,800	—	—
Michigan	32,200	30,300	31,400
New Mexico	5,700	6,300	6,800
Ohio	22,600	19,000	14,900
Texas	17,600	16,200	16,000
Utah	7,500	7,300	6,800
Washington	3,200	3,000	2,800
Total	111,500	94,800	90,500

(1) The Florida health plan began enrolling members in December 2008.

The following table provides details of member months (defined as the aggregation of each month's membership for the period) by state for the years ended December 31, 2009, 2008, and 2007:

	2009	2008	2007
Total Member Months by Health Plan:			
California	4,135,000	3,721,000	3,500,000
Florida(1)	386,000	—	—
Michigan	2,523,000	2,526,000	2,597,000
Missouri	927,000	910,000	136,000
New Mexico	1,042,000	970,000	803,000
Ohio	2,411,000	1,998,000	1,567,000
Texas	402,000	348,000	335,000
Utah	793,000	659,000	593,000
Washington	3,847,000	3,514,000	3,419,000
Total	16,466,000	14,646,000	12,950,000

(1) The Florida health plan began enrolling members in December 2008.

Expenses

Our operating expenses include expenses related to the provision of medical care services and general and administrative, or G&A, expenses. Our results of operations are impacted by our ability to effectively manage expenses related to health care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with the providers. We pay hospitals on a fee-for-service basis in a variety of ways, including by per diem amounts, by diagnostic-related groups, or DRGs, as a percentage of billed charges, and by case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract; under certain circumstances, we pay escalated charges in connection with these stop-loss agreements. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance costs, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a

substantial portion of these expenses. For the years ended December 31, 2009, 2008 and 2007, medically related administrative costs were approximately $74.6 million, $75.9 million and $65.4 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,								
	2009			2008			2007		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 2,077,489	$ 126.14	65.4%	$ 1,709,806	$ 116.69	65.2%	$ 1,343,911	$ 103.77	64.6%
Capitation	558,538	33.91	17.6	450,440	30.74	17.2	375,206	28.97	18.0
Pharmacy	414,785	25.18	13.1	356,184	24.31	13.6	270,363	20.88	13.0
Other	125,424	7.62	3.9	104,882	7.16	4.0	90,603	7.00	4.4
Total	$ 3,176,236	$ 192.85	100.0%	$ 2,621,312	$ 178.90	100.0%	$ 2,080,083	$ 160.62	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities. The following table provides the details of our medical claims and benefits payable as of the dates indicated (in thousands):

	December 31,	
	2009	2008
Fee-for-service claims incurred but not paid (IBNP)	$ 246,508	$ 236,492
Capitation payable	39,995	28,111
Pharmacy	20,609	18,837
Other	9,404	9,002
Total	$ 316,516	$ 292,442

G&A expenses largely consist of wage and benefit costs for our employees, premium taxes, and other administrative expenses. Some G&A services are provided locally, while others are delivered to our health plans from a centralized location. The primary centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally provided functions include member services, plan administration, and provider relations. G&A expenses include premium taxes for each of our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, and Washington.

Results of Operations

The following table sets forth selected consolidated operating ratios. All ratios, with the exception of the medical care ratio, are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium revenue earned and the cost of health care.

	Year Ended December 31,		
	2009	2008	2007
Premium revenue	99.8%	99.3%	98.8%
Investment income	0.2	0.7	1.2
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	86.8%	84.8%	84.5%
General and administrative expense ratio, excluding premium taxes	7.5%	8.0%	8.2%
Premium taxes included in general and administrative expenses	3.4	3.1	3.3
Total general and administrative expense ratio	10.9%	11.1%	11.5%
Depreciation and amortization expense ratio	1.0%	1.1%	1.1%
Effective tax rate	29.2%	40.0%	37.7%
Operating income	1.6%	3.6%	3.9%
Net income	0.8%	1.9%	2.3%

Year Ended December 31, 2009 Compared with the Year Ended December 31, 2008

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2009					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 481,717	$ 116.49	$ 443,892	$ 107.34	92.2%	$ 16,446
Florida(1)	102,232	264.94	95,936	248.62	93.8	16
Michigan	557,421	220.94	454,431	180.12	81.5	31,023
Missouri	230,222	248.25	191,585	206.59	83.2	—
New Mexico(2)	404,026	387.67	346,044	332.03	85.7	11,043
Ohio	803,521	333.33	691,402	286.82	86.1	47,849
Texas	134,860	335.69	110,794	275.78	82.2	2,513
Utah	207,297	261.43	190,319	240.02	91.8	—
Washington	726,137	188.77	613,876	159.58	84.5	14,175
Other(3),(4)	12,774	—	37,957	—	—	57
	$ 3,660,207	$ 222.24	$ 3,176,236	$ 192.85	86.8%	$ 123,122

	Year Ended December 31, 2008					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 417,027	$ 112.06	$ 363,776	$ 97.75	87.2%	$ 12,503
Florida(1)	—	—	—	—	—	—
Michigan	509,782	201.86	405,683	160.64	79.6	26,710
Missouri	225,280	247.62	184,298	202.58	81.8	—
New Mexico(2)	348,576	359.45	286,004	294.92	82.1	11,713
Ohio	602,826	301.76	549,182	274.91	91.1	30,505
Texas	110,178	316.32	84,324	242.09	76.5	1,995
Utah	155,991	236.75	139,011	210.98	89.1	—
Washington	709,943	202.02	575,085	163.64	81.0	11,668
Other(3),(4)	11,637	—	33,949	—	—	21
	$ 3,091,240	$ 210.97	$ 2,621,312	$ 178.90	84.8%	$ 95,115

(1) The Florida health plan began enrolling members in December 2008.

(2) The medical care ratio of the New Mexico health plan was 85.7% for the year ended December 31, 2009, up from 82.1% for the same period in 2008. During 2008, the New Mexico health plan had recognized $12.9 million of premium revenue due to the reversal of amounts previously recorded as payable to the state of New Mexico. Absent this revenue adjustment, the New Mexico health plan's medical care ratio would have been 85.2% for the year ended December 31, 2008.

(3) As of December 31, 2009, our Nevada health plan no longer served members. Premium revenue and medical care costs for the Nevada health plan have been included in "Other."

(4) "Other" medical care costs also include medically related administrative costs at the parent company.

Note: Estimates of utilization and unit costs may not match changes in reported costs due to the impact of shifts in case mix between the periods presented, prior period development, the existence of pass-through contracts in which third parties assume medical risk, and other factors. Additionally, estimates of utilization for the year ended December 31, 2009, exclude the month of December 2009 due to the substantial incompleteness of claims payment data for that month.

Operating results for the year ended December 31, 2009, were most significantly impacted by the following:

- Higher utilization due to widespread influenza-related illness across the Company's health plans.
- Margin compression related to state budget shortfalls.
- Enrollment growth and the higher costs associated with new members.
- Higher emergency room costs.

Net Income

For the year ended December 31, 2009, net income decreased to $30.9 million, or $1.19 per diluted share, from $59.6 million, or $2.15 per diluted share, for the year ended December 31, 2008.

Premium Revenue

Premium revenue grew approximately 18% in the year ended December 31, 2009 compared with the same period in 2008. During 2009, membership grew 16% overall, with Florida, California, Washington, and Ohio gaining the most members. Consolidated premium revenue increased 5.3% on a PMPM basis. Increased membership contributed 71% of the growth in premium revenue, and increases in PMPM revenue, as a result of both rate changes and shifts in member mix, contributed the remaining 29%.

We received PMPM premium reductions in 2009 that were in many cases correlated with reductions in the Medicaid fee schedule that also reduced our medical costs. However, PMPM premium reductions in Washington and Missouri in 2009 were not fully commensurate with changes in the Medicaid fee schedule in those states, and

thus decreases in premiums were not matched by lower medical costs. In Washington, premium reductions not linked to decreases in the Medicaid fee schedule lowered our medical margin by approximately $13 million in 2009. In Missouri, the retention of the pharmacy benefit by the state effective October 1, 2009 reduced our medical margin by approximately $1.2 million in 2009.

Investment income

Investment income for 2009 decreased $12.0 million to $9.1 million, from $21.1 million earned in 2008. This decline was due to lower interest rates in 2009.

Medical care costs

Medical care costs, in the aggregate, increased 8% on a PMPM basis for the year ended December 31, 2009 compared with the same period in 2008. The medical care ratio was 86.8% for the year ended December 31, 2009, compared with 84.8% for the same period in 2008. Increased expenses were generally the result of higher utilization rather than higher unit costs (except in the case of outpatient costs, where both utilization and unit costs increased) and were most pronounced in connection with physician and outpatient emergency room facility services. Influenza-related illnesses and the costs associated with more recently enrolled members were key factors in the higher utilization. We estimate that the incremental costs associated with influenza-related illnesses were approximately $35 million, or $0.83 per diluted share, in the year ended December 31, 2009 compared with the year ended December 31, 2008.

Physician and outpatient costs exhibited the most significant unfavorable cost trend in the year ended December 31, 2009. Together, these costs increased approximately 13% on a PMPM basis compared with the same period in 2008. Consistent with our experience throughout 2009, emergency room utilization (up approximately 9%) and cost per visit (up approximately 8%) were the primary drivers of increased cost in the year ended December 31, 2009.

Hospitals have billed us for more intensive levels of care than in the same period in 2008 for outpatient emergency room facility services. The billing codes for emergency room level of care — with Level 1 reflecting the least intensive care and Level 5 reflecting the most intensive care — changed significantly in the year ended December 31, 2009, compared with the same period in 2008. Level 1 and Level 2 visits decreased by 9% and 6%, respectively, while Level 3, Level 4, and Level 5 visits increased by 20%, 18%, and 20%, respectively.

Inpatient costs were flat on a PMPM basis year-over-year despite increased utilization.

Pharmacy costs (including the benefit of rebates) increased 6% on a PMPM basis year-over-year, excluding the Missouri health plan, where the pharmacy benefit was retained by the state of Missouri effective October 1, 2009. Pharmacy utilization increased approximately 6% year-over-year, while unit costs (excluding rebates) were flat.

Capitated costs increased approximately 10% PMPM year-over-year, primarily as a result of rate increases received for members capitated on a percentage of premium basis at the New Mexico health plan, and the transition of members into capitated arrangements in California.

General and administrative expenses

General and administrative expenses were $399.1 million, or 10.9% of total revenue, for 2009 compared with $344.8 million, or 11.1% of total revenue, for 2008. Included in G&A expenses were premium taxes totaling $123.1 million in 2009 and $95.1 million in 2008. Premium taxes increased in 2009 due to increased revenues in the states where premium taxes are assessed.

Core G&A expenses, which we define as G&A expenses less premium taxes, were 7.5% of revenue in the year ended December 31, 2009, compared with 8.0% in the same period in 2008. Year-over-year, premium revenue grew faster than administrative costs, causing administrative costs, as a percentage of revenue, to decrease. On a PMPM basis, core G&A decreased to $16.76 for the year ended December 31, 2009, from $17.04 for the same period in 2008.

	Year Ended December 31,			
	2009		2008	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 18,857	0.5%	$ 18,451	0.6%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	205,396	5.6	190,932	6.1
Florida health plan start up expenses	—	—	2,495	0.1
All other administrative expense	51,774	1.4	37,768	1.2
Core G&A expenses	$ 276,027	7.5%	$ 249,646	8.0%

Depreciation and Amortization

Depreciation and amortization expense increased $4.4 million for the year ended December 31, 2009 compared with 2008, primarily due to depreciation expense associated with investments in infrastructure. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2009	2008
Depreciation expense	$ 25,172	$ 20,718
Amortization expense on intangible assets	12,938	12,970
Total depreciation and amortization expense	$ 38,110	$ 33,688

Interest Expense

Interest expense for 2009 and 2008 includes non-cash interest expense relating to our convertible senior notes, as a result of the adoption of ASC Subtopic 470-20. The amounts recorded for this non-cash interest expense totaled $4.8 million for the year ended December 31, 2009, and $4.7 million for the same period in 2008.

Income Taxes

Income taxes were recorded at an effective rate of 29.2% for the year ended December 31, 2009 compared with 40.0% for the same period in 2008. The decrease in the effective tax rate was primarily due to discrete tax benefits recognized during the year relating to settling tax examinations, and higher than previously estimated California enterprise zone tax credits.

Year Ended December 31, 2008 Compared with the Year Ended December 31, 2007

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2008					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 417,027	$ 112.06	$ 363,776	$ 97.75	87.2%	$ 12,503
Michigan	509,782	201.86	405,683	160.64	79.6	26,710
Missouri	225,280	247.62	184,298	202.58	81.8	—
Nevada	8,037	1,106.45	9,099	1,252.61	113.2	—
New Mexico	348,576	359.45	286,004	294.92	82.1	11,713
Ohio	602,826	301.76	549,182	274.91	91.1	30,505
Texas	110,178	316.32	84,324	242.09	76.5	1,995
Utah	155,991	236.75	139,011	210.98	89.1	—
Washington	709,943	202.02	575,085	163.64	81.0	11,668
Other	3,600	—	24,850	—	—	21
	$ 3,091,240	$ 210.97	$ 2,621,312	$ 178.90	84.8%	$ 95,115

	Year Ended December 31, 2007					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 378,934	$ 108.29	$ 310,226	$ 88.66	81.9%	$ 11,338
Michigan	487,032	187.55	409,230	157.59	84.0	28,493
Missouri	30,730	226.65	26,396	194.69	85.9	—
Nevada	2,438	1,440.73	2,069	1,222.76	84.9	—
New Mexico	268,115	333.94	221,567	275.97	82.6	9,088
Ohio	436,238	278.39	394,451	251.72	90.4	19,631
Texas	88,453	263.90	68,173	203.40	77.1	1,598
Utah	116,907	197.19	109,895	185.36	94.0	—
Washington	652,970	190.96	519,763	152.00	79.6	10,844
Other	552	—	18,313	—	—	28
	$ 2,462,369	$ 190.13	$ 2,080,083	$ 160.62	84.5%	$ 81,020

Net Income

For the year ended December 31, 2008, net income increased to $59.6 million, or $2.15 per diluted share, from $57.7 million, or $2.03 per diluted share, for the year ended December 31, 2007.

Premium Revenue

Premium revenue for the year ended December 31, 2008 was $3,091.2 million, an increase of $628.8 million, or 26%, over the $2,462.4 million of premium revenue for the year ended December 31, 2007. Medicare premium revenue for 2008 was $95.1 million, compared with $49.3 million for 2007.

Investment income

Investment income for 2008 decreased $9.0 million to $21.1 million, from $30.1 million earned in 2007. This 30% decline was due to declining interest rates in 2008.

Medical care costs

Medical care costs as a percentage of premium revenue, or the medical care ratio, increased to 84.8% in 2008 from 84.5% in 2007. Excluding Medicare, our medical care ratio was 84.8% in 2008, compared with 84.7% in 2007.

- The medical care ratio of the California health plan was 87.2% for 2008, up from 81.9% in 2007. The increase in the plan's medical care ratio was caused primarily by increased fee-for-service and pharmacy costs that proportionally exceeded the increased revenue from premium rate increases.
- The medical care ratio of the Michigan health plan was 79.6% for 2008, down from 84.0% in 2007. This decrease was caused primarily by premium rate increases that proportionally exceeded the plan's increased medical costs.
- The medical care ratio of the Missouri health plan was 81.8% for 2008, down from 85.9% in 2007. Premium increases were proportionally greater than PMPM medical costs due to revised provider contracts and a fee schedule increase effective July 1, 2008.
- The medical care ratio of the New Mexico health plan was 82.1% in 2008, down from 82.6% in 2007. Between July 1, 2008 and December 31, 2008, the New Mexico health plan received a blended rate decrease of approximately 3% under the plan's Medicaid Salud! contract and two separate contracts serving membership under the state's coverage initiative for the uninsured. The impact of this blended rate decrease was exceeded by the reversal of a $12.9 million accrual established as of December 31, 2007, pursuant to a minimum medical care ratio contract provision. In 2007, the New Mexico health plan had recorded a charge of $6.0 million related to this contract provision. Absent the impact of the minimum medical care ratio contract provision, the New Mexico health plan's MCR would have been 85.2% in 2008, compared with 80.8% in 2007, due to higher fee-for-service and capitation costs and lower PMPM premium revenue.
- The medical care ratio of the Ohio health plan increased to 91.1% in the 2008 from 90.4% in the 2007, primarily due to higher pharmacy cost as a percentage of premium revenue. The medical care ratio of the Ohio health plan, by line of business, was as follows:

	Year Ended December 31,	
	2008	2007
Covered Families and Children (CFC)	89.7%	88.6%
Aged, Blind or Disabled (ABD)	93.7	94.7
Aggregate	91.1%	90.4%

- The medical care ratio of the Texas health plan was 76.5% in 2008, down from 77.1% in 2007. Increased premiums more than offset higher medical costs.
- The medical care ratio of the Utah health plan was 89.1% in 2008, down from 94.0% in 2007. In 2007, the Utah health plan had recorded a $4.2 million reduction of revenue as a result of a reconciliation of amounts due the state of Utah under a savings sharing arrangement. Absent the savings sharing adjustment, the medical care ratio in 2007 would have been 90.7%.
- The medical care ratio of the Washington health plan was 81.0% in 2008, up from 79.6% in 2007, primarily due to higher fee-for-service specialist and hospital costs.

General and administrative expenses

General and administrative expenses were $344.8 million, or 11.1% of total revenue, for 2008, compared with $285.3 million, or 11.5% of total revenue, for 2007. Included in G&A expenses were premium taxes totaling $95.1 million in 2008 and $81.0 million in 2007. Premium taxes increased in 2008 due to increased revenues in the states where premium taxes are assessed.

Core G&A expenses were 8.0% of revenue in 2008, compared with 8.2% in 2007. The decrease in core G&A compared with 2007 was primarily due to lower administrative payroll as a percentage of revenue, as indicated in the table below.

	Year Ended December 31,			
	2008		2007	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 18,451	0.6%	$ 9,778	0.4%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	190,932	6.1	163,420	6.6
Florida health plan start up expenses	2,495	0.1	—	—
All other administrative expense	37,768	1.2	31,077	1.2
Core G&A expenses	$ 249,646	8.0%	$ 204,275	8.2%

Depreciation and Amortization

Depreciation and amortization expense increased $5.7 million for the year ended December 31, 2008 compared to 2007, primarily due to depreciation expense associated with investments in infrastructure. Of the total increase, amortization expense contributed $2.1 million, primarily due to the Mercy CarePlus acquisition in Missouri in 2007. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2008	2007
Depreciation expense	$ 20,718	$ 17,118
Amortization expense on intangible assets	12,970	10,849
Total depreciation and amortization expense	$ 33,688	$ 27,967

Impairment Charge on Purchased Software

During the second quarter of 2007, we recorded an impairment charge of $782,000, related to purchased software no longer used for operations. No such charge was recorded in 2008.

Interest Expense

Interest expense increased to $13.2 million in 2008 from $5.6 million in 2007 primarily due to the issuance of our convertible senior notes in the fourth quarter of 2007. Interest expense for 2008 and 2007 includes non-cash interest expense relating to the convertible senior notes, as a result of the adoption of ASC Subtopic 470-20. The amounts recorded for this non-cash interest expense totaled $4.7 million and $1.0 million for the years ended December 31, 2008, and 2007, respectively.

Income Taxes

Income taxes were recorded at an effective rate of 40.0% for the year ended December 31, 2008, compared with 37.7% in the prior year. The increase in our effective tax rate was primarily the result of an increase in Michigan state taxes attributable to tax law changes that took effect on January 1, 2008. The increase in Michigan taxes was partially offset by prior years' tax benefits recorded during 2008 relating to California enterprise zone credits. Absent the enterprise zone credit tax benefits, our effective tax rate for the year ended December 31, 2008 would have been approximately 41%.

Acquisitions

HIM Business of Unisys. On January 19, 2010, we entered into a definitive agreement to acquire the Health Information Management business of Unisys Corporation. The purchase price is expected to be approximately $135 million, subject to a standard working capital adjustment, to be paid in cash at closing using our credit facility. The acquisition, which is expected to close in the first half of 2010, is subject to customary regulatory approvals and closing conditions, including receipt of customer consents.

The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. Annual revenues of the HIM business are currently approximately $110 million. We expect the approximately 900 employees of the HIM business to become our employees upon closing of the transaction, and following the closing Unisys has agreed to provide us certain transitional and technology support services for up to one year.

Florida Health Plan. On December 31, 2009 (the acquisition date), we acquired 100% of the voting equity interests in Florida NetPASS, LLC, or NetPASS. This acquisition included the purchase of the NetPASS limited liability company and its membership interests. We initially announced our intention to purchase NetPASS in August 2008. NetPASS was a provider of care management and administrative services at that time to approximately 58,000 Florida MediPass members in South and Central Florida (Florida MediPASS is the state of Florida's Medicaid program).

Our wholly owned subsidiary, Molina Healthcare of Florida, Inc., was awarded a Medicaid managed care contract by the state of Florida in October 2008. Subsequently, NetPASS members have been notified of our intention to acquire NetPASS and, beginning in December 2008, offered membership with our Florida health plan on a county-by-county basis. Once transitioned, these members become full-risk members of the Florida health plan. The Florida health plan receives fixed PMPM payments from the state of Florida for the care of these members, and the Florida health plan is at risk for the cost of the members' medical care.

As of December 31, 2009, we have transitioned approximately 48,000 NetPASS members to our Florida health plan, and have recorded $28.7 million of goodwill and intangible assets relating to these members. Of this amount, we have paid the sellers $23.4 million, with the balance accrued to accounts payable and accrued liabilities. The $5.3 million current liability includes a 10% indemnification hold back totaling $2.9 million, as provided in the purchase agreement, and a $2.4 million payable to the sellers for membership transitioned to date as of December 31, 2009. Because the final membership reconciliation will take place early in the second quarter of 2010, the provisional measurements of goodwill and intangible assets are subject to change.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of ten years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be four years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2009, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. The average annualized portfolio yields for the years ended December 31, 2009, 2008, and 2007 were approximately 1.2%, 3.0%, and 5.2%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the year ended December 31, 2009, was $155 million compared with $40 million for 2008, an increase of $115 million.

Significant components of cash provided by operating activities during 2009 included the following items:

- Net income, which decreased $29 million between 2008 and 2009.
- Deferred revenue, which contributed $114 million to the increase in cash provided by operating activities between 2008 and 2009. Deferred revenue increased substantially at the Ohio health plan between the years ended 2008 and 2009.
- Medical claims and benefits payable, which contributed $43 million to the increase in cash provided by operating activities between 2008 and 2009.

Cash used in investing activities was $37.7 million for the year ended December 31, 2009, compared with $64.5 million for 2008.

Cash used in financing activities totaled $35.3 million for the year ended December 31, 2009, compared with $47.8 million for 2008. The primary use of cash in both 2009 and 2008 was under our securities purchase programs, where we purchased $27.7 million and $49.9 million of our common stock in 2009, and 2008, respectively. In 2009, we additionally purchased, as described further below, convertible senior notes totaling $9.7 million ($9.8 million with accrued interest).

EBITDA(1)

	Year Ended December 31,	
	2009	2008
	(In thousands)	
Operating income	$ 57,393	$ 112,605
Add back:		
Depreciation and amortization expense	38,110	33,688
EBITDA	$ 95,503	$ 146,293

(1) We calculate EBITDA by adding back depreciation and amortization expense to operating income. Operating income included interest income of $8.0 million and $21.1 million for the years ended December 31, 2009, and 2008, respectively. EBITDA is not prepared in conformity with GAAP since it excludes depreciation and amortization expense, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to net income, operating income, operating margin, or cash provided by operating activities. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Securities Purchase Program. Under the $25 million securities purchase program announced in January 2009, we purchased and retired $13.0 million face amount of our convertible senior notes during the first quarter of 2009. We purchased the notes at an average price of $74.25 per $100 principal amount, for a total of $9.8 million, including accrued interest. The gain recognized during the quarter on the purchase of the notes was $1.5 million, or approximately $0.04 per diluted share. Also during the first quarter of 2009, we purchased approximately 808,000 shares of our common stock for $15 million (average cost of approximately $18.53 per share).

In March 2009, our board of directors authorized the purchase of up to an additional $25 million in aggregate of either our common stock or our convertible senior notes. The purchase program was funded with working capital.

Under the purchase program, we purchased approximately 544,000 shares of common stock for $12.7 million (average cost of approximately $23.41 per share) in the second quarter of 2009. We did not purchase any shares in the third or fourth quarters of 2009. This purchase program terminated December 31, 2009.

Capital Resources

At December 31, 2009, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $45.6 million, including $16.5 million in non-current auction rate securities, compared with $68.9 million of cash and investments at December 31, 2008. On a consolidated basis, at December 31, 2009, we had working capital of $321.2 million compared with $345.2 million at December 31, 2008. At December 31, 2009 and December 31, 2008, cash and cash equivalents were $469.5 million and $387.2 million, respectively. At December 31, 2009, investments were $234.5 million, including $59.7 million in non-current auction rate securities, and at December 31, 2008, investments were $248.0 million, including $58.2 million in non-current auction rate securities.

We intend to use a draw on our credit facility, which currently has no outstanding balance, to fund all or a substantial portion of the $135 million purchase price of the HIM business. Subject to the following discussion regarding our Credit Facility and its use to acquire the HIM business of Unisys Corporation, we believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

In 2005, we entered into an Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the “Credit Facility”). Effective May 2008, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for general corporate purposes.

Pending the closing of the acquisition of the HIM business as discussed below, interest rates on borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America’s prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest expense, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2009, there were no borrowings outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2009, we were in compliance with all financial covenants in the Credit Facility.

Subject to the closing of the HIM acquisition as described above under the heading, “Acquisitions,” in November 2009 we agreed to enter into a fourth amendment to the Credit Facility. The fourth amendment will become effective upon the closing of the acquisition of the HIM business. The fourth amendment is required because the $135 million purchase price for the HIM business exceeds the currently applicable deal size threshold under the terms of the Credit Facility. Pursuant to the fourth amendment, the lenders have consented to our acquisition of the HIM business.

Upon its effectiveness at the closing, the fourth amendment would increase the commitment fee on the total unused commitments of the lenders under the facility to 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR

loans and base rate loans would be raised by 200 basis points at every level of the pricing grid. The applicable margins would thus range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. Until the delivery of a compliance certificate with respect to our financial statements for the quarter ending after the HIM business acquisition closes, the applicable margin shall be fixed at 3.5% for LIBOR loans and 2.5% for base rate loans. In connection with the lenders' approval of the fourth amendment, a consent fee of 10 basis points was paid on the amount of each consenting lender's commitment. In addition, the fourth amendment would carve out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the Notes (although the $187.0 million indebtedness would still be included in the calculation of our consolidated leverage ratio); increase the amount of surety bond obligations we may incur; increase our allowable capital expenditures; and reduce the fixed charge coverage ratio from 3.50x to 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

On March 15, 2010, we agreed to enter into a fifth amendment to the Credit Facility. The fifth amendment will also become effective upon the closing of the acquisition of the HIM business. The fifth amendment is required because, after giving effect to the acquisition of the HIM business on a pro forma basis, and inclusive of the Company's fourth quarter 2009 EBITDA of only $5.9 million, the Company's consolidated leverage ratio for the preceding four fiscal quarters would exceed the currently applicable ratio of 2.75 to 1.0. The fifth amendment will increase the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if the Company has actually reduced its consolidated leverage ratio to no more than 2.75 to 1.0 on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we will pay an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the SEC covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Long-Term Debt

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, for a remaining aggregate principal amount of $187.0 million as of December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading

days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;

- During the five business day period immediately following any five consecutive trading day period in which the trading price per $1,000 principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the “principal return”) equal to the sum of, for each of the 20 Volume-Weighted Average Price, or VWAP, trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and $50 (representing 1/20th of $1,000); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above $50.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $368.7 million at December 31, 2009, and $355.0 million at December 31, 2008.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At December 31, 2009, our health plans had aggregate statutory capital and surplus of approximately $377.7 million, compared to the required minimum aggregate statutory capital and surplus of approximately $257.1 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2009. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2010.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Principal areas requiring the use of estimates include those areas listed below. The most significant of these estimates is the determination of medical claims and benefits payable, which is discussed in further detail below:

- The determination of medical claims and benefits payable;

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon either the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The impairment of long-lived and intangible assets;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Medical Claims and Benefits Payable

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management. As a result, the determination of our liability for claims and medical benefits is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed to providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. Our estimated IBNP liability represented $246.5 million of our total medical claims and benefits payable of $316.5 million as of December 31, 2009. Excluding amounts related to the run out of our cost-plus Medicaid contract in Utah (which contract was replaced with a prepaid capitation contract effective September 1, 2009) and amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider’s monthly capitation payment), our IBNP liability at December 31, 2009 was $235.0 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2009 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding

December 31, 2009, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 72,782
(4)%	48,521
(2)%	24,261
2%	(24,261)
4%	(48,521)
6%	(72,782)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2009 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per Member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$(41,722)
(4)%	(27,815)
(2)%	(13,907)
2%	13,907
4%	27,815
6%	41,722

The following per-share amounts are based on a combined federal and state statutory tax rate of 38%, and 26 million diluted shares outstanding for the year ended December 31, 2009. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2009, net income for the year ended December 31, 2009 would increase or decrease by approximately $7.5 million, or $0.29 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2009, net income for the year ended December 31, 2009 would increase or decrease by approximately $4.3 million, or $0.17 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $37.6 million, or $1.45 per diluted share, net of tax, and $21.6 million, or $0.83 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. For example, if completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $7.5 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, also using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims

development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which much of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process which we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP liability and the methods used to determine that liability. Any adjustments are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been accurately estimated, we would expect that amounts ultimately paid would be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results in 2009 and 2008 when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of those years by approximately 18% and 20%, respectively.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2009 and 2008 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the two years, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

For the year ended December 31, 2009, we recognized a benefit from prior period claims development in the amount of $51.6 million (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2008. The overestimation of claims liability at December 31, 2008 was the result of the following factors:

- In Michigan, we underestimated the impact of a steep drop in claims inventory during December 2008, thereby overestimating our liability at December 31, 2008.
- In New Mexico, we overestimated the ultimate amounts we would need to pay to resolve certain high dollar provider claims, thereby overestimating our liability at December 31, 2008.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008, thereby overestimating our liability at December 31, 2008.

- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008, thereby overestimating our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt of paper claims (as opposed to electronically submitted claims) would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

For the year ended December 31, 2008, we recognized a benefit from prior period claims development in the amount of $62.1 million (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2007. The overestimation of claims liability at December 31, 2007 was the result of the following factors:

- In Michigan, we had overestimated the extent to which both catastrophic claims and state-mandated changes to the methodology used to pay outpatient claims had increased our liability at December 31, 2007.
- In Washington, we had overestimated the extent to which state-mandated changes to hospital fee schedules implemented in August 2007 had increased our liability at December 31, 2007.

In estimating our claims liability at December 31, 2009, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The rapid growth of membership across nearly all of our health plans in fiscal year 2009, particularly the growth in membership at our Florida health plan and the growth in ABD membership during the fourth quarter of 2009 at our Ohio health plan.
- A decrease in claims inventory at our California, Ohio, and Utah health plans through the fourth quarter of 2009.
- The impact of the 2009 H1N1 flu through the fourth quarter of 2009.
- The degree of change in the utilization of medical services and the cost per unit of those services during 2009.
- The impact of reductions to the state Medicaid fee schedules in Washington and Michigan effective July 1, 2009, and in New Mexico effective December 1, 2009.
- Potential provider settlements across all states, particularly in Missouri, New Mexico, Ohio, and Washington.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability. In 2009 and 2008 the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

We seek to maintain a consistent claims reserving methodology across all periods. Accordingly, any prior period benefit from an un-utilized reserve for adverse claims development may be offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) in the current period, and thus the impact on earnings for the current period may be minimal.

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2009 and 2008. The negative amounts displayed for "*components of medical care costs related to prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2009	2008
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of period	$ 292,442	$ 311,606
Components of medical care costs related to:		
Current year	3,227,794	2,683,399
Prior years	(51,558)	(62,087)
Total medical care costs	3,176,236	2,621,312
Payments for medical care costs related to:		
Current year	2,919,240	2,413,128
Prior years	232,922	227,348
Total paid	3,152,162	2,640,476
Balances at end of period	$ 316,516	$ 292,442
Benefit from prior period as a percentage of:		
Balance at beginning of period	17.6%	19.9%
Premium revenue	1.4%	2.0%
Total medical care costs	1.6%	2.4%
Days in claims payable	37	41
Number of members at end of period	1,455,000	1,256,000
Fee-for-service claims processing and inventory information:		
Number of claims in inventory at end of period	93,100	87,300
Billed charges of claims in inventory at end of period	$ 131,400	$ 115,400
Claims in inventory per member at end of period	0.06	0.07
Billed charges of claims in inventory per member at end of period	$ 90.31	$ 91.88
Number of claims received during the period	12,930,100	11,095,100
Billed charges of claims received during the period	$ 9,769,000	$ 7,794,900

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2009, our lease obligations for the next five years and thereafter were as follows: $21.3 million in 2010, $20.8 million in 2011, $18.6 million in 2012, $15.2 million in 2013, $13.5 million in 2014, and an aggregate of $39.6 million thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 18 to the accompanying audited consolidated financial statements for the year ended December 31, 2009.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2009. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2010	2011-2012	2013-2014	2015 and Beyond
Medical claims and benefits payable	$ 316,516	$ 316,516	$ —	$ —	$ —
Long-term debt(1)	187,000	—	—	187,000	—
Operating leases	128,980	21,334	39,365	28,705	39,576
Interest on long-term debt(1)	33,309	7,012	14,025	12,272	—
Purchase commitments	23,472	8,201	11,955	3,316	—
Total contractual obligations	$ 689,277	$ 353,063	$ 65,345	$ 231,293	$ 39,576

(1) Amounts relate to our 3.75% Convertible Senior Notes due 2014.

As of December 31, 2009, we have recorded approximately $4.1 million of unrecognized tax benefits. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 13 to the accompanying audited consolidated financial statements for the year ended December 31, 2009 for further information.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Inflation

Although the general rate of inflation has remained relatively stable and health care cost inflation has stabilized in recent years, the national health care cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. While we currently believe our strategies will mitigate health care cost inflation, competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

MOLINA HEALTHCARE, INC.

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

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2009. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2009 and 2008, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2009, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, during 2009 the Company changed its method of accounting for convertible debt instruments.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 16, 2010 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2010

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31, 2009	December 31, 2008(1)
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 469,501	$ 387,162
Investments	174,844	189,870
Receivables	136,654	128,562
Income tax refundable	6,067	4,019
Deferred income taxes	8,757	9,071
Prepaid expenses and other current assets	15,583	14,766
Total current assets	811,406	733,450
Property and equipment, net	78,171	65,058
Intangible assets, net	80,846	79,133
Goodwill and indefinite-lived intangible assets	133,408	113,466
Investments	59,687	58,169
Restricted investments	36,274	38,202
Receivable for ceded life and annuity contracts	25,455	27,367
Other assets	19,988	33,223
	$ 1,245,235	$ 1,148,068
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 316,516	$ 292,442
Accounts payable and accrued liabilities	71,732	81,981
Deferred revenue	101,985	13,804
Total current liabilities	490,233	388,227
Long-term debt	158,900	164,873
Liability for ceded life and annuity contracts	25,455	27,367
Deferred income taxes	12,506	12,911
Other long-term liabilities	15,403	22,928
Total liabilities	702,497	616,306
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 25,607 shares at December 31, 2009 and 26,725 shares at December 31, 2008	26	27
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	129,902	170,681
Accumulated other comprehensive loss	(1,812)	(2,310)
Retained earnings	414,622	383,754
Treasury stock, at cost; 1,201 shares at December 31, 2008	—	(20,390)
Total stockholders' equity	542,738	531,762
	$ 1,245,235	$ 1,148,068

(1) The Company's consolidated financial position as of December 31, 2008, has been recast to reflect the adoption of FASB Accounting Standards Codification (ASC) Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2009	2008(1)	2007(1)
	(In thousands, except per share data)		
Revenue:			
Premium revenue	$ 3,660,207	$ 3,091,240	$ 2,462,369
Investment income	9,149	21,126	30,085
Total revenue	3,669,356	3,112,366	2,492,454
Expenses:			
Medical care costs	3,176,236	2,621,312	2,080,083
General and administrative expenses	399,149	344,761	285,295
Depreciation and amortization	38,110	33,688	27,967
Impairment charge on purchased software	—	—	782
Total expenses	3,613,495	2,999,761	2,394,127
Gain on purchase of convertible senior notes	1,532	—	—
Operating income	57,393	112,605	98,327
Interest expense	(13,777)	(13,231)	(5,605)
Income before income taxes	43,616	99,374	92,722
Provision for income taxes	12,748	39,776	34,996
Net income	$ 30,868	$ 59,598	$ 57,726
Net income per share:			
Basic	$ 1.19	$ 2.15	$ 2.04
Diluted(2)	$ 1.19	$ 2.15	$ 2.03
Weighted average shares outstanding:			
Basic	25,843	27,676	28,275
Diluted(2)	25,984	27,772	28,419

(1) The Company's consolidated statements of income for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

(2) Potentially dilutive shares issuable pursuant to the Company's 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2009, 2008, and 2007.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount		(In thousands)			
Balance at January 1, 2007	28,119	$ 28	$ 173,990	$ (337)	$ 266,875	$ (20,390)	$ 420,166
Comprehensive income:							
Net income(1)	—	—	—	—	57,726	—	57,726
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	609	—	—	609
Total comprehensive income	—	—	—	609	57,726	—	58,335
Adjustment to adopt ASC Subtopic 470-20(1)	—	—	24,502	—	—	—	24,502
Adjustment to adopt ASC Subtopic 740-10 *Accounting for Uncertainty in Income Taxes*	—	—	—	—	(445)	—	(445)
Stock options exercised, employee stock grants and employee stock plan purchases	325	—	10,965	—	—	—	10,965
Tax benefit from employee stock compensation	—	—	853	—	—	—	853
Balance at December 31, 2007	28,444	28	210,310	272	324,156	(20,390)	514,376
Comprehensive income:							
Net income(1)	—	—	—	—	59,598	—	59,598
Other comprehensive income, net of tax:							
Unrealized loss on investments	—	—	—	(7,025)	—	—	(7,025)
Other-than-temporary impairment of available-for-sale securities	—	—	—	4,443	—	—	4,443
Total comprehensive income	—	—	—	(2,582)	59,598	—	57,016
Purchase of treasury stock	—	—	—	—	—	(49,940)	(49,940)
Retirement of treasury stock	(1,943)	(1)	(49,939)	—	—	49,940	—
Stock issued in business purchase transaction	48	—	1,262	—	—	—	1,262
Stock options exercised, employee stock grants and employee stock plan purchases	176	—	9,340	—	—	—	9,340
Tax deficiency from employee stock compensation	—	—	(292)	—	—	—	(292)
Balance at December 31, 2008	26,725	27	170,681	(2,310)	383,754	(20,390)	531,762
Comprehensive income:							
Net income	—	—	—	—	30,868	—	30,868
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	498	—	—	498
Total comprehensive income	—	—	—	498	30,868	—	31,366
Purchase of treasury stock	—	—	—	—	—	(27,712)	(27,712)
Retirement of treasury stock	(1,352)	(1)	(48,101)	—	—	48,102	—
Retirement of convertible debt	—	—	(476)	—	—	—	(476)
Employee stock grants and employee stock plan purchases	234	—	8,516	—	—	—	8,516
Tax deficiency from employee stock compensation	—	—	(718)	—	—	—	(718)
Balance at December 31, 2009	25,607	$ 26	$ 129,902	$ (1,812)	$ 414,622	$ —	$ 542,738

(1) The Company's consolidated statements of stockholders' equity for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2009	2008(1)	2007(1)
		(In thousands)	
Operating activities:			
Net income	$ 30,868	$ 59,598	$ 57,726
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	38,110	33,688	27,967
Other-than-temporary impairment on available-for-sale securities	—	7,166	—
Unrealized (gain) loss on trading securities	(3,394)	399	—
Loss (gain) on rights agreement	3,100	(6,907)	—
Deferred income taxes	(1)	(3,404)	(9,427)
Stock-based compensation	7,485	7,811	7,188
Non-cash interest on convertible senior notes	4,782	4,707	1,012
Gain on purchase of convertible senior notes	(1,532)	—	—
Amortization of deferred financing costs	1,872	1,435	1,004
Tax deficiency from employee stock compensation	(749)	(335)	—
Loss on disposal of property and equipment	—	142	—
Changes in operating assets and liabilities, net of effects of acquisitions:			
Receivables	(8,092)	(17,025)	15,007
Prepaid expenses and other current assets	(817)	(2,245)	(2,911)
Medical claims and benefits payable	24,074	(19,164)	6,683
Accounts payable and accrued liabilities	(26,467)	10,830	18,700
Deferred revenue	88,181	(26,300)	21,984
Income taxes	(2,049)	(9,965)	13,693
Net cash provided by operating activities	155,371	40,431	158,626
Investing activities:			
Purchases of equipment	(35,870)	(34,690)	(22,299)
Purchases of investments	(186,764)	(263,229)	(264,115)
Sales and maturities of investments	204,365	246,524	103,718
Net cash paid in business purchase transactions	(11,294)	(1,000)	(70,172)
Decrease (increase) in restricted investments	1,928	(9,183)	(8,365)
Increase in other assets	(2,553)	(8,973)	(4,330)
(Decrease) increase in other long-term liabilities	(7,525)	6,031	9,290
Net cash used in investing activities	(37,713)	(64,520)	(256,273)
Financing activities:			
Treasury stock purchases	(27,712)	(49,940)	—
Purchase and retirement of convertible senior notes	(9,653)	—	—
Proceeds from issuance of convertible senior notes	—	—	200,000
Repayment of amounts borrowed under credit facility	—	—	(45,000)
Payment of credit facility fees	—	—	(551)
Payment of convertible senior notes fees	—	—	(6,498)
Tax benefit from employee stock compensation	31	43	853
Proceeds from exercise of stock options and employee stock plan purchases	2,015	2,084	4,257
Net cash (used in) provided by financing activities	(35,319)	(47,813)	153,061
Net increase (decrease) in cash and cash equivalents	82,339	(71,902)	55,414
Cash and cash equivalents at beginning of year	387,162	459,064	403,650
Cash and cash equivalents at end of year	$ 469,501	$ 387,162	$ 459,064

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (Continued)

	Year Ended December 31,		
	2009	2008(1)	2007(1)
		(In thousands)	
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 27,100	$ 50,130	$ 27,734
Interest	$ 8,205	$ 7,797	$ 9,419
Schedule of non-cash investing and financing activities:			
Unrealized gain (loss) on investments	$ 699	$ (3,956)	$ 977
Deferred income taxes	(201)	1,374	(368)
Net unrealized gain (loss) on investments	$ 498	$ (2,582)	$ 609
Retirement of common stock used for stock-based compensation	$ (984)	$ (555)	$ (480)
Accrued purchases of equipment	$ 935	$ 65	$ 672
Retirement of treasury stock	$ 48,102	$ 49,940	$ —
Impairment of purchased software	$ —	$ —	$ 782
Cumulative effect of adoption of FASB ASC Subtopic 740-10, *Accounting for Uncertainty in Income Taxes*	$ —	$ —	$ 445
Details of business purchase transactions:			
Fair value of assets acquired	$ (34,594)	$ (2,262)	$ (106,233)
Release of escrow and other deposits	18,000	—	—
Common stock issued to seller	—	1,262	—
Less cash acquired	—	—	10,843
Less payable to seller	5,300	—	—
Liabilities assumed	—	—	25,218
Net cash paid in business purchase transactions	$ (11,294)	$ (1,000)	$ (70,172)
Business purchase transactions adjustments:			
Accounts payable and accrued liabilities	$ —	$ 1,265	$ —
Other long-term liabilities	—	2,368	—
Deferred taxes	—	(7,549)	2,747
Goodwill and intangible assets, net	$ —	$ (3,916)	$ 2,747

(1) The Company's consolidated statements of cash flows for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010 we terminated operations at our small Medicare health plan in Nevada.

Our results of operations include the results of recent acquisitions, including the acquisition of Florida NetPASS, under which we began transitioning members in late December 2008. Additionally, we acquired Mercy CarePlus, a Medicaid managed care organization based in St. Louis, Missouri, effective November 1, 2007.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority-owned subsidiaries. All significant intercompany transactions and balances have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

Evaluation of Subsequent Events

We have evaluated subsequent events through the date of issuance of our financial statements in this Annual Report on Form 10-K.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable;
- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon either the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The impairment of long-lived and intangible assets;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Reclassification

We have reclassified certain prior year balance sheet amounts to conform to the 2009 presentation.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Recast of Prior Periods

In May 2008, the FASB issued a new standard relating to convertible debt instruments. This standard requires the proceeds from the issuance of applicable convertible debt instruments to be allocated between a liability component and an equity component. The resulting debt discount is amortized over the period the convertible debt is expected to be outstanding, as additional non-cash interest expense. We adopted this new standard effective as of January 1, 2009. For further information regarding our convertible senior notes, see Note 12, "Long-Term Debt."

The following tables illustrate the impact of adopting this accounting standard on our consolidated statements of income.

	Year Ended December 31, 2009		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Operating income	$ 58,786	$ (1,393)	$ 57,393
Interest expense	(9,344)	(4,433)	(13,777)
Income before income taxes	49,442	(5,826)	43,616
Provision for income taxes	14,961	(2,213)	12,748
Net income	$ 34,481	$ (3,613)	$ 30,868
Net income per share:			
Basic	$ 1.33	$ (0.14)	$ 1.19
Diluted	$ 1.33	$ (0.14)	$ 1.19

	Year Ended December 31, 2008		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Operating income	$ 112,605	$ —	$ 112,605
Interest expense	(8,714)	(4,517)	(13,231)
Income before income taxes	103,891	(4,517)	99,374
Provision for income taxes	41,493	(1,717)	39,776
Net income	$ 62,398	$ (2,800)	$ 59,598
Net income per share:			
Basic	$ 2.25	$ (0.10)	$ 2.15
Diluted	$ 2.25	$ (0.10)	$ 2.15

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Year Ended December 31, 2007		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Operating income	$ 98,327	$ —	$ 98,327
Interest expense	(4,631)	(974)	(5,605)
Income before income taxes	93,696	(974)	92,722
Provision for income taxes	35,366	(370)	34,996
Net income	$ 58,330	$ (604)	$ 57,726
Net income per share:			
Basic	$ 2.06	$ (0.02)	$ 2.04
Diluted	$ 2.05	$ (0.02)	$ 2.03

The following tables illustrate the impact of adopting this standard on our consolidated balance sheets.

	December 31, 2009		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Noncurrent assets:			
Other assets	$ 20,651	$ (663)	$ 19,988
Noncurrent liabilities:			
Long-term debt	187,000	(28,100)	158,900
Deferred income taxes	3,352	9,154	12,506
Stockholders' equity:			
Additional paid-in capital	104,603	25,299	129,902
Retained earnings	421,639	(7,017)	414,622

	December 31, 2008		
	Excluding the Effect of the Accounting Standard	Effect of the Accounting Standard	Including the Effect of the Accounting Standard
		(In thousands)	
Noncurrent assets:			
Other assets	$ 34,321	$ (1,098)	$ 33,223
Deferred income taxes	20	(20)	—
Noncurrent liabilities:			
Long-term debt	200,000	(35,127)	164,873
Deferred income taxes	—	12,911	12,911
Stockholders' equity:			
Additional paid-in capital	146,179	24,502	170,681
Retained earnings	387,158	(3,404)	383,754

There was no impact resulting from this accounting change on our cash flows from operating activities, investing activities, or financing activities as reflected in the consolidated statements of cash flows.

2. Significant Accounting Policies

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2009, we received approximately 92% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue by health plan for the periods indicated:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
California	$ 481,717	$ 417,027	$ 378,934
Florida(1)	102,232	—	—
Michigan	557,421	509,782	487,032
Missouri(2)	230,222	225,280	30,730
New Mexico	404,026	348,576	268,115
Ohio	803,521	602,826	436,238
Texas	134,860	110,178	88,453
Utah	207,297	155,991	116,907
Washington	726,137	709,943	652,970
Other	12,774	11,637	2,990
	$ 3,660,207	$ 3,091,240	$ 2,462,369

(1) The Florida health plan began enrolling members in December 2008.

(2) We acquired the Missouri health plan in late 2007.

For the year ended December 31, 2009, we received approximately 5% of our premium revenue in the form of “birth income” — a one-time payment for the delivery of a child — from the Medicaid programs in California (effective October 1, 2009), Michigan, Missouri, Ohio, Texas, Utah (effective September 1, 2009) and Washington. Such payments are recognized as revenue in the month the birth occurs. Approximately 2.5% of our premium revenue for the year ended December 31, 2009 was realized under a Medicaid cost-plus reimbursement agreement that our Utah health plan had with that state until August 31, 2009. Effective September 1, 2009, the Utah health plan’s contract with the state of Utah became a prepaid capitation contract, under which the plan is paid a fixed PMPM amount.

Certain components of premium revenue are subject to accounting estimates. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health.* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not expended on defined behavioral health care costs. At December 31, 2009, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not expended on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2009, we had not recorded any liability under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.
- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. Through December 31, 2009, our New Mexico health plan had received $3.6 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $2.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $1.4 million for the remainder.
- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009 our Ohio health plan had received $8.8 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $7.5 million of that amount as revenue through December 31, 2009 and recorded a liability of approximately $1.3 million for the remainder.
- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at December 31, 2009 and 2008.
- *Texas Health Plan Premium Revenue:* The contract entered into between our Texas health plan and the state of Texas includes a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in

calculating the rebate, if any. As of December 31, 2009, we had an aggregate liability of approximately $2.0 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2009 and 2010 contract years (ending August 31 of each year). During 2009, we paid the state of Texas $4.9 million relating to the 2008 and 2009 contract years, and the 2008 contract year is now closed. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care measures dictated by the state. Through December 31, 2009, our Texas health plan had received $1.7 million in at-risk revenue for state fiscal year 2009 and the first half of state fiscal year 2010 combined. We have recognized $1.2 million of that amount as revenue through December 31, 2009, and recorded a liability of approximately $0.5 million for the remainder.
- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue. Based upon our knowledge of member health care utilization patterns we have recorded a liability of approximately $0.6 million related to the potential recoupment of Medicare premium revenue at December 31, 2009.

Medical Care Costs

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

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to

significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2009, 2008, and 2007, medically related administrative costs were approximately $74.6 million, $75.9 million, and $65.4 million, respectively.

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

	Year Ended December 31,								
	2009			2008			2007		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for- service	$ 2,077,489	$ 126.14	65.4%	$ 1,709,806	$ 116.69	65.2%	$ 1,343,911	$ 103.77	64.6%
Capitation	558,538	33.91	17.6	450,440	30.74	17.2	375,206	28.97	18.0
Pharmacy	414,785	25.18	13.1	356,184	24.31	13.6	270,363	20.88	13.0
Other	125,424	7.62	3.9	104,882	7.16	4.0	90,603	7.00	4.4
Total	$ 3,176,236	$ 192.85	100.0%	$ 2,621,312	$ 178.90	100.0%	$ 2,080,083	$ 160.62	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates. See Note 11, “Medical Claims and Benefits Payable.”

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Our California, Florida, Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in general and administrative expenses. Premium tax expense totaled $123.1 million, $95.1 million, and $81.0 million in 2009, 2008, and 2007, respectively.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2009, or 2008.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2009, or 2008.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into three separate categories for accounting and reporting purposes: available-for-sale securities, held-to-maturity securities, and trading securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. Trading securities are recorded at fair value, and holding gains and losses are recognized in net income.

Except for restricted investments and certain student loan portfolios (the "auction rate securities"), our debt securities are designated as available-for-sale and are carried at fair value. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis. Fair values of securities are generally based on quoted prices in active markets.

Our investment policy requires that all of our investments have final maturities of ten years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be four years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. During 2008, our auction rate securities were classified as non-current assets. During the fourth quarter of 2008, certain auction rate securities were designated as trading securities. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," and Note 6, "Investments."

Receivables

Receivables consist primarily of amounts due from the various states in which we operate. All receivables are subject to potential retroactive adjustment. Because the amounts of nearly all receivables are readily determinable and our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables."

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Software developed for internal use is capitalized. Furniture and equipment are depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software is amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease or five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years. See Note 8, "Property and Equipment."

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are amortized on a straight-line basis over the expected period to be benefited (between one and 15 years). See Note 9, "Goodwill and Intangible Assets."

Goodwill and indefinite lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. We used a discounted cash flow methodology to assess the fair values of our reporting units at December 31, 2009 and 2008. If the carrying values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite lived asset balance. Based on the results of our impairment testing, no adjustments were required for the years ended December 31, 2009, 2008, and 2007.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted expected cash flows associated with that asset. In such circumstances, the asset is deemed to be impaired. We review material long-lived assets for impairment on an annual basis, as well as when events or changes in business conditions suggest potential impairment. Impaired assets are written down to fair value. In the second quarter of 2007, we recorded an impairment charge totaling $782,000 related to commercial software no longer used in operations.

Other than this 2007 charge, we have determined that no long-lived assets were impaired in the years ended December 31, 2009, 2008, and 2007.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, “Restricted Investments.”

Receivable/Liability for Ceded Life and Annuity Contracts

We report a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts.

Other Assets

Significant items included in other assets include deferred financing costs associated with our convertible senior notes and with our credit facility, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see Note 17, “Related Party Transactions”). The deferred financing costs are being amortized on a straight-line basis over the seven year term of the convertible senior notes and the five year term of the credit facility. As of December 31, 2009, other assets decreased compared with December 31, 2008 primarily due to the reclassification, to goodwill and intangible assets, of the $9.0 million initial purchase deposit of the Florida NetPASS acquisition (see Note 4, “Business Purchase Transactions”). Additionally, as of December 31, 2009, the fair value of the non-current asset relating to a rights agreement decreased $3.1 million (see Note 5, “Fair Value Measurements”) compared with the balance as of December 31, 2008.

Income Taxes

Deferred tax assets and liabilities are recorded based on temporary differences between the financial statement basis and the tax basis of assets and liabilities using presently enacted tax rates. We record accruals for uncertain tax positions by applying a two-step process. First, we determine whether it is more likely than not that a tax position will be sustained upon examination. In the second step, a tax position that meets the more-likely-than-not recognition threshold is measured to determine the amount of benefit to recognize in the financial statements. For further discussion and disclosure, see Note 13, “Income Taxes.”

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2009, and 2008, our investments with PFM totaled $296.0 million and $253.8 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2009, we operated in nine states (not including Nevada, where we no longer served members effective January 1, 2010), in some instances as a direct contractor with the state, and in others as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Segment Information

We present segment information externally in the same manner used by management to make operating decisions and assess performance. Each of our subsidiaries arranges for the provision of health care services to Medicaid, CHIP and Medicare members in return for compensation from state and Federal agencies. They share similar characteristics in the membership they serve, the nature of services provided and the method by which medical care is rendered. The subsidiaries are also subject to similar regulatory environments and long-term economic prospects. As such, we have one reportable segment.

Recent Accounting Pronouncements

In 2009, the FASB issued the FASB Accounting Standards Codification (the “Codification”) for financial statements issued for interim and annual periods ending after September 15, 2009. The Codification became the single authoritative source for GAAP. Accordingly, previous references to GAAP accounting standards are no longer used in our disclosures, including these Notes to the Consolidated Financial Statements. The Codification does not impact our consolidated financial position, results of operations or cash flows.

In October 2009, the Financial Accounting Standards Board (“FASB”) issued new revenue recognition standards for arrangements with multiple deliverables, where certain of those deliverables are non-software related. The new standards permit entities to initially use management’s best estimate of selling price to value individual deliverables when those deliverables do not have vendor specific objective evidence, or VSOE, of fair value or when third-party evidence is not available. Additionally, these new standards modify the manner in which the transaction consideration is allocated across the separately identified deliverables by no longer permitting the residual method of allocating arrangement consideration. These new standards are effective for annual periods ending after June 15, 2010, however early adoption is permitted. We are currently evaluating the impact of adopting these new standards on our consolidated financial position, results of operations and cash flows.

In October 2009, the FASB issued an update that offers guidance on how to use a net asset value per share to estimate the fair value of investments in various types of funds including hedge funds, private equity funds, real estate funds, venture capital funds, and offshore fund vehicles. We adopted the update in the fourth quarter of 2009, and because we do not invest in such funds, it did not impact our consolidated financial position, results of operations or cash flows.

In August 2009, the FASB issued an update that provides additional guidance clarifying the measurement of liabilities at fair value. Because we do not measure any of our liabilities at fair value, the adoption of the new standards did not impact our consolidated financial position, results of operations or cash flows.

In June 2009, the FASB issued an amended standard for determining whether to consolidate a variable interest entity. This new standard amends the evaluation criteria to identify the primary beneficiary of a variable interest entity and requires ongoing reassessment of whether an enterprise is the primary beneficiary of the variable interest entity. We adopted the standards in the fourth quarter of 2009, and the standard did not impact our consolidated financial position, results of operations or cash flows.

In May 2009, the FASB issued a new standard for subsequent events, which establishes general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. We adopted the new standard during the second quarter of 2009 and, because the pronouncement only requires additional disclosure, the adoption did not impact our consolidated financial position, results of operations or cash flows. The required disclosure is included in Note 1, "Basis of Presentation."

In April 2009, the FASB issued a new standard for the recognition and measurement of other-than-temporary impairments for debt securities which replaced the pre-existing "intent and ability" indicator. This new standard specifies that if the fair value of a debt security is less than its amortized cost basis, an other-than-temporary impairment is triggered in circumstances where (1) an entity has an intent to sell the security, (2) it is more likely than not that the entity will be required to sell the security before recovery of its amortized cost basis, or (3) the entity does not expect to recover the entire amortized cost basis of the security (that is, a credit loss exists). Other-than-temporary impairments are separated into amounts representing credit losses which are recognized in earnings and amounts related to all other factors which are recognized in other comprehensive income (loss). We adopted this standard in the second quarter of 2009 and it did not have a material effect on our consolidated financial position, results of operations or cash flows.

In April 2009, the FASB issued a new standard that provides guidance on how to determine the fair value of assets and liabilities when the volume and level of activity for the asset or liability has significantly decreased. This new standard also provides guidance on identifying circumstances that indicate a transaction is not orderly. In addition, we are required to disclose in interim as well as annual reporting periods the inputs and valuation techniques used to measure fair value and discussion of changes in valuation techniques. We adopted this standard in the second quarter of 2009 and it did not have a material effect on our consolidated financial position, results of operations or cash flows.

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

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Shares outstanding at the beginning of the year	26,725	28,444	28,119
Weighted-average number of shares repurchased	(988)	(871)	—
Weighted-average number of shares issued	106	103	156
Denominator for basic earnings per share	25,843	27,676	28,275
Dilutive effect of employee stock options and stock grants(1)	141	96	144
Denominator for diluted earnings per share(2)	25,984	27,772	28,419

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2009, 2008 and 2007, there were approximately 620,000, 532,000, and 136,000 anti-dilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per

share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2009, 2008 and 2007, there were approximately 21,000, 39,000, and 4,000 anti-dilutive weighted restricted shares, respectively.

(2) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2009, 2008 and 2007.

4. Business Purchase Transactions

On January 1, 2009, we adopted the FASB's revised standard for accounting for business combinations. The transaction described below under *"Florida health plan,"* was accounted for under the new standard. The adoption of the standard did not have a material effect on our consolidated financial position, results of operations or cash flows.

Florida health plan. On December 31, 2009 (the acquisition date), we acquired 100% of the voting equity interests in Florida NetPASS, LLC ("NetPASS"). This acquisition included the purchase of the NetPASS limited liability company and its membership interests. We initially announced our intention to purchase NetPASS in August 2008. NetPASS was a provider of care management and administrative services at that time to approximately 58,000 Florida MediPass members in South and Central Florida (Florida MediPASS is the state of Florida's Medicaid program). As a result of the acquisition, we have expanded our health plan operations to the southeastern United States.

Our wholly owned subsidiary, Molina Healthcare of Florida, Inc., was awarded a Medicaid managed care contract by the state of Florida in October 2008. Subsequently, NetPASS members have been notified of our intention to acquire NetPASS and, beginning in December 2008, offered membership with our Florida health plan on a county-by-county basis. Once transitioned, these members become full-risk members of the Florida health plan. That is, the Florida health plan receives fixed per member per month payments from the state of Florida for the care of these members, and the Florida health plan is at risk for the cost of the members' medical care. As of December 31, 2008, we had transitioned fewer than 50 NetPASS members to our Florida health plan.

As of December 31, 2009, we have transitioned approximately 48,000 NetPASS members to our Florida health plan, and have recorded $28.7 million to goodwill and intangible assets relating to these members. Of this amount, we have paid the sellers $23.4 million, with the balance accrued to accounts payable and accrued liabilities. The $5.3 million current liability includes a 10% indemnification hold back totaling $2.9 million, as provided in the purchase agreement, and a $2.4 million payable to the sellers for membership transitioned to date as of December 31, 2009. Because the final membership reconciliation will take place in the second quarter of 2010, the provisional measurements of goodwill and intangible assets recorded as of December 31, 2009, are subject to change. The final purchase price of the acquisition will be based on the final membership transitioned to our Florida health plan under the terms of the purchase agreement. As of December 31, 2009, we do not expect adjustments relating to the final membership reconciliation to be significant. The following table summarizes the estimated fair values of the assets acquired as of December 31, 2009:

	(In thousands)
Goodwill (indefinite life)	$ 17,048
Contract rights and licenses (five-year useful life)	8,576
Provider networks (10-year useful life)	3,076
	$ 28,700

The entire amount recorded for goodwill is deductible for income tax purposes. The amount recorded for goodwill as of December 31, 2009, represents intangible assets that do not qualify for separate recognition as identifiable intangible assets.

We have received a series of demand letters from the sellers of NetPASS related to the enrollment of members and the applicable purchase price. We believe the sellers' demands are without merit, and in the event arbitration or litigation is commenced by the sellers, we intend to vigorously contest the sellers' claims.

Missouri health plan. Effective November 1, 2007, we acquired Mercy CarePlus, a licensed Medicaid managed care plan based in St. Louis, Missouri, to expand our market share within our core Medicaid managed care business. The results of operations for Mercy CarePlus are included in the consolidated financial statements from periods following November 1, 2007. The purchase price for the acquisition was $80.0 million, and was funded with available cash and proceeds from our issuance of convertible senior notes in October 2007. The purchase price was subject to certain post-closing adjustments. During the third quarter of 2009, we paid the sellers $2.5 million to settle all outstanding issues relating to the post-closing adjustments. We recorded this amount to goodwill in the accompanying consolidated balance sheets. Additionally during the post-acquisition period in 2008, we reduced goodwill by approximately $6.2 million, primarily due to the establishment of a deferred tax asset relating to the carryover tax basis in certain identifiable intangibles.

Other. In June 2008, we paid $1.0 million and issued a total of 48,186 shares of our common stock in connection with our acquisition of the assets of The Game of Work, LLC. The purchase price consideration totaled $2.3 million. The Game of Work, LLC is a company specializing in productivity measurement and improvement, and is used internally to improve operational efficiency.

See Note 21, "Subsequent Events," for further information regarding a business purchase transaction we announced in January 2010.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was approximately $160.8 million, and $115.5 million as of December 31, 2009, and 2008, respectively. The carrying amount of the convertible senior notes was $158.9 million, and $164.9 million as of December 31, 2009, and 2008, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of December 31, 2009, we held certain assets that are required to be measured at fair value on a recurring basis. These included investments and restricted investments as follows:

Balance Sheet Classification	Description
Current assets:	
Investments	Investment grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1). See Note 6, "Investments," for further information regarding fair value.
Non-current assets:	
Investments	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
	Auction rate securities; designated as trading; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Restricted investments	Interest-bearing deposits and U.S. treasury securities required by the respective states in which we operate, or required by contractual arrangement with a third party such as a provider group; designated as held-to-maturity; reported at amortized cost which approximates market value and based on market prices that are readily available (Level 1). See Note 10, "Restricted Investments," for further information regarding fair value.
Other assets	Other assets include auction rate securities rights; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).

As of December 31, 2009, $67.8 million par value (fair value of $59.7 million) of our investments consisted of auction rate securities, all of which were collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2009. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, and continued to be unavailable as of December 31, 2009. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of December 31, 2009. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As of December 31, 2009, we held $40.9 million par value (fair value of $36.7 million) auction rate securities (designated as trading securities) with a certain investment securities firm. In the fourth quarter of 2008, we entered into a rights agreement with this firm that (1) allows us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gives the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we receive the par value.

We account for the Rights as a freestanding financial instrument, and record the value of the Rights at fair value, which totaled $3.8 million, and $6.9 million at December 31, 2009, and 2008, respectively. To determine the fair value estimate of the Rights, we use a discounted cash-flow model based on the expectation that the auction rate securities will be put back to the investment securities firm at par on June 30, 2010, as permitted by the rights agreement.

For the year ended December 31, 2009, we recorded a pretax gain on the change in the fair value of the auction rate securities underlying the Rights totaling $3.4 million, which was offset by a pretax loss on the Rights totaling $3.1 million. In 2008, simultaneous to the recognition of the $6.9 million rights agreement described above, we

recorded an other-than-temporary impairment of the underlying auction rate securities, and prior unrealized losses on the auction rate securities that had been recorded to other comprehensive loss through November 2008 were charged to income, totaling $7.2 million. We expect that the future changes in the fair value of the Rights will continue to be substantially offset by the fair value movements in the underlying auction rate securities.

As of December 31, 2009, the remainder of our auction rate securities (designated as available-for-sale securities) amounted to $26.9 million par value (fair value of $23.0 million). As a result of the increase in fair value of auction rate securities designated as available-for-sale, we recorded unrealized gains of $0.8 million ($0.5 million, net of tax) to accumulated other comprehensive income for the year ended December 31, 2009. We recorded unrealized losses of $7.6 million ($4.7 million, net of tax) to other comprehensive loss for the year ended December 31, 2008. We have deemed these unrealized gains and losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Based on market conditions that resulted in the absence of quoted prices in active markets for our auction rate securities, we changed our valuation methodology for auction rate securities to a discounted cash flow analysis during the first quarter of 2008. Our assets measured at fair value on a recurring basis at December 31, 2009, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
		(In thousands)		
Investments (not including auction rate securities)	$ 174,844	$ 174,844	$ —	$ —
Auction rate securities (available-for-sale)	22,957	—	—	22,957
Auction rate securities (trading)	36,730	—	—	36,730
Auction rate securities rights	3,807	—	—	3,807
Restricted investments	36,274	36,274	—	—
Total assets measured at fair value	$ 274,612	$ 211,118	$ —	$ 63,494

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3) (In thousands)
Balance at December 31, 2008	$ 65,076
Total gains (realized or unrealized):	
Included in earnings	294
Included in other comprehensive income	824
Settlements	(2,700)
Balance at December 31, 2009	$ 63,494
The amount of total gains for the period included in other comprehensive income attributable to the change in unrealized gains relating to assets still held at December 31, 2009	$ 824

6. Investments

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

	December 31, 2009			
	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
	(In thousands)			
Government-sponsored enterprise securities	$ 89,451	$ 504	$ 281	$ 89,674
Municipal securities (including auction rate securities)	82,009	3,120	4,154	80,975
U.S. treasury notes	28,052	92	84	28,060
Certificates of deposit	3,258	—	—	3,258
Corporate bonds	32,543	206	185	32,564
	$ 235,313	$ 3,922	$ 4,704	$ 234,531

	December 31, 2008			
	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
	(In thousands)			
Government-sponsored enterprise securities	$ 93,994	$ 1,309	$ 79	$ 95,224
Municipal securities (including auction rate securities)	85,973	23	5,313	80,683
U.S. treasury notes	8,604	295	—	8,899
Certificates of deposit	13,494	—	—	13,494
Corporate bonds	50,315	155	731	49,739
	$ 252,380	$ 1,782	$ 6,123	$ 248,039

The contractual maturities of our investments as of December 31, 2009 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 67,475	$ 67,387
Due one year through five years	106,624	106,934
Due after five years through ten years	1,430	1,400
Due after ten years	59,784	58,810
	$ 235,313	$ 234,531

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $60.3 million, $55.3 million, and $13.1 million for the years ended December 31, 2009, 2008 and 2007, respectively. Net realized investment gains (losses) for the years ended December 31, 2009, 2008 and 2007 were $267,000, $342,000 and $(78,000) respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at December 31, 2009 and 2008 are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Our investment in municipal securities consists primarily of auction rate securities. As described in Note 5, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at December 31, 2009.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months and those that have been in a loss position for 12 months or more as of December 31, 2009 and 2008.

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2009		In a Continuous Loss Position for 12 Months or More as of December 31, 2009		Total as of December 31, 2009	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Municipal securities	$ 10,427	$ 77	$ 24,031	$ 3,902	$ 34,458	$ 3,979
Government-sponsored enterprise securities	11,192	150	7,297	94	18,489	244
U.S. treasury notes	5,572	34	—	—	5,572	34
Corporate bonds	8,170	124	1,203	36	9,373	160
	$ 35,361	$ 385	$ 32,531	$ 4,032	$ 67,892	$ 4,417

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2008		In a Continuous Loss Position for 12 Months or More as of December 31, 2008		Total as of December 31, 2008	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Municipal securities	$ 41,901	$ 4,914	$ —	$ —	$ 41,901	$ 4,914
Government-sponsored enterprise securities	7,237	79	—	—	7,237	79
Corporate bonds	30,276	731	—	—	30,276	731
	$ 79,414	$ 5,724	$ —	$ —	$ 79,414	$ 5,724

7. Receivables

Accounts receivable by health plan operating subsidiary were as follows:

	December 31,	
	2009	2008
	(In thousands)	
California	$ 34,289	$ 20,740
Michigan	14,977	6,637
Missouri	19,670	24,024
New Mexico	11,919	5,712
Ohio	37,004	34,562
Utah	6,107	20,614
Washington	9,910	14,184
Other	2,778	2,089
Total	$ 136,654	$ 128,562

Accounts receivable as of December 31, 2009, increased compared with the prior year generally as a result of increased membership across several of our health plans. These increases were partially offset by the decrease at our Utah health plan, due to the termination of the plan's cost-plus reimbursement contract with the state of Utah effective September 1, 2009, as described further below.

Ohio. As of December 31, 2009, the receivable due our Ohio health plan included two significant components. The first is approximately $5.1 million of accrued birth income, net, due from the state of Ohio. Birth income is a one-time payment for the delivery of a child from the Medicaid program in Ohio.

The second significant component of the Ohio receivable is approximately $28.8 million due from a capitated provider group. Although we have a capitation arrangement with this provider group, our agreement with them calls for us to pay for certain medical services incurred by the provider group's members, and then to deduct the amount of such payments from future monthly capitation amounts owed to the provider group. Of the $28.8 million receivable, approximately $19.3 million represents medical services we have paid on behalf of the provider group, which we will deduct from capitation payments in the months of January and February 2010. The other component of the Ohio receivable includes an estimate of our liability for claims incurred by members of this provider group, not covered by capitation, for which we have not yet made payment. This amount totaled $9.5 million as of December 31, 2009. The offsetting liability for the amount of this receivable established for claims incurred but not paid is included in "Medical claims and benefits payable" in our consolidated balance sheets. As part of the agreement with this provider group, our Ohio health plan has withheld approximately $8.2 million from capitation payments due the group, and placed the funds in an escrow account. The Ohio health plan is entitled to the escrow amount if the provider group is unable to repay amounts owed to us for these incurred but not reported claims. The escrow account is included in "Restricted investments" in our consolidated balance sheets. During the year ended December 31, 2009, our average monthly capitation payment to this provider group was approximately $14 million.

Utah. Prior to September 1, 2009, our Utah health plan's agreement with the state of Utah called for the reimbursement of medical costs incurred in serving our members plus an administrative fee for a specified percentage of that medical cost amount (which was formerly 9% and most recently 6.5%), plus a portion of any cost savings realized as defined in the agreement. Our Utah health plan billed the state of Utah monthly for actual paid health care claims plus administrative fees. Prior to September 1, 2009, our receivable balance from the state of Utah included: (1) amounts billed to the state for actual paid health care claims plus administrative fees; and (2) amounts estimated for incurred but not paid claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid. Effective as of September 1, 2009, the Utah health plan's agreement with the state of Utah became a prepaid capitation contract, under which the plan is paid a fixed per member per month amount.

California. Effective October 1, 2009, the state of California implemented a delivery payment as part of its Medicaid managed care payment methodology. Accordingly, the California health plan only receives delivery payments upon acceptance by the state of a delivery encounter. The substitution of this methodology for a portion of the state payment that was previously paid as part of monthly capitation has, combined with the increase in enrollment at the California health plan during 2009, increased that health plan's accounts receivable at December 31, 2009 when compared with December 31, 2008.

Michigan. Accounts receivable at our Michigan health plan increased at December 31, 2009 when compared with December 31, 2008 as a result of: (1) the state's notice that we would be receiving additional premium for the months of October and November 2009 in connection with a rate increase we received effective October 1, 2009; (2) the accrual of a performance bonus from the state of Michigan that was accrued at December 31, 2009 and received in January 2010; and (3) state delays in processing new born premiums at December 31, 2009.

Missouri. Effective October 1, 2009, the state of Missouri carved out the Medicaid pharmacy benefit from the payments made to Medicaid health plans contracted in that state and retained responsibility for administering that benefit. As a result, monthly revenue (and the related receivable) recorded by the Missouri health plan have decreased at December 31, 2009 when compared with December 31, 2008.

New Mexico Effective July 1, 2009, the New Mexico health plan began performing certain administrative services for that state's Medicaid program under a separate contract. Accounts receivable recorded in connection with that contract represent the majority of the increase in accounts receivable at the New Mexico health plan between December 31, 2008 and December 31, 2009.

Washington. More rapid collection of delivery payments due from the state has reduced the Washington health plan's accounts receivable at December 31, 2009 when compared with December 31, 2008.

8. Property and Equipment

A summary of property and equipment is as follows:

	December 31,	
	2009	2008
	(In thousands)	
Land	$ 3,524	$ 3,461
Building and improvements	41,476	25,047
Furniture, equipment and automobiles	54,898	47,074
Capitalized computer software costs	66,526	56,211
	166,424	131,793
Less: accumulated depreciation and amortization on building and improvements, furniture, equipment and automobiles	(50,911)	(42,056)
Less: accumulated amortization on capitalized computer software costs	(37,342)	(24,679)
	(88,253)	(66,735)
Property and equipment, net	$ 78,171	$ 65,058

The increase in property and equipment for the year ended December 31, 2009 was primarily due to the build out and commencement of operations of our new information technology data center in Albuquerque, New Mexico. Depreciation expense recognized for building and improvements, furniture, equipment and automobiles was $11.0 million, $9.0 million, and $8.5 million for the years ended December 31, 2009, 2008, and 2007, respectively. Amortization expense recognized for capitalized computer software costs was $14.2 million, $11.7 million, and $8.6 million for the years ended December 31, 2009, 2008, and 2007, respectively.

9. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 11 years, and for provider networks is approximately 10 years. Amortization expense on intangible assets recognized for the years ended December 31, 2009, 2008, and 2007 was $12.9 million, $13.0 million, and $10.8 million, respectively. Based on the balances of our identifiable intangible assets as of December 31, 2009, we estimate that our intangible asset amortization expense will be $14.6 million in 2010, $13.4 million in 2011, $11.0 million in 2012, $7.8 million in 2013, and $7.0 million in 2014. The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses	$ 119,101	$ 51,246	$ 67,855
Provider networks	17,146	4,155	12,991
Balance at December 31, 2009	$ 136,247	$ 55,401	$ 80,846
Intangible assets:			
Contract rights and licenses	$ 114,219	$ 46,160	$ 68,059
Provider networks	14,548	3,474	11,074
Balance at December 31, 2008	$ 128,767	$ 49,634	$ 79,133

The changes in the carrying amount of goodwill and indefinite-lived intangible assets were as follows (in thousands):

Balance as of December 31, 2008	$ 113,466
Goodwill recorded for acquisition of Florida NetPASS	17,048
Goodwill adjustment related to acquisition of the Missouri health plan	2,894
Balance at December 31, 2009	$ 133,408

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

10. Restricted Investments

Pursuant to the regulations governing our subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities. Additionally, we maintain restricted investments as protection against the insolvency of

capitated providers. The following table presents the balances of restricted investments by health plan, and by our insurance company:

	December 31,	
	2009	2008
	(In thousands)	
California	$ 368	$ 367
Florida	2,052	9,828
Insurance Company	4,686	4,718
Michigan	1,000	1,000
Missouri	503	506
New Mexico	15,497	9,670
Ohio	9,036	8,459
Texas	1,515	1,521
Utah	578	577
Washington	151	151
Other	888	1,405
Total	$ 36,274	$ 38,202

As of December 31, 2009, the Florida health plan's restricted investments decreased compared with the prior year due to the release of escrow funds relating to a settlement agreement with the state of Florida that was a component of the purchase price of NetPASS (see Note 4, "Business Purchase Transactions"). The increase in the New Mexico health plan's restricted investments over the same period was due primarily to an increase in premium revenue at the plan, a percentage of which is used to determine the restricted investment balance required by the state of New Mexico. Additionally, the state of New Mexico's calculation methodology changed to use gross premium revenue, rather than the net premiums after taxes and assessments, also resulting in an increase to the required balance.

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2009 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 35,408	$ 35,425
Due one year through five years	724	721
Due after five years through ten years	142	155
	$ 36,274	$ 36,301

11. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2009 and 2008. The negative amounts displayed for "*Components of medical care costs related to: Prior periods*" represent the amount by which our original estimate of claims and benefits payable at the

beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2009	2008
	(Dollars in thousands)	
Balances at beginning of period	$ 292,442	$ 311,606
Components of medical care costs related to:		
Current period	3,227,794	2,683,399
Prior periods	(51,558)	(62,087)
Total medical care costs	3,176,236	2,621,312
Payments for medical care costs related to:		
Current period	2,919,240	2,413,128
Prior periods	232,922	227,348
Total paid	3,152,162	2,640,476
Balances at end of period	$ 316,516	$ 292,442
Benefit from prior period as a percentage of:		
Balance at beginning of period	17.6%	19.9%
Premium revenue	1.4%	2.0%
Total medical care costs	1.6%	2.4%

The overestimation of our liability for claims and medical benefits payable at December 31, 2008 led to the recognition of a benefit from prior period claims development for the year ended December 31, 2009 totaling $51.6 million. The overestimation of the claims liability at our Michigan, New Mexico, Ohio, and Washington health plans was principally the cause of the recognition of a benefit from prior period claims development. This was partially offset by the underestimation of our claims liability at December 31, 2008 at our California health plan. The details were as follows:

- In Michigan, we underestimated the impact of a steep drop in claims inventory during December 2008, thereby overestimating our liability at December 31, 2008.
- In New Mexico, we overestimated at December 31, 2008 the ultimate amounts we would need to pay to resolve certain high dollar provider claims, thereby overestimating our liability at December 31, 2008.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008, thereby overestimating our liability at December 31, 2008.
- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008, thereby overestimating our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt of paper claims (as opposed to electronically submitted claims) would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

In 2008, overestimation of our claims liability, particularly at our Michigan and Washington health plans, at December 31, 2007 led to the recognition of a benefit from prior period claims development totaling $62.1 million, as follows:

- In Michigan, we overestimated the extent to which both catastrophic claims and state-mandated changes to the methodology used to pay outpatient claims had increased our liability at December 31, 2007.

- In Washington, we overestimated the extent to which state-mandated changes to hospital fee schedules implemented in August 2007 had increased our liability at December 31, 2007.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability. In 2009 and 2008 the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations as the amount of benefit recognized in each your was roughly consistent with that recognized in the previous year.

12. Long-Term Debt

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the “Notes”). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, so the remaining aggregate principal amount totaled $187.0 million as of December 31, 2009 (see further discussion below regarding the purchase program). The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

In May 2008, the FASB issued new standards relating to certain convertible debt instruments, which we adopted effective January 1, 2009 (see Note 1, "Basis of Presentation"). These standards require the proceeds from the issuance of such convertible debt instruments to be allocated between a liability component and an equity component, which we have done with respect to the Notes. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of December 31, 2009, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 57 months. The Notes' if-converted value did not exceed their principal amount as of December 31, 2009. We allocated $24.5 million, net of the impact of deferred taxes, to the equity component of the Notes, which amount continued to be the carrying amount of the equity component as of December 31, 2008. At December 31, 2009, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The slight reduction in the amount of the equity component was due to amounts recorded as a result of our purchase of $13.0 million face amount of the Notes during the first quarter of 2009 (described further below). The following table provides the details of the liability amounts recorded:

	As of December 30, 2009	As of December 31, 2008
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 200,000
Unamortized discount	(28,100)	(35,127)
Net carrying amount	$ 158,900	$ 164,873

	Years Ended December 31,		
	2009	2008	2007
		(In thousands)	
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate of 3.75%	$ 7,076	$ 7,500	$ 1,688
Amortization of the discount on the liability component	4,782	4,707	1,012
Total interest cost recognized	$ 11,858	$ 12,207	$ 2,700

Securities Purchase Program. Under the $25 million securities purchase program announced in January 2009, we purchased and retired $13.0 million face amount of the Notes during the first quarter of 2009. We purchased the Notes at an average price of $74.25 per $100 principal amount, for a total of $9.8 million, including accrued interest. The gain recognized during the quarter ended March 31, 2009 on the purchase of the Notes was $1.5 million, or approximately $0.04 per diluted share.

In March 2009, our board of directors authorized the purchase of up to an additional $25 million in aggregate of either our common stock or the Notes. The purchase program was funded with working capital, and common stock purchases were made from time to time on the open market or through privately negotiated transactions during

2009. The purchase program extended through December 31, 2009. See the details regarding the common stock purchases at Note 14, "Stockholders' Equity."

Credit Facility

In 2005, we entered into the Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2007, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for general corporate purposes.

Pending the closing of the acquisition of the HIM business and the effectiveness of the fourth amendment, interest rates on borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest expense, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2009 and 2008, there were no amounts outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of our California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2009, we were in compliance with all financial covenants in the Credit Facility. See Note 21, "Subsequent Events," for further discussion of our fourth amendment and fifth amendment of the Credit Facility, relating to a business purchase transaction announced in January 2010.

13. Income Taxes

The provision for income taxes consisted of the following:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Current:			
Federal	$ 9,421	$ 32,972	$ 36,171
State	3,901	6,916	3,073
Total current	13,322	39,888	39,244
Deferred:			
Federal	1,924	378	(3,955)
State	(2,498)	(490)	(338)
Total deferred	(574)	(112)	(4,293)
Change in valuation allowance	—	—	45
Total provision for income taxes	$ 12,748	$ 39,776	$ 34,996

A reconciliation of the effective income tax rate to the statutory federal income tax rate is as follows:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Taxes on income at statutory federal tax rate (35%)	$ 15,266	$ 34,782	$ 32,453
State income taxes, net of federal benefit	912	4,176	1,925
(Benefit) liability for unrecognized tax benefits	(3,315)	450	85
Other	(115)	368	533
Reported income tax expense	$ 12,748	$ 39,776	$ 34,996

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California enterprise zone credits.

During 2009, 2008, and 2007, tax-related benefits (deficiencies) on share-based compensation were $(718,000), $(292,000), and $853,000, respectively. Such amounts were recorded as adjustments to income taxes payable with a corresponding increase (decrease) to additional paid-in capital.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2009 and 2008 were as follows:

	December 31,	
	2009	2008
	(In thousands)	
Accrued expenses	$ 2,494	$ 6,785
Reserve liabilities	285	1,046
State taxes	1,151	172
Other accrued medical costs	1,628	1,724
Net operating losses	27	27
Unrealized (gains) losses	(408)	1,274
Unearned premiums	6,554	2,063
Prepaid expenses	(2,894)	(3,979)
Other, net	(80)	(41)
Deferred tax asset, net of valuation allowance — current	8,757	9,071
Accrued expenses	(281)	—
Reserve liabilities	2,501	1,684
State taxes	—	1,830
Other accrued medical costs	(866)	108
Net operating losses	237	971
Unrealized losses	1,480	199
Unearned premiums	(264)	—
Depreciation and amortization	(10,415)	(10,698)
Deferred compensation	6,817	5,876
Debt basis	(11,555)	(12,931)
Other, net	(160)	745
Valuation allowance	—	(695)
Deferred tax liability, net of valuation allowance — long term	(12,506)	(12,911)
Net deferred income tax liability	$ (3,749)	$ (3,840)

At December 31, 2009, we had federal and state net operating loss carryforwards of $344,000 and $3.8 million, respectively. The federal net operating loss begins expiring in 2011, and state net operating losses begin expiring in 2028. The utilization of the net operating losses is subject to certain limitations under federal and state law.

At December 31, 2009, we had California enterprise zone tax credit carryovers of $2.1 million which do not expire.

We have determined that as of December 31, 2008, $695,000 of deferred tax assets did not satisfy the recognition criteria. Accordingly, we recorded a valuation allowance of $695,000 as of December 31, 2008. The valuation allowance primarily related to the uncertainty of realizing certain Indiana state net operating loss carryforwards. We determined in 2009 that we would no longer file an Indiana state tax return, thus, rendering the state net operating loss carryover worthless. As such, we recorded a write-off of the deferred tax asset and corresponding valuation allowance relating to the Indiana state net operating loss carryover.

During 2008, $7.4 million of net deferred tax assets were established with a corresponding reduction to goodwill for certain acquired intangible assets in connection with the 2007 purchase of Mercy CarePlus.

Additionally during 2008, $2.2 million of deferred tax assets relating to the 2006 purchase of the Cape Health Plan were derecognized which resulted in a corresponding increase to goodwill under purchase accounting.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audit. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Gross unrecognized tax benefits at beginning of period	$ (11,676)	$ (10,278)	$ (4,355)
Increases in tax positions for prior years	(3,748)	(3,310)	(3,197)
Decreases in tax positions for prior years	6,804	2,682	1,527
Increases in tax positions for current year	—	(2,061)	(4,935)
Decreases in tax positions for current year	—	892	—
Settlements	4,355	—	202
Lapse in statute of limitations	137	399	480
Gross unrecognized tax benefits at end of period	$ (4,128)	$ (11,676)	$ (10,278)

As of December 31, 2009, we had $4.1 million of unrecognized tax benefits of which $3.4 million, if fully recognized, would affect our effective tax rate. We anticipate a decrease of $408,000 to our liability for unrecognized tax benefits within the next twelve-month period due to normal expiration of tax statutes.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2009, December 31, 2008, and December 31, 2007, we had accrued $75,000, $1.4 million and $638,000, respectively, for the payment of interest and penalties.

We may be subject to examination by the Internal Revenue Service (“IRS”) for calendar years 2006 through 2009. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Missouri, and Michigan, for the years 2004 through 2009. Our subsidiary, HCLB, entered into a closing agreement with the IRS in December 2009 that successfully concluded with certainty the IRS examination of HCLB for the year ended May 2006.

14. Stockholders’ Equity

Under the purchase program described in Note 12, “Long-Term Debt,” we have purchased approximately 1.4 million shares of our common stock for $27.7 million (average cost of approximately $20.49 per share) during 2009. These purchases have increased diluted earnings per share for the year ended December 31, 2009 by $0.04. We have retired the $27.7 million of treasury shares purchased in 2009, and we have also retired $20.4 million of treasury shares that were purchased prior to 2009 ($48.1 million in aggregate). This resulted in the reduction of additional paid-in capital as of December 31, 2009, compared with December 31, 2008. Also in 2009, the treasury stock balance decreased as a result of the retirement of the $20.4 million of treasury shares purchased prior to 2009.

In April 2008, our board of directors authorized the purchase of up to $30 million of our common stock on the open market or through privately negotiated transactions, and then subsequently in July 2008, authorized the purchase of up to an additional one million shares of our common stock. We used working capital to fund the

purchases under these programs. The timing and amount of purchases were primarily made pursuant to a Rule 10b5-1 trading plans. Under these programs, we purchased approximately 1.9 million shares for an aggregate purchase price of $49.9 million (average cost of approximately $25.70 per share). These shares were subsequently retired in 2008.

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of securities, including common stock or debt securities, and up to 250,000 shares of our common stock, offered by selling stockholders. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

15. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $4.7 million, $3.9 million and $3.6 million in the years ended December 31, 2009, 2008, and 2007, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

16. Stock Plans

In 2002, we adopted the 2002 Equity Incentive Plan (the “2002 Plan”), which provides for the award of stock options, restricted stock, performance shares, and stock bonuses to the company’s officers, employees, directors, consultants, advisors, and other service providers. The 2002 Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares eligible for issuance automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. There were 4.0 million shares reserved for issuance under the 2002 Plan as of January 1, 2009.

Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our 2002 Employee Stock Purchase Plan (the “ESPP”), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. Under the ESPP, we issued 120,300 and 86,400 shares of our common stock during the years ended December 31, 2009 and 2008, respectively. Beginning January 1, 2004, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares available for issuance under the ESPP automatically increased by 1% of total outstanding capital stock. The aggregate number of unissued common shares available for future grants under the 2002 Plan and the ESPP combined was 3.8 million as of December 31, 2009, and 3.9 million as of December 31, 2008.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

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

	Year Ended December 31,					
	2009		2008		2007	
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock awards	$ 5,789	$ 3,589	$ 5,171	$ 3,206	$ 3,751	$ 2,335
Stock options (including expense relating to our ESPP)	1,696	1,052	2,640	1,637	3,437	2,139
Total	$ 7,485	$ 4,641	$ 7,811	$ 4,843	$ 7,188	$ 4,474

For both restricted stock and stock option awards, the expense is recognized over the vesting period, generally straight-line over four years. As of December 31, 2009, there was $12.2 million of unrecognized compensation cost related to unvested restricted stock awards, which we expect to recognize over a weighted-average period of 2.6 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 6% as of December 31, 2009. Also as of December 31, 2009, there was $0.9 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.3 years.

The total fair value of restricted shares vested during the years ended December 31, 2009, 2008, and 2007 was $3.2 million, $2.5 million, and $2.6 million, respectively. Unvested restricted stock activity for the year ended December 31, 2009 was as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested balance as of December 31, 2008	470,955	$ 31.95
Granted	425,000	$ 18.93
Vested	(163,700)	$ 30.52
Forfeited	(44,625)	$ 25.82
Unvested balance as of December 31, 2009	687,630	$ 24.64

No stock options were exercised during the year ended December 31, 2009; the total intrinsic value of stock options exercised during the year ended December 31, 2008 was nominal. The total intrinsic value of stock options exercised during the year ended December 31, 2007 amounted to $4.3 million. Stock option activity for the year ended December 31, 2009 was as follows:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value (000s)
Outstanding at December 31, 2008	665,339	$ 30.29		
Forfeited	(14,600)	$ 31.96		
Outstanding at December 31, 2009	650,739	$ 30.25	5.8	$ 288
Exercisable and expected to vest at December 31, 2009(a)	640,478	$ 30.22	5.8	$ 288
Exercisable at December 31, 2009	542,905	$ 29.92	5.5	$ 288

(a) Stock options exercisable and expected to vest at December 31, 2009 information is based on an estimated forfeiture rate of 13%.

The following is a summary of information about stock options outstanding and exercisable at December 31, 2009:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31, 2009	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable at December 31, 2009	Weighted-Average Exercise Price
$4.50 - $27.49	164,170	4.0	$ 23.11	162,670	$ 23.10
$28.66 - $28.66	173,744	6.1	$ 28.66	173,744	$ 28.66
$29.17 - $30.05	9,350	5.9	$ 29.86	9,350	$ 29.86
$31.32 - $44.29	303,475	6.7	$ 35.03	197,141	$ 36.66
	650,739	5.8	$ 30.25	542,905	$ 29.92

The Black-Scholes valuation model was used to estimate the fair value of stock options at grant date (for options awarded in 2008 and 2007; no options were awarded in 2009) based on the assumptions noted in the following table. The risk-free interest rate is based on the implied yield on U.S. treasury zero coupon issues for the expected option term. The expected volatility is based on historical volatility levels of our common stock. Beginning in the first quarter of 2008, we used an expected term for each option award based on historical experience of employee post-vesting exercise and termination behavior. Prior to 2008, the expected option term of each award granted was calculated using the "simplified method" in accordance with Staff Accounting Bulletin No. 107. This change did not produce materially different valuation results for the stock options awarded in 2008. The assumptions disclosed below represent a weighted-average of the assumptions used for all of our stock option grants throughout each of the years presented.

	Year Ended December 31,	
	2008	2007
Risk-free interest rate	2.5%	4.5%
Expected volatility	45.3%	47.1%
Expected option life (in years)	4	6
Expected dividend yield	0%	0%
Grant date weighted-average fair value	$12.80	$16.37

17. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2009 and 2008, our carrying amount for this investment totaled $4.1 million and $3.6 million, respectively. During 2008, we advanced this provider $1.3 million, all of which was collected during 2009. For the years ended December 31, 2009, 2008, and 2007, we paid $21.8 million, $15.4 million, and $10.9 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $745,000, $242,000, and $157,000 for the years ended December 31, 2009, 2008, and 2007, respectively. We also had a capitation arrangement with Pacific Hospital, where we paid Pacific Hospital a fixed monthly fee per member. This contract was terminated by the parties effective August 31, 2009. Amounts paid to Pacific Hospital for capitated services totaled approximately $1.1 million, $3.8 million, and $4.8 million for the years ended

December 31, 2009, 2008, and 2007, respectively. We believe that both arrangements with Pacific Hospital are based on prevailing market rates for similar services.

18. Commitments and Contingencies

Leases

We lease office space, clinics, equipment, and automobiles under agreements that expire at various dates through 2018. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases consist of the following approximate amounts:

Year ending December 31,	(In thousands)
2010	$ 21,334
2011	20,761
2012	18,604
2013	15,183
2014	13,522
Thereafter	39,576
Total minimum lease payments	$ 128,980

Rental expense related to these leases totaled $20.8 million, $17.5 million, and $18.1 million for the years ended December 31, 2009, 2008, and 2007, respectively.

Employment Agreements

During 2001 and 2002, we entered into employment agreements with three current executives with initial terms of one to three years, subject to automatic one-year extensions thereafter. In most cases, should the executive be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for 18 months. If any of the executives are terminated for cause, no further payments are due under the contracts.

In most cases, if termination occurs within two years following a change of control, the employee will receive two times their base salary and termination bonus, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for three years.

Executives who receive severance benefits, whether or not in connection with a change of control, will also receive all accrued benefits for prior service including a termination bonus.

Legal Proceedings

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Professional Liability Insurance

We carry medical malpractice insurance for health care services rendered through our clinics in California. Claims-made coverage under this policy is $1.0 million per occurrence with an annual aggregate limit of $3.0 million for each of the years ended December 31, 2009, 2008, and 2007. We also carry claims-made managed care errors and omissions professional liability insurance for our health plan operations. This insurance is subject to a coverage limit of $15.0 million per occurrence and $15.0 million in the aggregate for each policy year.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $368.7 million at December 31, 2009, and $355.0 million at December 31, 2008. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Washington, and Utah have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2009, our health plans had aggregate statutory capital and surplus of approximately $377.7 million compared with the required minimum aggregate statutory capital and surplus of approximately $257.1 million. All of our HMOs were in compliance with the minimum capital requirements at December 31, 2009. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

19. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2009 and 2008.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	For The Quarter Ended			
	March 31, 2009	June 30, 2009	September 30, 2009	December 31, 2009
	(In thousands)			
Premium revenue	$ 857,484	$ 925,507	$ 914,805	$ 962,411
Operating income (loss)	24,115	20,726	16,274	(3,722)
Income (loss) before income taxes	20,700	17,503	12,995	(7,582)
Net income (loss)	12,211	14,565	8,564	(4,472)
Net income (loss) per share(1),(2):				
Basic	$ 0.46	$ 0.56	$ 0.34	$ (0.18)
Diluted	$ 0.46	$ 0.56	$ 0.33	$ (0.18)

	For The Quarter Ended			
	March 31, 2008(1)	June 30, 2008(1)	September 30, 2008(1)	December 31, 2008(1)
	(In thousands)			
Premium revenue	$ 729,638	$ 761,153	$ 791,554	$ 808,895
Operating income	24,451	30,258	30,429	27,467
Income before income taxes(3)	21,083	26,833	27,309	24,149
Net income(3)	12,475	15,823	16,480	14,820
Net income per share(1),(3):				
Basic	$ 0.44	$ 0.57	$ 0.60	$ 0.55
Diluted	$ 0.44	$ 0.56	$ 0.60	$ 0.55

(1) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2009 and 2008.

(2) For the quarter ended December 31, 2009, no potentially dilutive options or nonvested stock were included in the computation of our diluted loss per share because to do so would have been anti-dilutive for that period.

(3) The Company's consolidated statement of income for the year ended December 31, 2008 has been recast to reflect the adoption of ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

20. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2009 and 2008, and our condensed statements of income and condensed statements of cash flows for each of the three years in the period ended December 31, 2009.

Condensed Balance Sheets

	December 31, 2009	December 31, 2008(1)
	(In thousands except per- share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 26,040	$ 42,776
Investments	3,002	9,745
Income tax receivable	—	3,119
Deferred income taxes	—	6,230
Due from affiliates	19,121	13,247
Prepaid and other current assets	11,435	10,228
Total current assets	59,598	85,345
Property and equipment, net	65,067	53,471
Goodwill	45,943	3,721
Investments	16,516	16,364
Investment in subsidiaries	545,731	568,224
Advances to related parties and other assets	16,742	19,379
	$ 749,597	$ 746,504
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 24,577	$ 24,595
Long-term debt	158,900	164,873
Deferred income taxes	10,769	12,530
Other long-term liabilities	12,613	12,744
Total liabilities	206,859	214,742
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized, outstanding 25,607 shares at December 31, 2009 and 26,725 shares at December 31, 2008	26	27
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	129,902	170,681
Accumulated other comprehensive loss, net of tax	(1,812)	(2,310)
Retained earnings	414,622	383,754
Treasury stock, at cost; 1,201 shares at December 31, 2008	—	(20,390)
Total stockholders' equity	542,738	531,762
	$ 749,597	$ 746,504

(1) The Registrant's condensed statement of financial position as of December 31, 2008, has been recast to reflect the adoption of FASB Accounting Standards Codification (ASC) Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Income

	Year Ended December 31,		
	2009	2008(1)	2007(1)
		(In thousands)	
Revenue:			
Management fees	$ 218,571	$ 190,361	$ 154,071
Other operating revenue	340	177	186
Investment income	1,540	2,733	2,915
Total revenue	220,451	193,271	157,172
Expenses:			
Medical care costs	26,865	21,759	22,042
General and administrative expenses	160,792	143,709	114,616
Depreciation and amortization	25,223	18,980	15,101
Total expenses	212,880	184,448	151,759
Gain on purchase of convertible senior notes	1,532	—	—
Operating income	9,103	8,823	5,413
Interest expense	(13,770)	(13,167)	(5,459)
Loss before income taxes and equity in net income of subsidiaries	(4,667)	(4,344)	(46)
Income tax (benefit) expense	(3,755)	(456)	1,963
Net loss before equity in net income of subsidiaries	(912)	(3,888)	(2,009)
Equity in net income of subsidiaries	31,780	63,486	59,735
Net income	$ 30,868	$ 59,598	$ 57,726

(1) The Registrant's condensed statements of income for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1).

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2009	2008	2007
		(In thousands)	
Operating activities:			
Cash provided by operating activities	$ 40,551	$ 17,532	$ 23,500
Investing activities:			
Net dividends from and capital contributions to subsidiaries	21,960	42,872	(16,890)
Purchases of investments	(3,844)	(25,515)	(74,604)
Sales and maturities of investments	12,669	56,833	29,946
Cash paid in business purchase transactions	(2,894)	(1,000)	(80,045)
Purchases of equipment	(32,245)	(33,047)	(20,159)
Changes in amounts due to and due from affiliates	(17,074)	(6,542)	2,887
Change in other assets and liabilities	(540)	3,170	1,192
Net cash provided by (used in) investing activities	(21,968)	36,771	(157,673)
Financing activities:			
Treasury stock purchases	(27,712)	(49,940)	—
Purchase of convertible senior notes	(9,653)	—	—
Proceeds from issuance of convertible senior notes	—	—	200,000
Repayments of amounts borrowed under credit facility	—	—	(45,000)
Payment of credit facility fees	—	—	(551)
Payment of convertible senior notes fees	—	—	(6,498)
Excess tax benefits from employee stock compensation	31	43	853
Proceeds from exercise of stock options and employee stock plan purchases	2,015	2,084	4,257
Net cash (used in) provided by financing activities	(35,319)	(47,813)	153,061
Net (decrease) increase in cash and cash equivalents	(16,736)	6,490	18,888
Cash and cash equivalents at beginning of year	42,776	36,286	17,398
Cash and cash equivalents at end of year	$ 26,040	$ 42,776	$ 36,286

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Notes to Condensed Financial Information of Registrant

Note A — Basis of Presentation

Molina Healthcare, Inc. (Registrant) was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The parent company-only financial statements should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B — Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2009, 2008, and 2007 for these services totaled $218.6 million, $190.4 million, and $154.1 million, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C — Capital Contribution and Dividends

During 2009, 2008, and 2007, the Registrant received dividends from its subsidiaries totaling $76.7 million, $91.5 million, and $39.0 million, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2009, 2008, and 2007, the Registrant made capital contributions to certain subsidiaries totaling $54.7 million, $48.6 million, and $55.9 million, respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D — Related Party Transactions

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because the Registrant has an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2009 and 2008, the Registrant's carrying amount for this investment totaled $4.1 million and $3.6 million, respectively. During 2008, the Registrant advanced this provider $1.3 million, all of which was collected during 2009. For the years ended December 31, 2009, 2008 and 2007, the Registrant paid $21.8 million, $15.4 million, and $10.9 million, respectively, for medical service fees to this provider.

The Registrant is a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $745,000, $242,000, and $157,000 for the years ended December 31, 2009, 2008, and 2007, respectively. The Registrant also had a capitation arrangement with Pacific Hospital, where the Registrant paid

Pacific Hospital a fixed monthly fee per member. This contract was terminated by the parties effective August 31, 2009. Amounts paid to Pacific Hospital for capitated services totaled approximately $1.1 million, $3.8 million, and $4.8 million for the years ended December 31, 2009, 2008, and 2007, respectively. The Registrant believes that both arrangements with Pacific Hospital are based on prevailing market rates for similar services.

Note 21. Subsequent Events

Acquisition of HIM

On January 18, 2010, we entered into a definitive agreement to acquire the Health Information Management, or HIM, business of Unisys Corporation. The purchase price is expected to be approximately $135 million, subject to a standard working capital adjustment, to be paid in cash at closing using our credit facility. The acquisition, which is expected to close in the first half of 2010, is subject to customary regulatory approvals and closing conditions, including receipt of customer consents.

The HIM business provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. The HIM business currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. Annual revenues of the HIM business are currently approximately $110 million. We expect the approximately 900 employees of the HIM business to become our employees upon closing of the transaction, and following the closing Unisys has agreed to provide certain transitional and technology support services to us for up to one year.

Subject to the closing of the HIM acquisition, in November 2009 we agreed to enter into a fourth amendment to the Credit Facility. The fourth amendment will become effective upon the closing of the acquisition of the HIM business. The fourth amendment is required because the $135 million purchase price for the HIM business exceeds the currently applicable deal size threshold under the terms of the Credit Facility. Pursuant to the fourth amendment, the lenders have consented to our acquisition of the HIM business.

Upon its effectiveness at the closing, the fourth amendment would increase the commitment fee on the total unused commitments of the lenders under the Credit Facility to 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans would be raised by 200 basis points at every level of the pricing grid. The applicable margins would thus range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. Until the delivery of a compliance certificate with respect to our financial statements for the quarter ending after the HIM business acquisition closes, the applicable margin shall be fixed at 3.5% for LIBOR loans and 2.5% for base rate loans. In connection with the lenders' approval of the fourth amendment, a consent fee of 10 basis points was paid on the amount of each consenting lender's commitment. In addition, the fourth amendment would carve out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the Notes (although the $187.0 million indebtedness would still be included in the calculation of our Consolidated Leverage Ratio); increase the amount of surety bond obligations we may incur; increase our allowable capital expenditures; and reduce the fixed charge coverage ratio from 3.50x to 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

On March 15, 2010, we agreed to enter into a fifth amendment to the Credit Facility. The fifth amendment will also become effective upon the closing of the acquisition of the HIM business. The fifth amendment is required because, after giving effect to the acquisition of the HIM business on a pro forma basis, and inclusive of the Company's fourth quarter 2009 EBITDA of only $5.9 million, the Company's consolidated leverage ratio for the preceding four fiscal quarters would exceed the currently applicable ratio of 2.75 to 1.0. The fifth amendment will increase the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if the Company has actually reduced its consolidated leverage ratio to no more than 2.75 to 1.0

on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we will pay an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting during the three months ended December 31, 2009 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2009. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework.* Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2009, based on those criteria.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on page 109 of this Annual Report on Form 10-K, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2009.

Item 9B. ***Other Information***

On March 15, 2010, we agreed to enter into a fifth amendment to our Credit Facility. The fifth amendment will become effective upon the closing of the acquisition of the HIM business. The fifth amendment is required because, after giving effect to the acquisition of the HIM business on a pro forma basis, and inclusive of the Company's fourth quarter 2009 EBITDA of only $5.9 million, the Company's consolidated leverage ratio for the preceding four fiscal quarters would exceed the currently applicable ratio of 2.75 to 1.0. The fifth amendment will increase the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma

basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if the Company has actually reduced its consolidated leverage ratio to no more than 2.75 to 1.0 on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we will pay an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010.

The foregoing summary of the terms of the fifth amendment does not purport to be complete and is qualified in its entirety by reference to the fifth amendment, which is filed as Exhibit 10.22 hereto.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2009 and our report dated March 16, 2010 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2010

PART III

Item 10. ***Directors, Executive Officers, and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Proposal No. 1 — Election of Three Class II Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item X of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders. Such portion of the Proxy Statement is incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Corporate Governance," "Corporate Governance and Nominating Committee," "Corporate Governance Guidelines," and "Code of Business Conduct and Ethics." These portions of our Proxy Statement are incorporated herein by reference.

***(d) Section 16*(a) Beneficial Ownership Reporting Compliance**

Section 16(a) of the Exchange Act requires our executive officers and directors, and persons who own more than 10% of a registered class of our equity securities, to file reports of ownership and changes in ownership with the SEC, and to furnish us with copies of the forms. Purchases and sales of our equity securities by such persons are published on our website at www.molinahealthcare.com. Based on our review of the copies of such reports, on our involvement in assisting our reporting persons with such filings, and on written representations from our reporting persons, we believe that, during 2009, each of our executive officers, directors, and greater than ten percent stockholders complied with all such filing requirements on a timely basis.

Item 11. ***Executive Compensation***

The information which will appear in our Proxy Statement for our 2010 Annual Meeting under the captions "Compensation Committee Interlocks," "Non-Employee Director Compensation," and "Compensation Discussion and Analysis," is incorporated herein by reference. The information which will appear in our Proxy Statement under the caption "Compensation Committee Report" is not incorporated herein by reference.

The table below, which was inadvertently omitted from our 2009 Proxy Statement, shows the number of shares of restricted stock held by our named executive officers which vested during fiscal year 2008.

OPTION EXERCISES AND STOCK VESTED

	Option Awards		Stock Awards	
Name	**Number of Shares Acquired On Exercise (#)**	**Value Realized on Exercise ($)**	**Number of Shares Acquired on Vesting (#)**	**Value Realized on Vesting ($)**
J. Mario Molina	—	—	—	—
John C. Molina	—	—	—	—
Mark L. Andrews	—	—	1,387	43,899(1)
	—	—	1,000	24,680(2)
Terry Bayer	—	—	1,387	43,899(3)
James W. Howatt	—	—	550	18,431(4)
	—	—	625	19,781(5)
	—	—	763	21,707(6)

1. On March 1, 2008, 1,387 restricted shares vested in favor of Mr. Andrews at a closing market price of $31.65.
2. On July 1, 2008, 1,000 restricted shares vested in favor of Mr. Andrews at a closing market price of $24.68.
3. On March 1, 2008, 1,387 restricted shares vested in favor of Ms. Bayer at a closing market price of $31.65.
4. On February 9, 2008, 550 restricted shares vested in favor of Dr. Howatt at a closing market price of $33.51.
5. On March 1, 2008, 625 restricted shares vested in favor of Dr. Howatt at a closing market price of $31.65.
6. On May 29, 2008, 763 restricted shares vested in favor of Dr. Howatt at a closing market price of $28.45.

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

Information concerning the security ownership of certain beneficial owners and management will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Information About Stock Ownership." This portion of the Proxy Statement is incorporated herein by reference. The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference.

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

Information concerning certain relationships and related transactions will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Related Party Transactions." Information concerning director independence will appear in our Proxy Statement under "Director Independence." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2010 Annual Meeting of Stockholders under "Disclosure of Auditor Fees." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The Company's consolidated financial statements, the notes thereto and the report of the Independent Registered Public Accounting Firm are on pages 60 through 108 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm
Consolidated Balance Sheets — At December 31, 2009 and 2008
Consolidated Statements of Operations — Years ended December 31, 2009, 2008, and 2007
Consolidated Statements of Stockholders' Equity — Years ended December 31, 2009, 2008, and 2007
Consolidated Statements of Cash Flows — Years ended December 31, 2009, 2008, and 2007
Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 16th day of March, 2010.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	March 16, 2010
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	March 16, 2010
/s/ Joseph W. White **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	March 16, 2010
/s/ Charles Z. Fedak **Charles Z. Fedak, CPA, MBA**	Director	March 16, 2010
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	March 16, 2010
/s/ Steven Orlando **Steven Orlando, CPA (inactive)**	Director	March 16, 2010
/s/ Sally K. Richardson **Sally K. Richardson**	Director	March 16, 2010
/s/ Ronna Romney **Ronna Romney**	Director	March 16, 2010
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	March 16, 2010

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INDEX TO EXHIBITS

Number	Description	Method of Filing
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.2 to registrant's Form 8-K filed February 17, 2009.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2008.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2008.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2008.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	Form of Stock Option Agreement under 2002 Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.4	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.5	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.6	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.10	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.
10.11	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
10.12	Amended and Restated Employment Agreement with Mark L. Andrews dated as of December 31, 2009	Filed as Exhibit 10.3 to registrant's Form 8-K filed January 7, 2010.
10.13	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
10.14	Amended and Restated Change in Control Agreement with James W. Howatt, M.D., dated as of December 31, 2009	Filed as Exhibit 10.5 to registrant's Form 8-K filed January 7, 2010.
10.15	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
10.16	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.17	Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare, Inc., as the Borrower, certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed March 10, 2005.

Number	Description	Method of Filing
10.18	First Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of October 5, 2005, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed October 13, 2005.
10.19	Second Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of November 6, 2006, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 10-Q filed November 9, 2006.
10.20	Third Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of May 25, 2008, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 31, 2008.
10.21	Fourth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of _____, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent (date to be inserted on Fourth Amendment Effective Date)	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 19, 2010.
10.22	Fifth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of _____, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent (date to be inserted on Fifth Amendment Effective Date)	Filed herewith.
10.23	Office Lease with Pacific Towers Associates for 200 Oceangate Corporate Headquarters.	Filed as Exhibit 10.34 to registrant's Form 10-K filed March 17, 2008.
10.24	Hospital Services Agreement (fee-for-service) by and between Molina Healthcare of California, a California corporation, and Pacific Hospital of Long Beach	Filed herewith.
10.25	Hospital Services Agreement (capitation) by and between Molina Healthcare of California, a California corporation, and HealthSmart Pacific, Inc., dba Pacific Hospital of Long Beach	Filed herewith.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.

Exhibit 10.22

FIFTH AMENDMENT

THIS **FIFTH AMENDMENT** dated as of [_____ ___][1], 2010 (this "***Fifth Amendment***"), among **MOLINA HEALTHCARE, INC.**, a Delaware corporation (the "***Borrower***"), the Lenders (as defined below) party hereto, and **BANK OF AMERICA, N.A.**, as Administrative Agent (in such capacity, the "***Administrative Agent***") for the Lenders.

W I T N E S S E T H:

WHEREAS, the Borrower is a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005 (as amended by the First Amendment and Waiver dated as of October 5, 2005, the Second Amendment and Waiver dated as of November 6, 2006, the Third Amendment dated as of May 25, 2007 and the Fourth Amendment, and as otherwise amended, restated, supplemented or modified to but excluding the Fifth Amendment Effective Date, as hereinafter defined, the "***Existing Credit Agreement***"; and as hereby amended and otherwise amended, restated, supplemented or modified from time to time on or after the Fifth Amendment Effective Date, the "***Amended Credit Agreement***") among the Borrower, the lenders from time to time party thereto (the "***Lenders***"), Bank of America, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer, and the other agents, joint lead arrangers and joint book managers party thereto. Capitalized terms used and not otherwise defined herein shall have the meanings assigned to such terms in the Existing Credit Agreement; and

WHEREAS, the Borrower, the Required Lenders and the Administrative Agent previously executed and delivered the Fourth Amendment to the Existing Credit Agreement (the "***Fourth Amendment***"), pursuant to which the Required Lenders consented to certain amendments and to the Dakota Acquisition upon the terms and conditions set forth in the Fourth Amendment; and

WHEREAS, the Borrower has requested that in connection with the pending Dakota Acquisition the Administrative Agent and the Required Lenders amend and modify the Existing Credit Agreement as provided herein;

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1.01. Amendments to the Existing Credit Agreement.

(a) The definition of "Letter of Credit Sublimit" in Section 1.01 of the Existing Credit Agreement is hereby amended by replacing the reference to"$10 million" in clause (a) thereof with a reference to "$40 million".

(b) Section 1.01 of the Existing Credit Agreement is hereby amended by inserting the following definitions in alphabetical order:

---

1 To be dated as of the Fifth Amendment Effective Date.

"Consolidated Leverage Ratio Reset Date" means either (x) August 15, 2010, if the Borrower has reduced its actual Consolidated Leverage Ratio to no more than 2.75 to 1.00 as of August 15, 2010 or (y) September 30, 2010, if the Borrower has not reduced its actual Consolidated Leverage Ratio to no more than 2.75 to 1.00 as of August 15, 2010.

"Fifth Amendment" means that certain Fifth Amendment, dated as of [_____ ___], 2010, among the Borrower, the Lenders party thereto and the Administrative Agent.

"Fifth Amendment Effective Date" has the meaning given such term in the Fifth Amendment.

(c) Section 2.06 of the Existing Credit Agreement is hereby amended by (i) numbering the existing paragraph as clause (a) and (ii) inserting the following new clause (b):

(b) The Aggregate Commitments shall be automatically, permanently and ratably reduced to $150,000,000 on the Consolidated Leverage Ratio Reset Date.

(d) Section 2.09 of the Existing Credit Agreement is hereby amended by inserting the following new clauses (c) and (d):

(c) Incremental Commitment Fee. The Borrower shall pay to the Administrative Agent for the account of each Lender in accordance with its Applicable Percentage, an incremental commitment fee equal to 0.125% per annum times the actual daily amount by which the Aggregate Commitments exceed the sum of (i) the Outstanding Amount of Loans and (ii) the Outstanding Amount of L/C Obligations; provided that for purposes of calculating such fee, Swing Line Loans will not be deemed to be utilized. The incremental commitment fee provided for in this clause (c) of Section 2.09 shall accrue at all times during the period from the Fifth Amendment Effective Date to the Consolidated Leverage Ratio Reset Date, including at any time during which one or more of the conditions in Article IV is not met, and shall be due and payable quarterly in arrears on the last Business Day of March and June during such period and on the Consolidated Leverage Ratio Reset Date.

(d) Duration Fee. If the actual Consolidated Leverage Ratio is not reduced to 2.75 to 1.0 or below as of August 15, 2010, the Borrower shall pay to the Administrative Agent for the account of each Lender in accordance with its Applicable Percentage a fee equal to 0.50% times the Aggregate Commitments, which fee shall be due and payable on August 15, 2010.

(e) Section 7.18(b) of the Existing Credit Agreement is hereby deleted in its entirety and replaced with the following:

(b) Consolidated Leverage Ratio. Permit the Consolidated Leverage Ratio at any time during any period set forth below to be greater than the ratio set forth below opposite such period.

Period	Maximum Consolidated Leverage Ratio
September 30, 2006 through September 30, 2009	2.75 to 1.00
October 1, 2009 through December 31, 2009	3.25 to 1.00
January 1, 2010 through but excluding the Consolidated Leverage Ratio Reset Date	3.50 to 1.00
Consolidated Leverage Ratio Reset Date and at all times thereafter	2.75 to 1.00

SECTION 1.02. Representations and Warranties. The Borrower hereby represents and warrants to the Administrative Agent and the Lenders, as follows:

(a) After giving effect to this Fifth Amendment, the representations and warranties of the Borrower contained in Article V of the Amended Credit Agreement or any other Loan Document or which are contained in any document furnished at any time under or in connection therewith are true and correct in all material respects on and as of the date hereof, (i) except to the extent such representations and warranties specifically refer to an earlier date, in which case they are true and correct in all material respects as of such earlier date, (ii) except the representations and warranties contained in subsections (a) and (b) of Section 5.05 of the Amended Credit Agreement shall be deemed to refer to the most recent financial statements furnished pursuant to subsections (a) and (b), respectively, of Section 6.01 of the Amended Credit Agreement and (iii) references to Schedules shall be deemed to refer to the most updated supplements to the Schedules furnished pursuant to subsection (b) of Section 6.02 of the Amended Credit Agreement.

(b) After giving effect to this Fifth Amendment, each of the Borrower and the other Loan Parties is in compliance with all the terms and conditions of the Amended Credit Agreement, as amended by this Fifth Amendment, and the other Loan Documents on its part to be observed or performed and no Default has occurred or is continuing under the Amended Credit Agreement.

(c) The execution, delivery and performance by the Borrower of this Fifth Amendment have been duly authorized by the Borrower.

(d) Each of this Fifth Amendment and the Amended Credit Agreement constitutes the legal, valid and binding obligation of the Borrower, enforceable against

the Borrower in accordance with its terms, except as enforceability may be limited by Debtor Relief Laws and by general equitable principles (whether enforcement is sought by proceedings in equity or at law).

(e) The execution, delivery, performance and compliance with the terms and provisions by the Borrower of this Fifth Amendment and the consummation of the transactions contemplated herein do not and will not: (i) contravene the terms of any of the Borrower's Organization Documents; (ii) conflict with or result in any breach or contravention of, or (except for the Liens created under the Loan Documents) the creation of any Lien under, (A) any material Contractual Obligation to which the Borrower is a party or (B) any order, injunction, writ or decree of any Governmental Authority or any arbitral award to which the Borrower or its property is subject or (C) violate any material Law, including, without limitation, state and Federal Laws relating to health care organizations and health care providers, except for such violations as could not reasonably be expected to have a Material Adverse Effect.

SECTION 1.03. Effectiveness. This Fifth Amendment shall become effective only upon satisfaction of the following conditions precedent (the first date upon which each such condition has been satisfied being herein called the "***Fifth Amendment Effective Date***"):

(a) The Administrative Agent shall have received duly executed counterparts of this Fifth Amendment which, when taken together, bear the authorized signatures of the Borrower, the Administrative Agent and the Required Lenders.

(b) The Fourth Amendment Effective Date (as defined in the Fourth Amendment) shall have occurred.

(c) The Administrative Agent shall have received duly executed counterparts of the Consent executed by each Guarantor in the form of Exhibit A hereto.

(d) The Borrower shall have certified in writing that the representations and warranties set forth in Section 1.03 hereof are true and correct on and as of such date.

(e) There shall exist no actions, suits, proceedings, claims or disputes pending or, to the Actual Knowledge of the Borrower, threatened, at law, in equity, in arbitration or before any Governmental Authority, by or against the Borrower or any of the Subsidiaries or against any of their respective properties or revenues or injunctions, writs, temporary restraining orders or other orders of any nature issued by any court or Governmental Authority that (i) purport to affect, pertain to or enjoin or restrain the execution, delivery or performance of this Fifth Amendment or the Amended Credit Agreement or any other Loan Document, or any transactions contemplated hereby or thereby or (ii) either individually or in the aggregate, in the case of any such suit, proceeding, claim or dispute which is reasonably likely to be adversely determined, either individually or in the aggregate, if determined adversely, could reasonably be expected to have a Material Adverse Effect.

(f) The Administrative Agent on behalf of the Lenders shall have received such other documents, instruments and certificates as they shall reasonably request and such other documents, instruments and certificates shall be satisfactory in form and substance to the Lenders and their counsel. All corporate and other proceedings taken or to be taken in connection with this Fifth Amendment and all documents incidental thereto, whether or not referred to herein, shall be satisfactory in form and substance to the Lenders and their counsel.

(g) The Borrower shall have paid in full (i) all expenses referred to in Section 1.06, and (ii) all fees due and payable as of the Fifth Amendment Effective Date under the Engagement Letter, dated as of March 8, 2010, among the Borrower, the Administrative Agent and Banc of America Securities LLC, including, without limitation, the 25.0 basis point Amendment Fee payable to each Lender that timely consents to this Fifth Amendment, calculated based upon the full amount of each consenting Lender's commitment.

SECTION 1.04. Lender Consent. For purposes of determining compliance with the conditions specified in Section 1.03, each Lender that has signed this Fifth Amendment shall be deemed to have consented to, approved or accepted or to be satisfied with, each document or other matter required thereunder to be consented to or approved by or acceptable or satisfactory to a Lender unless the Administrative Agent shall have received notice from such Lender prior to the proposed Fifth Amendment Effective Date specifying its objection thereto.

SECTION 1.05. APPLICABLE LAW. THIS FIFTH AMENDMENT SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK, EXCEPT TO THE EXTENT THAT THE FEDERAL LAWS OF THE UNITED STATES OF AMERICA MAY APPLY.

SECTION 1.06. Costs and Expenses. On the Fifth Amendment Effective Date, the Borrower shall pay all reasonable out-of-pocket costs and expenses of the Administrative Agent in connection with the preparation, execution and delivery of this Fifth Amendment and the other instruments and documents to be delivered hereunder (including, without limitation, the reasonable fees and expenses of counsel for the Administrative Agent) in accordance with the terms of Section 10.04(a) of the Amended Credit Agreement which are invoiced to the Borrower on or prior to the date payment would be due hereunder.

SECTION 1.07. Counterparts. This Fifth Amendment may be executed in any number of counterparts, each of which shall constitute an original but all of which when taken together shall constitute but one agreement. Delivery by facsimile or PDF by any of the parties hereto of an executed counterpart of this Fifth Amendment shall be as effective as an original executed counterpart hereof and shall be deemed a representation that an original executed counterpart hereof will be delivered, but the failure to deliver a manually executed counterpart shall not affect the validity, enforceability or binding effect of this Fifth Amendment.

SECTION 1.08. Existing Credit Agreement. Except as expressly set forth herein, the amendment provided herein shall not, by implication or otherwise, limit, constitute a waiver of, or otherwise affect the rights and remedies of the Lenders or the Administrative Agent under the Existing Credit Agreement or any other Loan Document, nor shall it constitute a waiver of any Default, nor shall it alter, modify, amend or in any way affect any of the terms, conditions, obligations, covenants or agreements contained in the Existing Credit Agreement or any other

Loan Document. The amendments provided herein shall apply and be effective only on the Fifth Amendment Effective Date and only with respect to the provisions of the Existing Credit Agreement specifically referred to by such amendments. Except to the extent a provision in the Existing Credit Agreement is expressly amended herein, the Existing Credit Agreement shall continue in full force and effect in accordance with the provisions thereof.

[Signature pages follow]

IN WITNESS WHEREOF, the parties hereto have caused this Fifth Amendment to be duly executed by their duly authorized officers, all as of the date first above written.

MOLINA HEALTHCARE, INC., a Delaware corporation, as the Borrower

By: _____

Name: _____

Title: _____

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

By: _____

Name: _____

Title: _____

BANK OF AMERICA, N.A., as a Lender, Swing Line Lender and L/C Issuer

By: _____

Name: _____

Title: _____

CIBC INC., as Lender

By: _____

Name: _____

Title: _____

CITICORP NORTH AMERICA, INC., as Lender

By: _____

Name: _____

Title: _____

U.S. BANK NATIONAL ASSOCIATION, as Lender

By: _____

Name: _____

Title: _____

UBS LOAN FINANCE LLC, as Lender

By: _____

Name: _____

Title: _____

HARRIS N.A., as Lender

By: _____

Name: _____

Title: _____

UNION BANK, NATIONAL ASSOCIATION, as Lender

By: _____

Name: _____

Title: _____

EAST WEST BANK, as Lender

By: _____

Name: _____

Title: _____

JPMORGAN CHASE BANK, N.A., as Lender

By: _____

Name: _____

Title: _____

CITY NATIONAL BANK, as Lender

By: _____

Name: _____

Title: _____

JEFFERIES FINANCE LLC, as Lender

By: _____

Name: _____

Title: _____

EXHIBIT A
to
Fifth Amendment

FORM OF
CONSENT

This **CONSENT**, dated as of [_____] [___], 2010 (this "***Consent***"), to the Agreement referred to below is delivered by each of the undersigned (each a "***Guarantor***").

W I T N E S S E T H:

WHEREAS, in connection with the transactions contemplated by the Amended and Restated Credit Agreement, dated as of March 9, 2005 among Molina Healthcare, Inc. (the "***Borrower***"), the lenders from time to time party thereto (the "***Lenders***"), Bank of America, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer (the "***Administrative Agent***"), and the other agents, joint lead arrangers and joint book managers party thereto, as amended by the First Amendment and Waiver dated as of October 5, 2005, the Second Amendment and Waiver dated as of November 6, 2006, and the Third Amendment dated as of May 25, 2007, and as may be amended by the Fourth Amendment upon its effectiveness, should it become effective, (the "***Existing Credit Agreement***") each Guarantor has executed and delivered to the Administrative Agent and the Lenders that certain Subsidiary Guaranty dated as of March 9, 2005 (as amended or otherwise modified from time to time, the "***Subsidiary Guaranty***");

WHEREAS, the Borrower, the Lenders and the Administrative Agent have entered into the Fifth Amendment dated as of the date hereof (the "***Fifth Amendment***"; capitalized terms not otherwise defined herein to have the meanings provided in the Fifth Amendment and in the Existing Credit Agreement) to amend certain provisions in the Existing Credit Agreement; and

WHEREAS, it is a condition of effectiveness of the Fifth Amendment that each Guarantor deliver to the Administrative Agent and the Lenders an executed counterpart of this Consent;

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, each Guarantor hereby agrees, as follows:

1. each Guarantor consents and agrees to the terms of (a) the Fifth Amendment and (b) the Existing Credit Agreement, as amended by the Fifth Amendment (the "***Amended Credit Agreement***"); and

2. each Guarantor confirms and agrees that notwithstanding the effectiveness of the Fifth Amendment, the Subsidiary Guaranty is, and shall continue to be, in full force and effect and is hereby ratified and confirmed in all respects, except that, on and after the effectiveness of the Fifth Amendment, each reference in the Subsidiary Guaranty to the "Credit Agreement", "thereunder", "thereof" or words of like import shall mean and be a reference to the Amended Credit Agreement.

IN WITNESS WHEREOF, the undersigned have caused this Consent to be executed by their respective officers thereunto duly authorized, as of the date first above written.

[INSERT GUARANTORS' NAMES]

By: _____
Name:
Title:

MOLINA HEALTHCARE OF CALIFORNIA

HOSPITAL SERVICES AGREEMENT

This Hospital Services Agreement ("Agreement") is entered by and between Molina Healthcare of California, a California corporation ("Health Plan"), and **Pacific Hospital of Long Beach.**

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE — DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B.

ARTICLE TWO — PROVIDER OBLIGATIONS

2.1 Serving as a Panel Provider. Provider shall provide hospital inpatient and/or outpatient services to Members for the products specified in Attachment C. Provider agrees that its facility information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material

made available to the public and Members. Facility Information includes, but is not limited to, name, address, telephone number, hours of operation, and services. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care.**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member as an inpatient or outpatient, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Provider shall notify Health Plan or its agent within twenty-four (24) hours of admission and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan's notification procedures described in the Provider Manual for all inpatient admissions (acute, rehabilitation, mental health and SNF) including admissions resulting from an outpatient visit, and Provider shall notify Health Plan of any admission within twenty-four (24) hours of admission.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

g. **Availability of Services.** Provider shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

h. **Hospital Services** are those Plan benefits to include short term inpatient or outpatient general hospital services including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, emergency services, drugs, including drugs to be dispensed at time of emergency room visit in amount sufficient to last until such time Member can reasonably be expected to fill a prescription, medications, biological, anesthesia and oxygen services, ambulatory care services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

2.3 **Standards for Hospital Providers.**

a. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Provider's contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information.** Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the

provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(s) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.

e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's contracted providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider's medical staff and the bylaws, rules and regulations of Provider.

f. **Notification.** Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider's notification to Health Plan shall state Provider's actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the

same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **National Provider Identification ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider shall obtain an NPI from the National Plan and Provider Enumeration System ("NPPES")

for itself or for any subpart of the Provider. Provider shall make best efforts to report its NPI and any subparts to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider shall use its NPI to identify itself on all claims and encounters (both electronic and paper formats) submitted to Health Plan.

e. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify,

confirm, and/or assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.

e. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Promotional Activities.** At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) shall cooperate with and participate in all reasonable Health Plan's marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.8 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act

(42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider shall deliver copies of such insurance policies to Health Plan within five business days of a written request by Health Plan.

2.9 **Claims Payment**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within ninety (90) days of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments and Deductibles.** Provider is responsible for collection of co- payments and deductibles, if any.

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.

e. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan, who receives a global capitation from Health Plan for both professional and facility services and is responsible for arranging for Covered Services through subcontract arrangements ("Capitated Provider"), that Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

2.10 **Claims Review.**

a. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider's intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider's operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in a one (1) day admission, Health Plan reserves the right to retrospectively review such claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition. Health Plan will not retrospectively deny payment for any services rendered by Provider in good faith pursuant to the prior authorization of Health Plan.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or

prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless Provider's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.

c. **Reporting Requirements.** Provider's failure to comply with Health Plan's requirements regarding Provider's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.

d. **Offset.** In the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days notice in which to exercise Provider's appeal rights under this Agreement. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

e. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits.

Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

2.11 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to state licensing statutes and regulations set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.

c. Provider acknowledges that all Covered Services rendered in conjunction with the Medicare program are subject to the Medicare provisions set forth in Attachment H, the effect of which provisions is limited solely to activities and Covered Services related to the Medicare program.

2.12 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.13 **Fraud and Abuse Reporting.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to

and during the course of any such investigations.

2.14 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self- Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2.15 **Reciprocity Agreements.** Provider shall cooperate with Health Plan's Participating Providers and affiliates of Health Plan and agrees to provide Covered Services to Members enrolled in various government sponsored health programs and other health products, and various government sponsored health programs and other health products of affiliates, and to assure reciprocity of health care services. Without limiting the foregoing, if any Member receives services or treatment constituting Covered Services from Provider and a capitated Participating Provider is financially responsible for such services, such Participating Provider shall be solely responsible for compensating Provider for any Covered Services provided by the Provider in accordance with the applicable Payments which are the Responsibility of a Capitated Provider provisions of this Agreement. Payment by the Participating Provider shall be at; (i) the rates agreed by the Participating Provider and Provider, or (ii) if there is no applicable agreement, at the lesser of Provider's billed charges or an amount equivalent to one hundred percent (100%) of the governing rates provided by applicable State and Federal Law specific to the Member's enrolled benefit plan (i.e. Medicaid, Medicare, etc) in place at the time services are rendered, or (iii) at the election of the Participating Provider, at the rates set forth in this Agreement. Provider agrees that the applicable provisions of the Compensation section of this Agreement shall continue to be binding upon Provider, especially in that Provider shall not balance bill Members for any Covered Services. Provider shall comply with the procedures established by Health Plan or its affiliates and this Agreement for reimbursement of such services or treatment. Provider shall not encourage Members to receive Covered Services from non-Participating Providers. Breach of this section shall constitute breach of a material term of the Agreement and will give rise to cause for termination of this Agreement pursuant to the applicable Termination with Cause provisions of this Agreement. Provider shall abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

ARTICLE THREE — HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member

eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be in the interest of the Member.

3.5 **Provider Directory.** Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of both the; (i) medical, and (ii) medically-related scientific and technical, aspects of Health Plan.

ARTICLE FOUR — TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for one year; thereafter, it shall automatically renew for successive one year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable provisions set forth in the attachments.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least one hundred and twenty (120) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty

(30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

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

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

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

h. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.

ARTICLE FIVE — GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees,

agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The contract between the state and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend this Agreement only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without

the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules then in effect by a single arbitrator in Long Beach, CA; provided, however, that binding arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters. If possible, the arbitrator shall be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor shall the arbitrator have the authority to award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement

Attachment A — Provider Identification Sheet
Attachment B — Definitions
Attachment C — Products/Programs
Attachment D — Compensation Schedule
Attachment E — Licensing Provisions
Attachment F — Medicaid Program Provisions
Attachment G — Acknowledgment of Receipt of Provider Manual
Attachment H — Medicare Program Provisions
Attachment I — Disclosure Form
Attachment J — Certificate of Ownership

5.10 **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:
Molina Healthcare of California
200 Oceangate, Suite 100, Long Beach, California, 90802
Attention: President/CEO

If to Provider:
Pacific Hospital of Long Beach

Attention: Michael D Drobot, CEO

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

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

SIGNATURE AUTHORIZATION

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

Pacific Hospital of Long Beach		**Molina Healthcare of California**	
Provider Signature:	/s/ M. Drobot	Molina Signature:	/s/ Lisa Rubino
Signatory Name (Printed):	M. Drobot	Signatory Name (Printed):	Lisa Rubino
Signatory Title (Printed):	CEO	Signatory Title (Printed):	President
Signature Date:	4/16/09	Signature Date:	4/30/09
		Effective Date:	(To be completed by Health Plan)

ATTACHMENT A

Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

_____	Primary Care Physician	_____
_____	Specialist: type	_____
		_____
_____	Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)	
X	Hospital	_____
_____	Ancillary Provider: type	_____
_____	Pharmacy	_____
_____	Other: type	_____

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

Provider Name	Pacific Hospital of Long Beach	Billing Address:
Telephone No.	562-997-2500	P O Box 77417, Los Angeles, CA, 90084
Facsimile No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.		_____
NPI (or UPIN if NPI not yet designated)	NPI: 1861407637 UPIN:	
DEA No.		

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

Provider Signature:	/s/ M. Drobot
Signatory Name (Printed):	M. Drobot
Signatory Title (Printed):	CEO
Signature Date:	4/16/09

ATTACHMENT A
Provider Identification Sheet (Continuation Page)

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Health Plan under more than one TIN and/or billing address. Please enter "N/A" for the following if not applicable or not available:

Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
Email Address		State, Zip ,
Tax I.D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,
Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
Email Address		State, Zip ,
Tax I.D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,
Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
Email Address		State, Zip ,
Tax I.D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,
Provider Name		Billing Address:
Telephone No.		Street
Facsimile No.		City
Email Address		State, Zip ,
Tax I.D. No.		Physical Address:
License No.		Street
NPI (or UPIN if NPI	NPI:	City
not yet designated)	UPIN:	
DEA No.		State, Zip ,

ATTACHMENT B

Definitions

1. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

2. **Agreement** means this Provider Services Agreement, all Attachments, and incorporated documents or materials.

3. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.

4. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

5. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.

6. **CMS Agreement** means the Medicare Advantage contract between Health Plan and CMS.

7. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.

8. **Emergency Services are Covered Services** necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid / Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.

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

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

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

12. **IPA** means Independent Practice Association.

13. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

14. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

15. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D services.

16. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

17. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

18. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a Group/IPA or Hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Group/IPA or Hospital. All of said persons are bound by the terms of this Agreement.

19. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

20. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

21. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

22. **Utilization Management Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event that Provider is de-delegated responsibility for utilization management.

ATTACHMENT C

Products/Programs

Provider hereby elects to participate as a panel provider for each of the following Health Plan products as offered and applicable.

_____	1.	Medi-Cal Primary Care Case Manager
_____	2.	Medi-Cal Prepaid Health Plan
_____	3.	Medi-Cal Geographic Managed Care
X	4.	Medi-Cal Two-Plan Model
X	5.	Healthy Families
X	6.	Medicare Advantage (Molina Medicare Options)
X	7.	MA-SNP (Molina Medicare Options Plus)
_____	8.	Other Products — Provider agrees that Health Plan may from time to time add additional products for which provider agrees to participate as a contracted provider

Health Plan shall maintain any applicable benefit and Covered Services descriptions in its Provider Manual.

ATTACHMENT D

Compensation Schedule
Pacific Hospital of Long Beach
Medi-Cal & Healthy Families

Molina shall pay Provider on a fee for service basis at the lesser of: (i) Provider's billed charges; or (ii) in accordance with the fee schedule set forth below for all Covered Services provided to a Member, which are authorized, by Molina or its designee for Molina Healthcare's Managed Medi-Cal & Healthy Family Members, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

SERVICE DESCRIPTION	APPLICABLE CODES (if designated)	PAYMENT RATES
Medical/Surgical	UB: 100, 101, 110, 111, 112, 117, 119, 120, 121, 127, 129, 130, 131, 132, 137, 139, 140, 141, 142, 147, 149, 150, 151, 152, 157, 159, 160, 164, 169,	$1,200 Per Diem
DOU	UB: 206, 214	$1,200 Per Diem
ICU/CCU	UB: 200, 201, 202, 207, 208, 209, 210, 211, 213, 219	$1,300 Per Diem
OB Vaginal Delivery 2 days	DRG's 767, 768, 774, 775 includes One well baby defined by UB codes 170 or 171 Additional baby is Reimbursed at Boarder Baby Rate	$2,400 Case Rate
OB C-Section 3 days	DRG-765, 766 includes one well baby defined by UB codes 170-or 171	$3,600 Case Rate
Outpatient Diagnostic Services/Emergency Room Procedures	UB: 300-319, UB: 320-359, UB: 610-619; UB: 730-749, UB: 450-459, UB: 351, 352, 359	105% of Medi-Cal
Outpatient Surgery	UB: 360, 361, 369, 490, 499, 500	100% of applicable APC. Multiple procedures shall be reimbursed according to the Medicare guidelines.
Partial Psych Care	UB: 114, 124, 134, 154, 513	$600.00 Case Rate
Exclusions	UB: 274, 275, 276, 278	The following items with a cost greater than $500.00 are excluded from the rates above and shall be reimbursed at a rate of Hospital Cost plus 5%: Implantable devices (including non-reusable orthopedic instrumentations, spinal cages, alugraphs, putty, pacemakers, leads, orthotics and prosthetics.

ATTACHMENT D-1

Compensation Schedule

Pacific Hospital of Long Beach
Molina Medicare Options (MMO) &
Molina Medicare Options Plus (MMOP)

Molina shall pay Provider on a fee for service basis at the lesser of: (i) Provider's billed charges; or (ii) in accordance with the fee schedule set forth below for all Covered Services provided to a Member, which are authorized, by Molina or its designee for Molina Healthcare's Managed Molina Medicare Options & Molina Medicare Options Plus Members, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

INPATIENT SERVICES:
Inpatient Services with Codable Medicare DRGs:

- Health Plan agrees to reimburse Provider **one hundred percent (100%)** of the prevailing Medicare Inpatient Prospective Payment System **(DRG)** in effect at the time of service. Such Medicare DRG reimbursement will include DME, IME, DSH, Capital, and all other Medicare payments, including outliers.
- This reimbursement methodology is not intended to imply any governance or regulations set forth by Centers of Medicare and Medicaid Services (CMS), but is used to describe the type of mathematical reimbursement formula agreed upon by Provider and Health Plan.
- Provider uses its Fiscal Intermediary to administer their Medicare program. The Fiscal Intermediary calculates and updates factors used in the calculation of the Medicare reimbursement formulas, which will be adopted for use in this Agreement. Any change in the reimbursement formula factors, including, but not limited to, changes in DRG definitions to comply with industry mandated standards, will be applicable to the reimbursement set forth in this Agreement, effective concurrently with the effective date of updates to the Inpatient PPS PC Pricer.

OUTPATIENT SERVICES

- Health Plan agrees to reimburse Provider at **one hundred percent (100%)** of the prevailing Medicare Ambulatory Payment Classification **(APC)** in effect at the time services are rendered.

ARTICLE FIVE — NOTATIONS

6.1 Capitalized terms utilized in this Attachment, which are not otherwise defined in this Attachment, if any, shall have the same meaning set forth in the definitions to this Agreement.

6.2 Unless otherwise set forth above, the stipulated Hospital Provider payment rates shall apply to all Professional Clean Claims submitted by Hospital Providers.

ATTACHMENT E

REQUIRED PROVISIONS

(Health Care Service Plans)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

DMHC Provisions

1. In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan. Provider shall not collect or attempt to collect from a Member or subscriber any sums owed to Provider by the Health Plan. Provider may not and will not maintain any action at law against a Member or subscriber to collect sums owed to the Provider by Health Plan. (Health and Safety Code section 1379)
2. To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system. (Rule 1300.51, J-5)
3. Provider is responsible for coordinating the provision of health care services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))
4. Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))
5. Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))
6. To the extent Provider has any role in rendering emergency health care services, Provider shall make such emergency health care services available and accessible twenty-four (24) hours a day, seven days a week. (Rule 1300.67.2(c))
7. Provider shall participate in Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or inability to maintain Health Plan's access standards. (Rule 1300.67(f))

8. Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 of the Health and Safety Code), and the Regulations promulgated hereunder (subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulation that is required to be in this Agreement shall bind the Health Plan whether or not expressly set forth in this Agreement. (Rule 1300.67.4(a)(9))

9. Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Section 1345 of the Health and Safety Code) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code section 1373.96) (Rule 1300.67.4(a)(10))

10. Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f)

11. Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least two years: this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code section 1381) (Rule 1300.67.8(b))

12. Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c))

13. Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services. Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and

offsetting the cost of the same against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))

14. Upon Health Plan's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code section 1385)

15. To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)

16. Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Provider Services Department, Molina Medical Centers, Third Floor, One Golden Shore Drive, Long Beach, CA 90802 (800) 526-8196, ext. 1249. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)

17. Provider shall display in each reception and waiting area a notice informing Members how to contact their health plan, file a complaint with their plan, obtain assistance from the DMHC, and seek an independent medical review. (Rule 1300.67.8(f))

18. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68(b))

19. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code section 3040.

20. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend the Provider Manual only after forty-five (45) business days prior written notice to Provider and only if

mutually agreed to by the parties as evidenced by the amendment being executed by each party.

21. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider is not the primary payer under coordination of benefits, Provider may submit claims to Health Plan or Health Plan's capitated provider within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

22. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider denies a claim because it was filed beyond the claim filing deadline, Health Plan will, upon Provider's submission of a provider dispute pursuant to Title 28, California Code of Regulations, section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to California Health & Safety Code section 1371 or 1371.35, which ever is applicable, and the California Code of Regulations.

ATTACHMENT F

DHCS Provisions

The following provisions apply exclusively to Covered Services provided and activities engaged in pursuant to Medicaid Program:

1. All Medicaid covered services are set forth in Attachment C and the Provider Manual as set forth in this Agreement. (Rule 53250(c)(1))
2. This Agreement shall be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Health Plan. (Rule 53250(c)(2))
3. This Agreement shall become effective upon approval by the Department of Health Care Services ("DHCS") in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within 60 days of receipt. (Rule 53250(c)(3))
4. Amendments to this Agreement shall be submitted to the DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the Amendment, whichever is later. (Rule 53250(c)(3))
5. Provider agrees to submit all reports required and requested by Health Plan, in a form acceptable to Health Plan. (Rule 53250(c)(5))
6. Provider shall make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:
   a. By the DHCS, the United States Department of Health and Human Services, the DMHC, and the Department of Justice;
   b. At all reasonable times, at Provider's place of business or at such other mutually agreeable location in California;
   c. In a form maintained in accordance with the general standards applicable to such book or record keeping;
   d. For a term of at least five years from the close of the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created;

e. Including all encounter data for a period of at least five years. (Rule 53250(e)(1))

7. Provider agrees to notify the DHCS in the event that this Agreement is amended or terminated. Notice to the DHCS shall be considered given when properly addressed and deposited in the United States Postal Service as First Class Registered Mail, postage attached.
(Rule 53250(e)(4))

8. Provider shall maintain and make available to the DHCS, upon request, copies of all subcontracts and shall ensure that all subcontracts are in writing and require that subcontractors:

   a. Make all applicable books and records available at all reasonable times for inspection, examining or copying by the DHCS, the U.S. Department of Health and Human Services, the DMHC, and the Department of Justice;

   b. Retain such books and records for a term of at least five years from the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created. (Rule 53250(e)(3))

9. Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. (Rule 53250(e)(5))

10. Provider agrees to hold harmless both the State of California and Health Plan members in the event that Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. (Rule 53250(e)(6))

11. Provider shall assist Health Plan in the transfer of care in the event Health Plan's Two-Plan Model Contract with the DHCS expires or terminates. Providers shall assist Health Plan in the transfer and care in the event this Agreement expires or terminates for any reason.

12. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers' compensation. Provider shall report to the DHCS within ten (10) days after discovery any circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation award. (Rule 53222(b))

13. Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider, if any, and major creditors holding more than five percent (5%) of the dept of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (W&I Code section 14452(a))

14. Provider acknowledges that Health Plan bears significant risk by assuming financial responsibility for all in-patient hospitalization expenditures, including expenditures for services connected with the period of hospitalization. (Rule 53251(c) & (e))

15. Non-Discrimination Clause. During the performance of this Agreement, Provider and Provider's subcontractors will not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and denial of family care leave. Provider and Provider's subcontractors will ensure the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. Provider and Provider's subcontractors will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et. seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990(a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and Provider's subcontractors as the case may require will give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

16. Provider agrees to arrange for the provision of interpreter services for Members at all provider sites.

17. Nothing in this Agreement shall be interpreted in any manner to terminate or diminish Health Plan's independent obligations to the State of California under one or more of its contracts with the Department of Health Services.

Upon request by DHCS, Provider shall timely gather, preserve and provide to DSHS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan's contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms

specified in Health Plan’s contract with DHCS.

ATTACHMENT G

Acknowledgement of Receipt of Provider Manual

Provider hereby acknowledges receipt of Health Plan's Provider Manual.

Date of receipt: 4|16|09

Initials of authorized
representative of Provider: /s/ Michael D. Drobot

ATTACHMENT H

Medicare Program Provisions

The following provisions apply to all services rendered in conjunction with Health Plan's Medicare Programs as set forth in Attachment C to this Agreement. The Agreement shall be automatically modified to conform to subsequent amendments to Medicare standards. Any purported modification to the Agreement inconsistent with Medicare standards is not effective. In the event of any inconsistency between the terms of this Attachment and the terms of the Agreement, the terms of this Attachment shall control.

1. Right to Audit. Provider shall make all of its "Relevant Records" available for inspection, examination and copying by all federal and state agencies with regulatory authority over the subject matter of this Agreement. Provider shall permit such inspection at Provider's place of business and at all reasonable times. "Relevant Records" shall mean all books and records of Provider related directly or indirectly to the goods and services furnished under the terms of this Agreement. Provider shall maintain such Relevant Records for the period of time required by applicable federal and state statutes, but in no event less than ten (10) years. This provision shall survive termination of the Agreement. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

2. Confidentiality. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

3. Hold Harmless. Provider agrees that under no circumstance shall a subscriber or enrollee be liable to the Provider for any sums owed by Health Plan to the Provider. (42 CFR 422.504(g)(1)(i).

4. Delegation. If Provider is delegated any of the activities or functions of Health Plan as required in the CMS Agreement, Provider agrees to comply with all applicable contractual provisions in the same manner as if Provider had executed such contract with CMS directly. The activities or functions delegated to Provider are set forth in the Agreement. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. Health Plan shall monitor the performance of such delegated activities on an ongoing basis, and Provider shall cooperate with all reasonable requests made by Health Plan in order to accomplish such monitoring. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or

terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(3)(iii), 422.504(i)(4)) and 422.504(i)(5).

5. Medicare Claims Payment. Health Plan and Provider agree that Health Plan shall pay all Clean Claims within sixty (60) days of the date such claim is delivered by Provider to Health Plan and Health Plan determines such claim is complete/clean. Any claims that are not submitted to Health Plan within six (6) months of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. Health Plan shall pay interest on Clean Claims that are not paid within sixty (60) days for the period beginning on the day after the required payment date and ending on the date on which payment is made. Interest shall be computed at the rate of interest provided under 41 U.S.C. §611. (42 CFR 422.520(b)).

6. Reporting. Provider shall comply with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 422.257. (42 CFR 504(a)(8)).

7. Accountability. Provider acknowledges and agrees that Health Plan is accountable to CMS for overseeing any functions or responsibilities delegated to Provider. (42 CFR 422.504(i)(3)(ii)(A)).

8. Medicare Compliance. Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

9. Benefit Continuation. Notwithstanding the termination of the Provider Agreement, Provider shall not abandon any Medicare patients, and shall continue to see and treat those patients requiring ongoing medical care (including, but not limited to, patients that are hospitalized on the termination date of the Provider Agreement) on the same terms and conditions as prior to termination, and shall continue to see and treat such ongoing patients until such time as such patients may be transitioned to another appropriate medical provider (or, if applicable, such patients are discharged from the hospital). (42 CFR 422.504(g)(2)(I), 422.504(g)(2)(ii), and 422.504(g)(3)).

ATTACHMENT I

DISCLOSURE FORM

(Welfare and Institutions Code Section 14452 (a))
HealthSmart Pacific, Inc., dba

Name of Subcontractor **Pacific Hospital of Long Beach**

The undersigned hereby certifies that the following information regarding **Pacific Hospital of Long Beach** (the "Organization") is true and correct as of the date set forth below.

1. Officers/Directors General Partners: Please see attachment
2. Co-Owner(s):
3. Stockholders owning more than ten percent (10%) of the stock of the Organization:

   Abraws Healthcare, Inc.
4. Major creditors holding more than five percent (5%) of Organization's debt:

   East West Bank, Future Opportunities, LLC
5. Form of Organization (Corporation, Partnership, Sole Proprietorship, Individual):

   Corporation
6. If not already disclosed above, is Organization, either directly or indirectly, related to or affiliated with the Contracting Health Plan? Explain:

   Yes. Faustino Bernadette

Date: 4/11/09

By: /s/ M. Drobot
Print Name: M. Drobot
Title: CEO

HealthSmart Pacific, Inc. dba
Pacific Hospital of Long Beach

Officers/Directors/General Partners:

Chairman of the Board	**Faustino Bernadett, M.D.**
Chief Executive Officer	**Michael D. Drobot**
President	**Clark Todd**
Treasurer	**G. William Hammer**
Secretary	**Michael J. Tichon**

ATTACHMENT J

CERTIFICATE OF OWNERSHIP

I, Mr. Drobot, an authorized representative of **Pacific Hospital of Long Beach**, do certify that, to the best of my knowledge, the individuals or entities listed below have a five percent or more ownership, direct or indirect, or control interest in the aforementioned entity as defined under 42 U.S. C. Section 1320 a 3 (2). This form is to be submitted annually to the organization contracting with the Managed Risk Medical Insurance Board for the Healthy Families Program and/or Access to Infants and Mothers Program.

Name of Individual/Entity	Employer Identification Number	Social Security Number
/s/ Tino Bernadett		

o No one is listed because there are no individuals or entities with a five (5%) percent or more interest

o No one is listed because the plan is under government ownership.

o No one is listed because the provider of services is a non-profit, public benefit corporation for which there are no outside controlling interests.

/s/ Michael D. Drobot CEO 4/16/09

Signature of Authorized Representative and Title Date

HOSPITAL SERVICES AGREEMENT

This Hospital Services Agreement ("Agreement") is entered by and between Molina Healthcare of California, a California corporation ("Health Plan"), and HealthSmart Pacific, Inc., dba Pacific Hospital of Long Beach ("Provider").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE — DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B.

ARTICLE TWO — PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall provide hospital inpatient and/or outpatient services to Members, as are specifically set forth in Attachment C. Provider agrees that its practice information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Facility Information includes, but is not limited to, name, address, telephone number, hours of operation, and services. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member as an inpatient or outpatient, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Provider shall notify Health Plan or its agent within twenty-four (24) hours of admission and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan's notification procedures described in Provider Manual for all inpatient (acute, rehabilitation, mental health and SNF) and outpatient admission on the same day of admission or at a maximum within twenty-four (24) hours of admission.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("participating providers").

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

g. **Availability of Services.** Provider shall make Covered Services available 24 hours a day, 7 days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

2.3 **Standards for Hospital Providers**

a. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Provider's contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information.** Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(c) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious

deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.

e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's contracted providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider's medical staff and the bylaws, rules and regulations of Provider.

f. **Notification.** Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider's notification to Health Plan shall state Provider's actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping**

a. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

e. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of

state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 **Program Participation**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.

e. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Promotional Activities.** At the request of Health Plan, Provider shall (1) display Health Plan promotional materials in its offices and facilities as practical, and (2) shall cooperate with and participate in all reasonable Health Plan's marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.8 **Licensure and Standing**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Provider shall deliver copies of such insurance policies to Health Plan within five business days of a written request by Health Plan.

2.9 **Claims Payment**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within 180 days of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider does not waive any AB-1455 right to payment.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments and deductibles, if any.

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.

e. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan, who receives a global capitation from Health Plan for both professional and facility services and is responsible for arranging for Covered Services through subcontractual arrangements ("Capitated Provider"), that Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

2.10 **Claims Review**

a. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider's intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider's operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in more than a one (1) day admission, Health Plan reserves the right to retrospectively review such claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition. Health Plan will not retrospectively deny payment for any services rendered by Provider in good faith pursuant to the prior authorization of Health Plan.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless Provider's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.

c. **Reporting Requirements.** Provider's failure to comply with Health Plan's requirements regarding Provider's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.

d. **Offset.** In the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days notice in which to exercise Provider's appeal rights under this Agreement. As a material condition to Health Plan's obligations under this Agreement, Provider agrees

that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider. Health Plan may not offset any claim that date-of-services is older than 360 days, unless Health Plan can show just cause for delay of submission from provider, according to AB-1455 regulations.

e. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

2.11 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to applicable state licensing statutes and regulations. Accordingly, Provider shall abide by those provisions set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.

2.12 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Provider Services Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.13 **Fraud and Abuse Reporting.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to and during the course of any such investigations.

2.14 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

ARTICLE THREE — HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be in the interest of the Member.

3.5 **Provider Directory.** Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of the scientific, technical, and medical aspects of Health Plan.

ARTICLE FOUR — TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the first day of the month immediately following the date this Agreement is signed by Health Plan (Effective Date) and shall continue in effect for one year; it shall automatically renew for successive one year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state licensing statutes and regulations set forth in Attachment E and Attachment F.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least 120 days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have 30 days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this 30-day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such 30-day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority:

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

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

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

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

h. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety

ARTICLE FIVE — GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is

intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The contract between the state and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement. Health Plan may otherwise materially amend this Agreement only after 45 business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Arbitration.** Any controversy between Health Plan and Provider shall be resolved, to the extent possible, within forty-five (45) days by informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining controversies or claims which, when determined on a cumulative basis, exceed $10,000 or more, arising from or related to this Agreement and the rendition of services to Members pursuant to this Agreement, shall be settled by binding arbitration; provided, however, that binding arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be

available as a mechanism for appeal of any determinations made as to such matters. The arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules then in effect, and shall be conducted by a single arbitrator in Long Beach, California. The arbitrator shall be an attorney with at least fifteen years of experience, including at least five in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law. Nor shall the arbitrator have the authority to award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept the arbitrator's decision as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction hereof. Any arbitration must be initiated within one year after the controversy or claim arises, is discovered or should have been discovered with reasonable diligence; if not so initiated, any such claim shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement:

Attachment A — Provider Identification Sheet
Attachment B — Definitions
Attachment C — Products/Programs
Attachment D — Compensation Schedule
Attachment E — Licensing Provisions
Attachment F — Medicaid Program Provisions
Attachment G — Acknowledgment of Receipt of Provider Manual
Attachment H — Division of Financial Responsibility — Medicare Advantage

/s/ David C. Zembik
Molina Healthcare of California

David C. Zembik
Name (printed)

Executive Director
Title

Date 6/19/06

SIGNATURE AUTHORIZATION

The individual signing below on behalf of Provider-acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

HealthSmart Pacific Inc.
dba Pacific Hospital of Long Beach

"Provider"

/s/ Faustino Bernadett
By

CEO
Title

Faustino Bernadett
Name (printed)

Date 6/1/06

ATTACHMENT A
Provider Identification Sheet

(Initial applicable category)

_____ Primary Care Physician

_____ Specialist: type _____

_____ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)

X Hospital

_____ Ancillary Provider: type _____

_____

_____ Pharmacy

_____ Other: type _____

Provider Name HealthSmart Pacific, Inc. dba Pacific Hospital of Long Beach Address 2776 Pacific Avenue, Long Beach, CA 90806

Telephone No. (562) 595-1911
Facsimile No. (562) 492-1363
Tax I.D. No.
License No.
UPIN
DEA No.

All capitated managed care activities are administered by:
HealthSmart Management Services Organization, Inc.
P.O. Box 7110
Newport Beach, CA 92658-7110
Attn: President

Tel: (949) 999-3700
Fax: (949) 999-3806

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

/s/ Faustino Bernadett Date: 6/1/06
Provider Signature

Faustino Bernadett
(Name)

CEO
(Title)

ATTACHMENT B

Definitions

Agreement means this Provider Services Agreement, all Attachments, and incorporated documents or materials.

1. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.
2. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
3. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.
4. **Credentialing Payment Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event Provider is dedelegated responsibility for credentialing.
5. **Emergency Services** are Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid/Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.
6. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.
7. **Health Plan** means Molina Healthcare of California
8. **HEDIS Studies** means Health Employer Data and Information Set.
9. **IPA** means Independent Practice Association.

10. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

11. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

12. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a Group/IPA or Hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Group/IPA or Hospital. All of said persons are bound by the terms of this Agreement.

13. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

14. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

15. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

16. **Utilization Management Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event that Provider is de-delegated responsibility for utilization management.

ATTACHMENT C

Products/Benefits Inventory

Provider hereby elects to participate as a panel provider for each of the Health Plan products initialed below.

_____ 1. Medi-Cal Primary Care Case Manager
(Description of benefits appended as Attachment C-1)

_____ 2. Medi-Cal Prepaid Health Plan
(Description of benefits appended as Attachment C-2)

_____ 3. Medi-Cal Geographic Managed Care
(Description of benefits appended as Attachment C-3)

_____ 4. Medi-Cal Two-Plan Model
(Description of benefits appended as Attachment C-4)

_____ 5. Healthy Families
(Description of benefits appended as Attachment C-5)

_____ 6. Commercial
(Description of benefits appended as Attachment C-6)

X 7. Medicare
(Description of benefits appended as Attachment C-7)

_____ 8. Other Products
Provider agrees that Health Plan may from time to time add additional products for which provider agrees to participate as a contracted provider

Provider hereby acknowledges receipt of a description of the benefits for each of the Health Plan products initialed above.

Initials of authorized
representative of Provider:

ATTACHMENT D

Compensation Schedule

Pacific Hospital of Long Beach (Capitated Hospital) full risk with Pacific Healthcare IPA Medical Associates, Inc.

Medicare Advantage (Special Needs Program) Capitation Payment Amount:

43% of the CMS Premium*

Capitation Payments to Provider shall be made to the Provider by the 10th day of each month.

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* The gross revenue Molina receives each month from CMS, as determined by CMS for Parts A, B and Medi-Cal portion only, as determined by CMS, for the medical coverage of each member, including the Medicare rebates and retro-active payments. The revenue shall not be deducted to pay for any or all broker fees nor deducted from the gross revenue prior to the capitation split.

Initials of authorized
representative of Provider:

ATTACHMENT E

REQUIRED PROVISIONS
(HEALTH CARE SERVICE PLANS)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

1. In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan. Provider shall not collect or attempt to collect from an Member or subscriber any sums owed to Provider by the Health Plan. Provider may not and will not maintain any action at law against an Member or subscriber to collect sums owed to the Provider by Health Plan (Health and Safety Code section 1379)
2. To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system.
(Rule 1300.51, J-5)
3. Provider is responsible for coordinating the provision of health care services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))
4. Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))
5. Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))
6. To the extent Provider has any role in rendering emergency health care services, Provider shall make such emergency health care services available and accessible 24 hours a day, seven days a week.
(Rule 1300.67.2(c))

Initials of authorized
representative of Provider:

7. Provider shall participate in Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or inability to maintain Health Plan's access standards. (Rule 1300.67(f))

8. Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 of the Health and Safety Code), and the Regulations promulgated hereunder (subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulation that is required to be in this Agreement shall bind the Health Plan whether or not expressly set forth in this Agreement. (Rule 1300.67.4(a)(9))

9. Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Section 1345 of the Health and Safety Code) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code section 1373.96) (Rule 1300.67.4(a)(10))

10. Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f)

11. Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least two years: this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code section 1381) (Rule 1300.67.8(b))

Initials of authorized
representative of Provider:

12. Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c))

13. Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services, Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and offsetting the cost of the same against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))

14. Upon Health Plan's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code section 1385)

15. To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)

16. Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Provider Services Department, Molina Medical Centers, Third Floor, One Golden Shore Drive, Long Beach, CA 90802 (800) 526-8196, ext. 1249. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)

17. Provider shall display in each reception and waiting area a notice informing Members how to contact their health plan, file a complaint with their plan, obtain assistance from the DMHC, and seek an independent medical review. (Rule 1300.67.8(f))

Initials of authorized
representative of Provider:

18. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68(b))

19. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code section 3040.

20. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon 45 business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend the Provider Manual only after 45 business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party.

21. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider is not the primary payer under coordination of benefits, Provider may submit claims to Health Plan or Health Plan's capitated provider within 90 days from the date of payment or date of contest, denial or notice from the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within 90 days from the date of payment or date of contest, denial or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

Initials of authorized
representative of Provider:

22. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider denies a claim because it was filed beyond the claim filing deadline, Health Plan will, upon Provider's submission of a provider dispute pursuant to Title 28, California Code of Regulations, section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to California Health & Safety Code section 1371 or 1371.35, which ever is applicable, and the California Code of Regulations.

23. In the event Provider participates in Molina Advantage, the following provisions shall apply:

    a. Provider shall make all of its "Relevant Records" available for inspection, examination and copying by all federal and state agencies with regulatory authority over the subject matter of this Agreement. Provider shall permit such inspection at Provider's place of business and at all reasonable times. "Relevant Records" shall mean all books and records of Provider related directly or indirectly to the goods and services furnished under the terms of this Agreement. Provider shall maintain such Relevant Records for the period of time required by applicable federal and state statutes, but in no event less than ten (10) years. This provision shall survive termination of the Agreement. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

    b. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

    c. Provider agrees that under no circumstance shall a subscriber or enrollee in Molina Advantage be liable to the Provider for any sums owed by Health Plan to Provider. (42 CFR 422.504(g)(1)(i).

Initials of authorized
representative of Provider:

d. If Provider is delegated any of the activities or functions of Health Plan as required in its contract with CMS, Provider agrees to comply with all applicable contractual provisions in the same manner as if Provider had executed such contract with CMS directly. The activities or functions delegated to Provider are set forth in the Agreement. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. The performance of such delegated activities shall be monitored by Health Plan on an ongoing basis, and Provider shall cooperate with all reasonable requests made by Health Plan in order to accomplish such monitoring. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).

Initials of authorized
representative of Provider:

ATTACHMENT E-1

DMHC Financial Solvency Provisions

This Attachment is required to comply with the financial standards and reporting requirements Rules 1300.75.4 through 1300.75.4.8. References to the term "Rule" identity regulatory citations in Title 28 of the California Code of Regulations.

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

I. DEFINITIONS

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

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

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

1.4 **"DMHC"** means the California Department of Managed Health Care. Whenever the Solvency Regulations reference the Department, that reference includes the DMHC or its External Party.

Initials of authorized
representative of Provider:

1.5 **"External Party"** means the DMHC or its designated agent, which may be contracted or appointed to fulfill the functions stated in these Solvency Regulations.

1.6 **"Grading Criteria"** means the four grading/reviewing criteria specified in Health and Safety Code sections 1375.4(b)(1)(A)(i), (ii), (iii), and (iv) and the Cash-to-Claims Ratio as defined above.

1.7 **"Risk Arrangement"** is defined to include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(a) Risk-Sharing Arrangement means any compensation arrangement between Provider and Health Plan under which Provider shares the risk of financial gain or loss with Health Plan.

(b) Risk-Shifting Arrangement means a contractual arrangement between Provider and Health Plan under which Health Plan pays Provider on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by Provider.

1.8 **"Solvency Regulations"** means Rules 1300.75.4 through 1300.75.4.8.

II. OBLIGATIONS OF HEALTH PLAN

2.1 Monthly Membership Reports. Notwithstanding any different provisions of the Agreement, Health Plan will provide the following information to Provider on a monthly basis for members assigned to Provider, within ten (10) calendar days following the start of each month:

(a) Membership information containing at least the following elements for each member: i) identification number; ii) name; iii) birth date; iv) gender; v) address (including zip code); vi) benefit plan selected; vii) employer group identification (name and number); viii) identity of other third party coverage (if known); ix) dates of enrollment/disenrollment from Provider; x) Provider number; xi) primary care physician selected; xii) primary care physician effective date; xiii) type of change to coverage; xiv) co-payment amounts; xv) deductible (if applicable); xvi) amount of monthly capitation payment.

Initials of authorized
representative of Provider:

(b) The following additional information: i) member additions and terminations for the month (including at least: member name, member identification number); ii) number of additional members under each managed care plan; iii) number of terminated members under each managed care plan.

(c) Health Plan shall submit the information from Section 2.1(a) and 2.1(b) to Provider electronically, unless both Health Plan and Provider agree in writing that hard copy reports will be submitted instead.

(d) If the information from Section 2.1(a) and 2.1(b) above is provided to Provider in more than one report, all reports shall be processed by Health Plan on the same date.

(e) Within forty-five (45) calendar days of the close of each calendar quarter, Health Plan shall disclose to Provider a reconciliation of any variances between the reports for information listed in sections 2.1(a) and 2.1(b) above through electronic transmission, or in hard copy if mutually agreed upon by Provider and Health Plan.

2.2 Intentionally Left Blank.

2.3 Intentionally Left Blank.

2.4 Annual Financial Risk Disclosure. On the Agreement anniversary date each year, Health Plan shall disclose to Provider the financial risk assumed under the Agreement by providing to Provider the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under the Agreement:

(a) A matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Provider, a hospital(s) or Health Plan under the Risk Arrangement.

(b) Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

Initials of authorized
representative of Provider:

2.5 Annual Disclosure of Capitation Payments. On the Agreement anniversary date each year, Health Plan shall disclose to Provider the amount of capitation payments to be paid per member per month.

2.6 Capitation Deduction Detail. Health Plan shall provide to Provider sufficient details to allow Provider to verify the accuracy and appropriateness of any deductions from capitation payments made by Health Plan including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

III. OBLIGATIONS OF MEDICAL GROUP

3.1 Cash-to-Claims Ratio. Provider shall maintain at least the following Cash-to-Claims Ratio:

(a) 0.60 — January 1, 2006 through June 30, 2006
(b) 0.65 — July 1, 2006 through December 31, 2006
(c) 0.75 — January 1, 2007 and thereafter

3.2 Quarterly Financial Survey. No later than forty-five (45) calendar days following the close of each quarter of its fiscal year beginning on or after July 1, 2005, Provider agrees to submit a quarterly financial survey report in an electronic format to the DMHC as required by Rule 1300.41.8 of Title 28 of the California Code of Regulations as set forth below:

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

Initials of authorized
representative of Provider:

(i) A Financial survey report, (including a balance sheet, an income statement and a statement of cash flows), or comparable financial statements if Provider is a nonprofit entity, and supporting schedule information (including, but not limited to, aging of receivable information), reflecting the results of operations for the immediately preceding quarter, prepared in accordance with Generally Accepted Accounting Principles ("GAAP"). Financial survey reports must be on a combining basis with an affiliate, if Provider or such Provider affiliate is legally or financially responsible for payment of Provider's claims. Any affiliated entity included in this financial survey report must be separately identified in a combining schedule format. For the purposes of this section, Provider's use: (1) of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial - obligation to pay Provider's claims liability.

(ii) A claims report, which includes the percentage of claim's that have been timely reimbursed, contested or denied during the quarter by Provider in accordance with the requirements of sections 1371 and 1371.35 of the California Health & Safety Code, Rule 1300.71, and any other applicable state and federal laws and regulations. If less than ninety-five percent (95%) of all complete claims have been reimbursed, contested or denied on a timely basis, the claims report must also describe the reasons why Provider's claims adjudication process is not meeting the requirements of applicable law, any actions taken to correct the deficiency, and any results of the actions. This claims report is for the purpose of monitoring the financial solvency of Provider and is not intended to change or alter existing state and federal laws and regulations relating to claims payment settlement practices and timeliness.

Initials of authorized
representative of Provider:

(iii) A statement as to whether or not Provider has estimated and documented, on a monthly basis, its liability for ("IBNR") claims in accordance with Rule 1300.77.2 ("IBNR Statement") and that these estimates are the basis for the quarterly financial survey report submitted to the DMHC. If the estimated and documented liability is not in compliance with Rule 1300.77.2 in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider's failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and records on an accrual accounting basis shall result in Provider's failure to maintain, at all times, positive tangible net equity ("TNE") and positive working capital as set forth in section 3.2(a)(iv) below.

(iv) A statement as to whether or not Provider has maintained at all times throughout the quarter (1) a positive TNE as defined in Rule 1300.76(e) and (2) a positive level of working capital, calculated according to GAAP ("TNE/Working Capital Statement"). If either the required TNE or the required working capital has not been maintained at all times, a statement must be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider may reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital and Cash-to-Claim Ratio in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B) so long as the sponsoring organization has filed with the DMHC: (1) its audited annual financial statements within one hundred twenty (120) calendar days of the end of the sponsoring organization's fiscal year and (2) a copy of the written guarantee meeting the requirements of Health and Safety Code Rule 1375.4(b)(1)(B). For purposes of the Health and Safety Code Rule 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or TNE in a lesser amount approved by the DMHC, in situations where Provider can demonstrate to the DMHC's satisfaction that a lesser amount of TNE is sufficient. If Provider has a sponsoring organization, Provider shall provide a statement demonstrating the capacity of the sponsoring organization to guarantee Provider's debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code Section 1375.4(b)(1)(B).

Initials of authorized
representative of Provider:

(v) For the quarter beginning on or after January 1, 2006, a statement as to whether or not Provider has, at all times during the quarter, maintained a Cash-to-Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

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

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

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

3.3 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:

Initials of authorized
representative of Provider:

(a) An annual financial survey report, based upon Provider's annual audited financial statements, (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures) or comparable financial statements if Provider is a nonprofit entity, and supporting schedule information, (including, but not limited to, aging of receivable information and debt maturity information) for the immediately preceding fiscal year, prepared by an independent certified public accountant in accordance with GAAP. For the purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16 of the California Code of Regulations) shall apply.

(b) The financial survey reports of Provider shall be on a combining basis with an affiliate if Provider or such affiliate is legally or financially responsible for the payment of Provider's claims. Any affiliated entity included in the report shall be separately identified. Provider's use of: (1) a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay Provider's claims liability. When combined financial statements are required, the independent accountant's report or opinion must address all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, Provider shall also file the report or opinion issued by the other auditor.

(c) Opinion of an independent certified public accountant indicating whether Provider's annual audited statements present fairly, in all material respects, the financial position of Provider and whether the financial statements were prepared in accordance with GAAP. If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.

Initials of authorized
representative of Provider:

(d) An IBNR Statement consistent with the requirements outlined in section 3.2(a)(iii) of this Amendment. If the estimated and documented liability is not in compliance with Rule 1300.77.2 in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider's failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and records on an accrual accounting basis shall result in Provider's failure to maintain, at all times, positive tangible net equity ("TNE") and positive working capital as set forth in section 3.3(e) below.

(e) A TNE/Working Capital Statement consistent with the TNE reporting requirements as outlined in Section 3.2(a)(iv) of this Amendment. If either the required TNE or the required working capital has not been maintained at all times, the TNE/Working Capital Statement shall describe in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider may reduce its liabilities for purposes of calculating its TNE and working capital in a manner as required by Rule 1300.41.8 and as outlined in section 3.2(a)(iv) of this Amendment.

(f) For fiscal years beginning on or after January 1, 2006, a statement as to whether or not Provider has at all times during the year maintained a Cash-to Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(g) A statement as to whether Provider maintains reinsurance and/or professional stop-loss coverage.

(h) A copy of Provider's complete annual audited financial statement, including footnotes and the certificate or opinion of the independent certified public accountant.

Initials of authorized
representative of Provider:

3.4 Annual Statement of Organization Survey. Provider shall submit to the DMHC a "Statement of Organization," in an electronic format determined by the DMHC to be filed with Provider's annual financial survey report, Such Statement of Organization shall include the following information as of December 31 of each calendar year prior to the filing:

(a) Name and address of Provider;

(b) Financial and public contact person, with title, address, telephone, fax and e-mail address;

(c) A list of all health plans with which Provider has Risk Arrangements;

(d) Type of Provider: Independent Practice Association (IPA), Medical Group, Foundation or other entity, or some combination. If Provider is a foundation, identify each and every medical group within the foundation and whether any of those medical groups independently qualifies as a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g).

(e) Corporate status: professional corporation, partnership, not-for-profit corporation, sole proprietor or other form of business;

(f) The name, address and principal officer of each of Provider's affiliates as defined in Rule 1300.45(c)(1) and (2);

(g) Whether Provider is partially or wholly owned by a hospital or hospital system;

(h) A matrix listing all major categories of medical care offered by Provider, including but not limited to anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology, and radiology, and next to each listed category in the matrix a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by Provider to compensate the majority of providers of that category of care;

Initials of authorized
representative of Provider:

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

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

(k) Total number of contracted physicians in employment and/or contractual arrangements with Provider;

(l) Disclosure by California county or counties of Provider's primary service area (excluding out-of-area tertiary facilities and providers);

(m) Provider's address, telephone number and website link, if available, where providers may access written information and instructions for filing of provider disputes with Provider's dispute resolution mechanism consistent with requirements of Rule 1300.71.38;

(n) Any other information which the DMHC deems reasonable and necessary, as permitted by law, to understand the operational structure and finances of Provider.

3.5 Attestation. Provider shall submit a written verification for each report made under Sections 3.2, 3.3, and 3.4 of this Amendment stating that the report is true and correct to the best knowledge and belief of a principal officer of Provider, and signed by a principal officer, as defined by Rule 1300.45(o).

3.6 Notification to DMHC & Health Plan. Provider agrees to notify the DMHC and Health Plan no later than five (5) business days from discovering that Provider has experienced any event that materially alters its financial situation or threatens its solvency.

3.7 DMHC Evaluation of Provider. Provider shall:

(a) Permit the DMHC to make any examination that it deems reasonable and necessary to implement section 1375.4 of the Health and Safety Code, and provide to the DMHC for inspection and copying, upon request, any books or records that the DMHC deems relevant or useful in such examination, as permitted by law.

Initials of authorized
representative of Provider:

(b) Comply with the DMHC's review and audit process that is used to determine Provider's compliance with the Grading Criteria.

(c) Permit the DMHC to obtain and evaluate supplemental financial information pertaining to Provider when:

(i) Provider fails to satisfactorily demonstrate its compliance with the Grading Criteria;

(ii) Provider experiences an event that materially alters its ability to remain compliant with the Grading Criteria;

(iii) The External Party's review or audit process indicates that Provider may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of Rules 1300.70(b)(2)(H)(1);

(iv) The DMHC receives information from complaints submitted to the HMO Help Center, Health Plan reporting, medical audits and surveys or any other source that indicates Provider may be delaying referrals or authorizations or failing to meet access standards for basic health care services based on financial considerations.

IV. OBLIGATIONS OF MEDICAL GROUP & HEALTH PLAN

4.1 Corrective Action Plans. Provider and Health Plan shall comply with the DMHC's Corrective Action Plan ("CAP") process as set forth below.

(a) Beginning with the financial survey submission filed for the third quarter of calendar year 2005, in the event Provider has deficiencies in any of the Grading Criteria, it shall simultaneously submit a self-initiated CAP proposal, in an electronic format developed by the DMHC, to the DMHC and Health Plan that meets the following requirements:

(i) Identifies the Grading Criteria that Provider has failed to meet;

(ii) Identifies the amount by which Provider has failed to meet the Grading Criteria;

(iii) Identifies Health Plan and other Contracted Plans, including the identification of the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at Health Plan and each Contracted Plan for monitoring compliance with the CAP;

Initials of authorized
representative of Provider:

Exhibit 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2009	2008(1)	2007(1)	2006	2005
			(Dollars in thousands)		
Earnings:					
Income before income taxes	$ 43,616	$ 99,374	$ 92,722	$ 73,458	$ 43,851
Add fixed charges:					
Interest expense, including amortization of debt discount and exp	13,777	13,231	5,605	2,353	1,529
Estimated interest portion of rental expense	5,181	4,370	3,988	2,682	2,852
Total fixed charges	18,958	17,601	9,593	5,035	4,381
Total earnings available for fixed charges	$ 62,574	$ 116,975	$ 102,315	$ 78,493	$ 48,232
Fixed Charges from above	$ 18,958	$ 17,601	$ 9,593	$ 5,035	$ 4,381
Ratio of Earnings to Fixed Charges	3.3	6.6	10.7	15.6	11.0
Total rent expense	$ 20,723	$ 17,481	$ 18,127	$ 12,193	$ 9,505
Interest factor	25%	25%	22%	22%	30%
Interest component of rental expense	$ 5,181	$ 4,370	$ 3,988	$ 2,682	$ 2,852

(1) The Registrant's condensed statements of income for the years ended December 31, 2008 and 2007 have been recast to reflect the adoption of FASB ASC Subtopic 470-20, *Debt with Conversion and Other Options* (see Note 1 of the notes to consolidated financial statements).

Exhibit 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Nevada, Inc.	Nevada
Molina Healthcare Insurance Company	Ohio
Alliance for Community Health LLC, dba Molina Healthcare of Missouri	Missouri
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Virginia, Inc.	Virginia
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the Registration Statements (Forms S-8, No. 333-108317, No. 333-138552 and No. 333-153246) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan, and 2002 Employee Stock Purchase Plan, and in the Registration Statement (Form S-3, No. 333-155995) and related Prospectus of Molina Healthcare, Inc. for the registration of $300,000,000 of its securities, of our reports dated March 16, 2010, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2009.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 16, 2010

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2009 of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Joseph M. Molina
Joseph M. Molina
Chief Executive Officer and President

March 16, 2010

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2009, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ JOHN C. MOLINA
John C. Molina, J.D.
Chief Financial Officer and Treasurer

March 16, 2010

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2009 as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Joseph M. Molina
Joseph M. Molina, M.D.
Chief Executive Officer and President

March 16, 2010

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2009 as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN C. MOLINA
John C. Molina, J.D.
Chief Financial Officer and Treasurer

March 16, 2010

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.