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# UNITED STATES
# SECURITIES AND EXCHANGE COMMISSION
**Washington, D.C. 20549**

# Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2006

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 001-31719

# 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.)** |
| **One Golden Shore Drive, Long Beach, California** | **90802** |
| **(Address of principal executive offices)** | **(Zip Code)** |

**(562) 435-3666**
**(Registrant's telephone number, including area code)**

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☒ Non-accelerated filer ☐

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

The number of shares of the issuer's Common Stock, par value $0.001 per share, outstanding as of August 7, 2006, was 28,005,413.

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**Part I – Financial Information**

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## PART I - FINANCIAL INFORMATION

**Item 1: Financial Statements.**

### MOLINA HEALTHCARE, INC.

### CONDENSED CONSOLIDATED BALANCE SHEETS
**(amounts in thousands, except share data)**

| | June 30, 2006 (unaudited) | December 31, 2005 |
|---|---|---|
| **ASSETS** | | |
| **Current assets:** | | |
| Cash and cash equivalents | $ 312,118 | $ 249,203 |
| Investments | 94,570 | 103,437 |
| Receivables | 77,201 | 70,532 |
| Income tax receivable | 4,785 | 3,014 |
| Deferred income taxes | 2,878 | 2,339 |
| Prepaid expenses and other current assets | 7,534 | 10,321 |
| Total current assets | 499,086 | 438,846 |
| Property and equipment, net | 34,093 | 31,794 |
| Goodwill and intangible assets, net | 150,699 | 124,914 |
| Restricted investments | 18,302 | 18,242 |
| Receivable for ceded life and annuity contracts | 35,834 | 38,113 |
| Other assets | 8,608 | 8,018 |
| Total assets | $ 746,622 | $ 659,927 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | |
| **Current liabilities:** | | |
| Medical claims and benefits payable | $ 249,789 | $ 217,354 |
| Deferred revenue | 8,896 | 803 |
| Accounts payable and accrued liabilities | 33,540 | 31,457 |
| Total current liabilities | 292,225 | 249,614 |
| Long-term debt | 15,000 | — |
| Deferred income taxes | 7,346 | 4,796 |
| Liability for ceded life and annuity contracts | 35,834 | 38,113 |
| Other long-term liabilities | 4,660 | 4,554 |
| Total liabilities | 355,065 | 297,077 |
| **Stockholders' equity:** | | |
| Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 27,995,782 shares at June 30, 2006 and 27,792,360 shares at December 31, 2005 | 28 | 28 |
| Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding | — | — |
| Paid-in capital | 169,743 | 162,693 |
| Accumulated other comprehensive loss | (714) | (629) |
| Retained earnings | 242,890 | 221,148 |
| Treasury stock (1,201,174 shares, at cost) | (20,390) | (20,390) |
| Total stockholders' equity | 391,557 | 362,850 |
| Total liabilities and stockholders' equity | $ 746,622 | $ 659,927 |

See accompanying notes.

**CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**
**(amounts in thousands, except per share data)**
**(unaudited)**

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2006 | 2005 | 2006 | 2005 |
| **Revenue:** | | | | |
| Premium revenue | $479,823 | $401,915 | $929,117 | $794,102 |
| Investment income | 4,811 | 2,359 | 8,893 | 4,124 |
| Total revenue | 484,634 | 404,274 | 938,010 | 798,226 |
| **Expenses:** | | | | |
| Medical care costs: | | | | |
| Medical services | 86,020 | 67,604 | 160,878 | 131,271 |
| Hospital and specialty services | 267,689 | 259,016 | 530,559 | 485,548 |
| Pharmacy | 48,006 | 42,870 | 93,525 | 85,785 |
| Total medical care costs | 401,715 | 369,490 | 784,962 | 702,604 |
| Salary, general and administrative expenses | 56,308 | 37,060 | 107,521 | 70,606 |
| Loss contract charge | — | 939 | — | 939 |
| Depreciation and amortization | 4,870 | 3,558 | 9,632 | 6,756 |
| Total expenses | 462,893 | 411,047 | 902,115 | 780,905 |
| Operating income (loss) | 21,741 | (6,773) | 35,895 | 17,321 |
| **Other expense:** | | | | |
| Interest expense | (577) | (418) | (991) | (707) |
| Other, net | — | (400) | — | (400) |
| Total other expense | (577) | (818) | (991) | (1,107) |
| Income (loss) before income taxes | 21,164 | (7,591) | 34,904 | 16,214 |
| Income tax expense (benefit) | 8,012 | (2,885) | 13,162 | 6,161 |
| Net income (loss) | $ 13,152 | $ (4,706) | $ 21,742 | $ 10,053 |
| Net income (loss) per share: | | | | |
| Basic | $ 0.47 | $ (0.17) | $ 0.78 | $ 0.36 |
| Diluted | $ 0.47 | $ (0.17) | $ 0.77 | $ 0.36 |
| Weighted average shares outstanding: | | | | |
| Basic | 27,947 | 27,707 | 27,901 | 27,662 |
| Diluted | 28,270 | 27,707 | 28,207 | 27,981 |

See accompanying notes.

**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**
**(dollars in thousands)**
**(unaudited)**

| | Six months ended June 30 | |
|---|---|---|
| | 2006 | 2005 |
| **Operating activities** | | |
| Net income | $ 21,742 | $ 10,053 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | |
| Depreciation and amortization | 9,632 | 6,756 |
| Amortization of capitalized credit facility fees | 429 | 338 |
| Deferred income taxes | (2,483) | 68 |
| Stock-based compensation | 2,747 | 341 |
| Changes in operating assets and liabilities: | | |
| Receivables | (6,208) | (3,544) |
| Prepaid expenses and other current assets | 3,098 | (287) |
| Medical claims and benefits payable | 9,919 | 19,127 |
| Accounts payable and accrued liabilities | (2,922) | (6,637) |
| Income taxes | 2,634 | (17,784) |
| Net cash provided by operating activities | 38,588 | 8,431 |
| **Investing activities** | | |
| Purchases of equipment | (7,333) | (6,798) |
| Purchases of investments | (57,737) | (19,645) |
| Sales and maturities of investments | 66,476 | 22,358 |
| Decrease (increase) in restricted cash | 940 | (89) |
| Net cash acquired (paid) in purchase transactions | 5,820 | (31,200) |
| Increase in other long-term liabilities | 106 | 295 |
| Increase in other assets | (1,070) | (5,210) |
| Net cash provided by (used in) investing activities | 7,202 | (40,289) |
| **Financing activities** | | |
| Tax benefit from exercise of employee stock options recorded as additional paid-in capital | 653 | 1,758 |
| Proceeds from exercise of stock options and employee stock purchases | 1,472 | 1,474 |
| Borrowings under credit facility | 20,000 | 3,100 |
| Principal payments on credit facility, capital lease obligation and mortgage note | (5,000) | (82) |
| Net cash provided by financing activities | 17,125 | 6,250 |
| Net increase (decrease) in cash and cash equivalents | 62,915 | (25,608) |
| Cash and cash equivalents at beginning of period | 249,203 | 228,071 |
| Cash and cash equivalents at end of period | $312,118 | $202,463 |
| **Supplemental cash flow information** | | |
| Cash paid during the period for: | | |
| Income taxes | $ 12,411 | $ 22,122 |
| Interest | $ 1,055 | $ 281 |
| Schedule of non-cash investing and financing activities: | | |
| Change in unrealized gain on investments | $ (128) | $ (202) |
| Deferred taxes | 43 | 79 |
| Change in net unrealized gain on investments | $ (85) | $ (123) |
| Value of stock issued for employee compensation earned in previous year | $ 2,178 | $ — |
| Details of acquisitions: | | |
| Fair value of assets acquired | $ 86,003 | $ 31,200 |
| Less cash acquired in purchase transaction | (49,820) | — |
| Liabilities assumed in purchase transaction | (42,003) | — |
| Cash (acquired) paid in purchase transaction, net of cash acquired | $ (5,820) | $ 31,200 |

See accompanying notes.

**MOLINA HEALTHCARE, INC.**
**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**
**(amounts in thousands, except share data)**
**(unaudited)**
**June 30, 2006**

## 1. The Reporting Entity

Molina Healthcare, Inc. (the Company) is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other government-sponsored programs for low-income families and individuals. We operate our business through wholly owned corporate subsidiaries licensed as health maintenance organizations, or HMOs, in the states of California, Indiana, Michigan, New Mexico, Ohio, Utah, and Washington. We have licensed a health plan in Texas, where we expect to begin serving members in late 2006.

## 2. Basis of Presentation

The unaudited condensed consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2005. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2005 audited financial statements have been omitted. These unaudited condensed consolidated interim financial statements should be read in conjunction with our December 31, 2005 audited financial statements.

The condensed consolidated financial statements include the accounts of the Company and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented, which consist solely of normal recurring adjustments, have been included. All significant inter-company balances and transactions have been eliminated in consolidation. The condensed consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2006.

*Stock-Based Compensation*

At June 30, 2006, we had two stock-based employee compensation plans: the 2000 Omnibus Stock and Incentive Plan, and the 2002 Equity Incentive Plan. The 2000 Omnibus Stock and Incentive Plan is frozen. Common shares issued pursuant to the exercise of stock options for the six months ended June 30, 2006 and 2005 were 86,519 and 19,531, respectively.

Through December 31, 2005, we accounted for stock-based compensation under the recognition and measurement principles (the intrinsic-value method) prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations. Compensation cost for stock options was reflected in net income and was measured as the excess of the market price of the Company's stock at the date of grant over the amount an employee must pay to acquire the stock. At December 31, 2005, we had adopted the disclosure provisions required by SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure*.

In December 2004, the Financial Accounting Standards Board (FASB) issued SFAS No. 123R, *Share-Based Payment*. SFAS No. 123R is a revision of SFAS No. 123, and supersedes APB 25. Among other items, SFAS No. 123R eliminates the use of APB Opinion 25 and the intrinsic value method of accounting, and requires companies to recognize in the financial statements the cost of employee services received in exchange for awards of equity instruments, based on the grant date fair value of those awards. SFAS No. 123R permits companies to adopt its requirements using either a "modified prospective" method or a "modified retrospective" method. Under the "modified prospective" method, compensation cost is recognized in the financial statements beginning with the effective date, based on the requirements of SFAS No. 123R for all share-based payments granted after that date, and based on the requirements of SFAS No. 123 for all unvested awards granted prior to the effective date of SFAS No. 123R. Under the "modified retrospective" method, the requirements are the same as under the "modified prospective" method, but entities are also permitted to restate financial statements of previous periods based on pro forma disclosures made in accordance with SFAS No. 123.

Effective January 1, 2006, we adopted SFAS No. 123R using the modified prospective method. Our adoption of SFAS No. 123R reduced net income for the three and six months periods ended June 30, 2006 by approximately $572, or $.02 per basic and diluted share and $1,081, or $0.04 per basic and diluted share, respectively.

The following table illustrates the effect on net income and earnings per share if we had applied the fair value recognition provisions to stock-based employee compensation permitted by SFAS No. 148 for the three and six-month periods ended June 30, 2005:

| | Three months ended June 30, 2005 | Six months ended June 30, 2005 |
|---|---|---|
| Net income (loss), as reported | $ (4,706) | $ 10,053 |
| Reconciling items (net of related tax effects): | | |
| Add: Stock-based employee compensation expense determined under the intrinsic-value based method for all awards | — | — |
| Deduct: Stock-based employee compensation expense determined under the fair-value based method for all awards | (200) | (436) |
| Net adjustment | (200) | (436) |
| Net income (loss), as adjusted | $ (4,906) | $ 9,617 |
| Earnings (loss) per share: | | |
| Basic—as reported | $ (0.17) | $ 0.36 |
| Basic—as adjusted | $ (0.18) | $ 0.35 |
| Diluted—as reported | $ (0.17) | $ 0.36 |
| Diluted—as adjusted | $ (0.18) | $ 0.34 |

The following table illustrates the components of our stock-based compensation expense (net of tax) for the three months and six months ended June 30, 2006 and 2005 as reported in the Condensed Consolidated Statements of Operations:

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2006 | 2005 | 2006 | 2005 |
| Stock options | $ 572 | $ — | $ 1,081 | $ — |
| Stock grants | 373 | 102 | 630 | 211 |
| Total stock-based compensation expense | $ 945 | $ 102 | $ 1,711 | $ 211 |

The recognition and measurement of stock grants is the same under APB Opinion No. 25 and SFAS No. 123, *Accounting for Stock Based Compensation*. The related expenses for the fair value of stock grants were charged to salary, general and administrative expenses and are included in net income, as reported in the pro forma net income table above.

Stock option activity during the six months ended June 30, 2006 is summarized below:

| | Shares | Weighted Average Exercise Price | Aggregate Intrinsic Value | Weighted Average Remaining Contractual Term (months) |
|---|---|---|---|---|
| Outstanding as of December 31, 2005 | 651,047 | $ 20.98 | | |
| Granted | 347,202 | 28.95 | | |
| Exercised | (86,519) | 9.71 | | |
| Forfeited | (20,359) | 39.16 | | |
| Outstanding as of June 30, 2006 | 891,371 | $ 24.59 | $ 12,000 | 95 |
| Exercisable as of June 30, 2006 | 365,245 | $ 14.81 | $ 8,488 | 73 |

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model based on the following weighted-average assumptions:

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2006 | 2005 | 2006 | 2005 |
| Risk-free interest rate | 5.00% | 4.06% | 4.54% | 4.06% |
| Expected volatility | 51.6% | 53.2% | 53.1% | 53.2% |
| Expected option life (in years) | 6 | 5 | 6 | 5 |
| Expected dividend yield | None | None | None | None |

The risk-free interest rate is based on the implied yield currently available on U.S. Treasury zero coupon issues. The expected volatility is primarily based on historical volatility levels along with the implied volatility of exchange traded options to purchase our common stock. The expected option life of each award granted was calculated using the "simplified method" in accordance with Staff Accounting Bulletin No. 107. There were no material changes made to the methodology used to determine the assumptions during the second quarter of 2006.

The weighted-average fair value of options granted during the three and six-months periods ended June 30, 2006 were $16.55 and $12.87, respectively. The total intrinsic value of stock options exercised during the three and six-months periods ended June 30, 2006 was $614 and $1,869, respectively. The total intrinsic value of stock options exercised during the three and six-months periods ended June 30, 2005 was $2,160 and $4,959, respectively.

Non-vested restricted stock and restricted stock unit activity for the six months ended June 30, 2006 is summarized below:

| | Shares | Weighted Average Grant Date Fair Value |
|---|---|---|
| Non-vested balance as of December 31, 2005 | 100,497 | $ 41.71 |
| Granted | 48,776 | 34.01 |
| Vested | (15,976) | 37.89 |
| Forfeited | (8,675) | 44.48 |
| Non-vested balance as of June 30, 2006 | 124,622 | $ 38.99 |

As of June 30, 2006, there was $10,438 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans. That cost is expected to be recognized over a weighted-average period of two years.

*Earnings Per Share*

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

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2006 | 2005 | 2006 | 2005 |
| Shares outstanding at the beginning of the period | 27,935,000 | 27,668,000 | 27,792,000 | 27,602,000 |
| Weighted average number of shares issued for stock options, stock grants and employee stock purchases | 12,000 | 39,000 | 109,000 | 60,000 |
| Denominator for basic earnings (loss) per share | 27,947,000 | 27,707,000 | 27,901,000 | 27,662,000 |
| Dilutive effect of employee stock options | 323,000 | — | 306,000 | 319,000 |
| Denominator for diluted earnings (loss) per share | 28,270,000 | 27,707,000 | 28,207,000 | 27,981,000 |

*New Accounting Pronouncements*

In May 2005, the FASB issued Statement No. 154 (SFAS No. 154), *Accounting Changes and Error Corrections*, which replaced APB Opinion No. 20, *Accounting Changes*, and FASB Statement No. 3, *Reporting Changes in Interim Financial Statements*. SFAS No. 154 requires retrospective application to prior periods' financial statements of voluntary changes in accounting principles and changes required by a new accounting standard when the standard does not include specific transition provisions. Previous guidance required most voluntary changes in accounting principle to be recognized by including in net income of the period in which the change was made the cumulative effect of changing to the new accounting principle. SFAS No. 154 carries forward existing guidance regarding the reporting of the correction of an error and a change in accounting estimate. SFAS No. 154 is effective for accounting changes and corrections of errors made in fiscal years beginning after December 15, 2005. Adoption of SFAS No. 154 as of January 1, 2006 did not have a material effect on our consolidated financial position or results of operations.

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.

*Reclassifications*

Certain amounts for 2005 have been reclassified to conform to the 2006 presentation. Such reclassifications had no impact on net income or stockholders' equity as previously reported.

As of June 30, 2006, we reported an acquired 100% ceded reinsurance arrangement related to the December 2005 purchase of Phoenix National Insurance Company by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. Prior period amounts have been reclassified to conform to the 2006 presentation. The reclassification has no effect on our earnings, working capital or stockholders' equity as previously reported.

**3. Loss Contract Charge**

In connection with the sale by our New Mexico HMO of certain commercial employer group contracts to another health plan on August 1, 2004, our New Mexico HMO entered into a transition services agreement (the TSA). The TSA required the New Mexico HMO to provide certain administrative services in support of the commercial membership through the date of each member group's renewal. In exchange for those services, the New Mexico HMO was compensated by the buyer at a specific amount per member per month. The New Mexico HMO entered into the TSA as an inducement to the buyer to purchase the commercial membership, and anticipated that the TSA would be unprofitable. Effective with the implementation of the TSA (August 1, 2004), the New Mexico HMO recorded a liability for the costs of the run out of the commercial business of $2,640, the bulk of which consisted of anticipated losses under the TSA. During the second quarter of 2005, that reserve was exhausted. We anticipated that we would continue to provide services under the TSA through December 31, 2005 at a net cost of $939 and recorded a loss contract charge for that amount at June 30, 2005. As of June 30, 2006, only insignificant run out services remained to be performed under the TSA. A summary of activity for the net liability for termination of commercial operations for the period July 1, 2004 through June 30, 2006 follows:

| | |
|---|---|
| Net liability for termination of commercial operations at July 1, 2004 | $ 2,640 |
| Revenue earned on transition services agreement | 1,888 |
| Costs incurred in providing transition services | (5,317) |
| Additional loss contract charge expensed in 2005 | 939 |
| Net liability for termination of commercial operations at June 30, 2006 | $ 150 |

**4. Receivables**

Receivables consist primarily of amounts due from the various states in which we operate. Accounts receivable by operating subsidiary are as follows:

| | June 30, 2006 | December 31, 2005 |
|---|---|---|
| California HMO | $15,031 | $ 19,952 |
| Utah HMO | 47,757 | 32,929 |
| Washington HMO | 4,755 | 7,486 |
| Others | 9,658 | 10,165 |
| Total receivables | $77,201 | $ 70,532 |

Substantially all receivables due our California HMO at June 30, 2006 and December 31, 2005 were collected in July and January of 2006, respectively.

Our agreement with the state of Utah calls for the reimbursement of our Utah HMO for medical costs incurred in serving our members plus an administrative fee of 9% of medical costs and all or a portion of any cost savings realized, as defined in the agreement. Our Utah HMO bills the state of Utah monthly for actual paid health care claims plus administrative fees. Our receivable balance from the state of Utah includes: 1) amounts billed to the state for actual paid health care claims plus administrative fees; 2) amounts estimated to be due under the savings sharing provision of the agreement; and 3) amounts estimated for incurred but not reported claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid.

**5. Other Assets**

Other assets at June 30, 2006 included an equity investment of approximately $1,600 in a vision services provider that provides medical services to the Company's members. Payments to the vision services provider were $1,999 and $3,461 for the three months and six months ended June 30, 2006. Payments to the vision services provider were $579 and $1,044 for the three months and six months ended June 30, 2005. Other assets also includes deferred financing costs associated with our secured credit agreement and certain investments held in connection with our deferred employee compensation program. A liability approximately equal to the assets held in connection with our deferred employee compensation program is included in other long-term liabilities.

**6. Long-Term Debt**

On March 9, 2005, we entered into an amended and restated five-year secured credit agreement for a $180,000 revolving credit facility with a syndicate of lenders. The credit facility will be used for working capital purposes. This credit facility amends and restates the facility that we entered into on March 19, 2003.

The credit facility has a term of five years and all amounts outstanding under the credit facility will be due and payable on March 8, 2010. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the credit facility to up to $200,000.

Borrowings under the credit facility are based, at our election, on the London interbank deposit rate, or LIBOR, or the so-called base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.5% 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 EBITDA (earnings before interest, tax, depreciation and amortization). The applicable margins range between 1.00% and 1.75% for LIBOR loans and between 0% and 0.75% for base rate loans. The commitment fee ranges between 0.375% and 0.500%. In addition, we will 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.

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 Indiana, Michigan, New Mexico, Utah, and Washington HMO subsidiaries and our Molina Healthcare Insurance Company subsidiary.

The credit agreement 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, and investments. The credit agreement also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.00 to 1.00 at any time and a fixed charge coverage ratio of 1.75 to 1.00 for the quarter ended March 31, 2005 and thereafter ranging from 1.20 to 1:00 for the quarter ended June 30, 2006 up to 3.00 to 1.00 for all quarters ending after December 31, 2009. At June 30, 2006, we were in compliance with all financial covenants in the credit agreement.

At June 30, 2006, the amount outstanding under the credit facility was $15 million. At December 31, 2005, no amounts were outstanding under the credit facility.

**7. Commitments and Contingencies**

*Legal*

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.

Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired Company stock between November 3, 2004 and July 20, 2005. The class action complaints were consolidated into a single consolidated action, Case No. CV 05-5460 GPS (SHx) (the "Class Action"), and a lead plaintiff was appointed. On March 13, 2006, the lead plaintiff filed its consolidated complaint. The consolidated complaint purports to allege claims against Molina Healthcare, Inc., J. Mario Molina, John C. Molina, and Joseph W. White for alleged violations of the Securities Exchange Act of 1934 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On May 1, 2006, the defendants filed a motion to dismiss the consolidated complaint for failure to state a claim upon which relief can be granted, and the motion has been fully briefed by the parties. On July 27, 2006, the federal court judge vacated the hearing on the motion and took the motion under submission. The Class Action is in the early stages, and no prediction can be made as to the outcome.

On August 8, 2005, a shareholder derivative complaint was filed in the Superior Court of the State of California for the County of Los Angeles, Case No. BC 337912 (the "Derivative Action"). The Derivative Action purports to allege claims on behalf of the Company against certain current and former officers and directors for breach of fiduciary duty, breach of the duty of loyalty, gross negligence, and violation of California Corporations Code Section 25402 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On February 7, 2006, the Superior Court ordered that the Derivative Action be stayed pending the outcome of the Class Action. The Derivative Action is in the early stages, and no prediction can be made as to the outcome.

*Arbitration with Tenet Hospital.* In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital, or Tenet, seeking damages of approximately $4,500 involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospital claimants and to increase its damage claim to approximately $8,000. The parties have agreed to present their arguments in phases. The first phase of the arbitration, comprising approximately $3,000 of the total demand, concluded in December 2005. At that time, Tenet was awarded approximately $1,700 by the arbitrator. We paid the award in January 2006. This amount is in addition to approximately $330 we paid earlier in the fourth quarter of 2005 to settle a portion of the claims included in the first phase of the arbitration. The parties are currently conducting the second phase of the arbitration. We believe that the California HMO has meritorious defenses to Tenet's claims and we intend to vigorously defend this matter. Nevertheless, at December 31, 2005, we had recorded additional expense beyond the amount of $2,030 discussed above in connection with this matter; and the liability associated with that additional expense remains on our consolidated balance sheet at June 30, 2006. We do not believe that the ultimate resolution of this matter will materially affect our consolidated financial position, results of operations, or cash flows beyond the impact of the liability recorded in connection with this matter.

*Starko.* Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named HMOs participating in the New Mexico Medicaid program as defendants, including the predecessor of the New Mexico HMO. Plaintiff asserts that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. Discovery has recently commenced. It is not currently possible to assess the amount or range of potential loss or probability of a favorable or unfavorable outcome. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to the New Mexico HMO, an indemnification escrow account was established and funded with $6,000 in order indemnify our New Mexico HMO against the costs of such litigation and any eventual liability or settlement costs. Currently, $4,456 remains in the indemnification escrow fund.

*Antelope Valley*. On May 1, 2006, Antelope Valley Healthcare District ("Antelope Valley") filed a complaint in Los Angeles County Superior Court against our California HMO, Case No. BC351590. To date, our California HMO has not been served with the complaint, and upon information and belief the complaint was filed by Antelope Valley at this stage in order to toll the applicable statute of limitations. The complaint alleges claims for breach of contract, breach of implied contract, quantum meruit, unfair business practice, and declaratory relief related to the payment of emergency room claims for Molina members who sought treatment at Antelope Valley facilities from January 2002 to the present. Antelope Valley alleges that the emergency room claims, which our California HMO paid in accordance with its Medicaid contract with the California Department of Health Services and Title 22 of the California Code of Regulations, Section 53855, were underpaid. The complaint seeks damages in the amount of $2,001, plus interest and attorney fees. An administrative hearing currently pending before a California Department of Health Services (DHS) hearing officer involves the same parties and the same general subject matter as the complaint, but the amount at issue in that hearing is considerably less than the damage amount alleged in the complaint. The parties are currently awaiting the ruling of the DHS hearing officer in the administrative matter. The Antelope Valley matter is in the early stages, and no prediction can be made either as to its outcome or the circumstances under which Antelope Valley would serve the complaint on our California HMO.

We are involved in other legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, 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.

*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.

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.

*Subscriber Group Claims*

The United States Office of Personnel Management (OPM) has contacted our New Mexico HMO seeking repayment of approximately $3,800 in premiums paid by OPM on behalf of Federal employees for the years 1999, 2000 and

2002. OPM is also seeking recovery of approximately $500 in interest in connection with this matter. OPM is asserting that it did not receive rate discounts equivalent to the largest discount given by the New Mexico HMO for Similar Sized Subscriber Groups, as required by the New Mexico HMO's agreement with OPM, during the years in question. We are continuing to analyze the OPM claim and are unable at this time to determine either the validity of the claim or the degree, if any, of our liability in regards to this matter.

*Regulatory Capital and Dividend Restrictions*

Our principal operations are conducted through our seven HMO subsidiaries operating in California, Indiana, Michigan, New Mexico, Ohio, Utah, and Washington. Our HMOs 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 transferred to us in the form of loans, advances, or cash dividends, was $174,200 at June 30, 2006 and $155,900 at December 31, 2005. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Washington, Indiana, Michigan, Ohio and Utah have adopted these rules (which vary from state to state). While New Mexico has not formally adopted the RBC rules, that state holds our New Mexico HMO to those rules. California has not yet adopted NAIC risk-based capital requirements for HMOs and has not given notice of any intention to do so. Such requirements, if adopted by California, may increase the minimum capital required by that state.

At June 30, 2006, our HMOs had aggregate statutory capital and surplus of approximately $178,400 compared with the required minimum aggregate statutory capital and surplus of approximately $118,600. All of our HMOs were in compliance with the minimum capital requirements. We have the ability and commitment to provide additional working capital to each of our HMOs when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

**8. Acquisitions**

**Michigan HMO**

On May 18, 2006, the Company completed its acquisition of HCLB, Inc. ("HCLB"). HCLB is the parent company of Cape Health Plan, Inc. ("Cape"), a Michigan corporation based in Southfield, Michigan. Cape serves approximately 90,000 Medicaid members primarily in Southeast Michigan. The Cape acquisition has expanded our geographic presence within Michigan. The purchase price was $44.0 million in cash and the acquisition was deemed effective May 15, 2006 for accounting purposes. Accordingly, the results of operations for Cape are included in the consolidated financial statements for the periods following May 15, 2006.

The Company has allocated the purchase price to the fair value of HCLB assets acquired and liabilities assumed, including identifiable intangible assets, and the excess of purchase price over the fair value of net assets acquired was recorded as goodwill. Based upon our preliminary valuation we have assigned $13.4 million of the purchase price to finite-lived intangible assets with a life of between five and ten years and approximately $16.2 million to goodwill. These amounts are subject to change upon completion of the final valuation.

**9. Related Party Transactions**

Effective March 1, 2006, we assumed an office lease from Millworks Capital Ventures with a remaining term of 52 months. Millworks Capital Ventures is owned by John C. Molina, our Chief Financial Officer and his wife. The monthly base lease payment is approximately $18 and is subject to an annual increase. Based on a market report prepared by an independent realtor, we believe the terms and conditions of the assumed lease are at fair market value. We are currently using the office space under the lease for an office expansion.

On June 14, 2006, Mr. Wayne Lowell was elected to serve as a director by our Board of Directors. Prior to his election, Mr. Lowell had provided consulting services to the company. For the three months and six months ended June 30, 2006, total payments for his consulting services were $19.1 and $34.1, respectively. For the three months and six months ended June 30, 2005, total payments for his services were $95.9 and $136.6, respectively. It is our expectation that Mr. Lowell will continue to provide us with his consulting services in the future.

Effective June 1, 2006, we entered into an additional contract with Pacific Hospital of Long Beach ("Pacific Hospital") as part of a capitation arrangement. Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, our Executive Vice President, Research and Development. Under this arrangement, Pacific Hospital will receive a fixed fee from us based on member type. For the one month ended June 30, 2006, approximately $146 was accrued as medical care costs and no payment was made to Pacific Hospital for capitation services. The Company had previously entered into a fee for service contract with Pacific Hospital. Amounts paid under the terms of that agreement were $106.9 and $242.9 for the three and six months ended June 30, 2006, respectively, and $70.5 and $159.1 for the three and six months ended June 30, 2005, respectively. The claims submitted to us by Pacific Hospital were reimbursed at prevailing market rates.

## Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

### Forward Looking Statements

The information made available below and elsewhere in this quarterly report on Form 10-Q contains forward-looking statements that involve risks and uncertainties. These forward-looking statements are often accompanied by words such as "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "goal," "may," "will" and similar expressions. These statements include, without limitation, statements about our anticipated financial performance, our market opportunity, our growth strategy, competition, expected activities, future acquisitions and investments, and the adequacy of our available cash resources. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements as a result of, but not limited to, the following factors:

- Uncertainty regarding our ability to control our medical costs and other operating expenses.
- Uncertainty regarding our ability to accurately estimate incurred but not reported medical care costs.
- Our dependence upon a relatively small number of government contracts and subcontracts for our revenue.
- Uncertainty regarding our ability to renew our government contracts.
- Government efforts to limit Medicaid expenditures.
- Uncertainty regarding high dollar or "catastrophic" claims.
- Changes to government laws and regulations or in the interpretation and enforcement of those laws and regulations, including the recently enacted citizenship certification requirements.
- Difficulties we encounter in managing, integrating, and securing our information systems.
- Difficulties we encounter in executing our acquisition strategy, including obtaining the necessary government approvals and integrating our acquisitions.
- Ineffective management of our growth.
- The superior financial resources of our competitors.
- Restrictions and covenants in our credit facility that may impede our ability to make or finance acquisitions and declare dividends.
- The implementation of rate increases.
- Uncertainty regarding our ability to enter into more favorable provider contracts.
- Risks associated with our start-up health plans and our Medicare Advantage special needs plans.
- Uncertainty regarding membership eligibility processes and methodologies.
- Our dependence upon certain key employees.
- Our increased exposure to malpractice and other litigation risks as a result of the operation of our primary care clinics in California.
- The existence of state regulations that may impair our ability to upstream cash from our subsidiaries.
- Demographic changes or unexpected changes in utilization patterns.
- Inherent uncertainties involving pending legal or administrative proceedings.

Investors should refer to our Annual Report on Form 10-K for the year ended December 31, 2005 for a discussion of certain risk factors which could materially affect our business, financial condition, or future results. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution investors not to place undue reliance on these statements.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Report on Form 10-K for the year ended December 31, 2005.

**Overview**

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other government-sponsored programs for low-income families and individuals. Our objective is to become the leading managed care organization in the United States focused primarily on serving people who receive health care benefits through government-sponsored programs for low-income populations.

We generate revenues primarily from premiums we receive from the states in which we operate. Premium revenue is fixed in advance of the periods covered and is not subject to significant accounting estimates. For the six months ended June 30, 2006, we received approximately 86.7% of our premium revenue as a fixed amount per member per month pursuant to our contracts with state Medicaid agencies and other managed care organizations with which we operate as a subcontractor. These premium revenues are recognized in the month members are entitled to receive health care services. Approximately 7.7% of our premium revenue in the six months ended June 30, 2006 was realized under a cost plus reimbursement agreement that our Utah HMO has with that state. We also received approximately 5.6% of our premium revenue for the six months ended June 30, 2006 in the form of birth payments (one-time payments for the delivery of children) from the Medicaid programs in Indiana, Michigan, New Mexico, Ohio, and Washington. Such payments are recognized as revenue in the month the birth occurs. The state Medicaid programs periodically adjust premium rates.

Membership growth has been the primary reason for our increasing revenues. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members by state as of the dates indicated.

| Market | As of June 30, 2006 | As of December 31, 2005 | As of June 30, 2005 |
|---|---|---|---|
| California | 307,000 | 321,000 | 339,000 |
| Indiana | 37,000 | 24,000 | 8,000 |
| Michigan | 232,000 | 144,000 | 152,000 |
| New Mexico | 59,000 | 60,000 | 60,000 |
| Ohio | 30,000 | N/A(1) | — |
| Utah | 57,000 | 59,000 | 54,000 |
| Washington | 286,000 | 285,000 | 285,000 |
| Total | 1,008,000 | 893,000 | 898,000 |

(1) The Company's Ohio HMO commenced operations in December 2005. Enrollment at December 31, 2005 was less than 250 members.

The following table details member months (defined as the aggregation of each month's ending membership for the period) by state for the periods indicated:

| | Three months ended June 30, | | % of Increase (Decrease) | Six months ended June 30, | | % of Increase (Decrease) |
|---|---|---|---|---|---|---|
| | 2006 | 2005 | | 2006 | 2005 | |
| California | 927,000 | 839,000 | 10.5% | 1,874,000 | 1,592,000 | 17.7% |
| Indiana | 99,000 | 20,000 | 395.0% | 178,000 | 20,000 | 790.0% |
| Michigan | 565,000 | 463,000 | 22.0% | 996,000 | 934,000 | 6.6% |
| New Mexico | 176,000 | 183,000 | (3.8)% | 354,000 | 370,000 | (4.3)% |
| Ohio | 86,000 | — | — | 134,000 | — | — |
| Utah | 179,000 | 169,000 | 5.9% | 360,000 | 328,000 | 9.8% |
| Washington | 858,000 | 842,000 | 1.9% | 1,726,000 | 1,665,000 | 3.7% |
| Total | 2,890,000 | 2,516,000 | 14.9% | 5,622,000 | 4,909,000 | 14.5% |

Our operating expenses include expenses related to the provision of medical care services and salary, general and administrative, or SG&A, costs. Our results of operations depend on our ability to effectively manage expenses related to health care services and accurately predict costs incurred.

Expenses related to medical care services include two components: direct medical expenses and medically related administrative costs. Direct medical expenses include payments to physicians, hospitals, and providers of ancillary medical services, such as pharmacy, laboratory, and radiology services. Medically-related administrative costs include expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, member services, and compliance. Some of our primary care physicians are paid on a capitation basis (a fixed amount per member per month regardless of actual utilization of medical services), while others are paid on a fee-for-service basis. Specialists and hospitals are paid for the most part on a fee-for-service basis. For the six months ended June 30, 2006, approximately 84.2% of our direct medical expenses were related to fees paid to providers on a fee-for-service basis, with the balance paid on a capitation basis. 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 in a variety of ways, including fee-for-service, per diems, diagnostic-related groups, capitation, and case rates.

Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. Fee-for-service payments are expensed in the period services are provided to our members. Medical care costs include actual historical claims experience and estimates of medical expenses incurred but not reported, or IBNR. We estimate our IBNR monthly based on a number of factors, including prior claims experience, inpatient hospital utilization data, and prior authorization of medical services. As part of this review, we also consider estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, claims payment patterns, and membership and medical cost trends. These estimates are adjusted monthly as more information becomes available. We employ our own actuary and engage the service of independent actuaries as needed. We believe that our process for estimating IBNR is adequate, but all estimates are subject to uncertainties and our actual medical care costs have in the past exceeded such estimates. Our estimates of IBNR may be inadequate in the future, which would negatively affect our results of operations. Additionally, our inability to accurately estimate IBNR may also affect our ability to take timely corrective actions, further exacerbating the extent of the negative impact on our results of operations.

SG&A costs are largely comprised of wage and benefit costs related to our employee base and other administrative expenses. Some SG&A services are provided locally, while others are delivered to our health plans from a centralized location. The major centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally-provided functions include marketing (to the extent permitted by law and regulation), plan administration, and provider relations. Included in SG&A expenses are premium taxes for our California HMO (beginning July 1, 2005), Michigan HMO, New Mexico HMO, Ohio HMO, and Washington HMO.

**Results of Operations**

The following table sets forth selected 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.

| | Three Months Ended June 30, | | Six Months Ended June 30, | |
|---|---|---|---|---|
| | 2006 | 2005 | 2006 | 2005 |
| Premium revenue | 99.0% | 99.4% | 99.1% | 99.5% |
| Investment income | 1.0% | 0.6% | 0.9% | 0.5% |
| Total revenue | 100.0% | 100.0% | 100.0% | 100.0% |
| Medical care ratio | 83.7% | 91.9% | 84.5% | 88.5% |
| Salary, general and administrative expenses | 11.6% | 9.2% | 11.5% | 8.8% |
| Operating income (loss) | 4.5% | (1.7)% | 3.8% | 2.2% |
| Net income (loss) | 2.7% | (1.2)% | 2.3% | 1.3% |

**Three Months Ended June 30, 2006 Compared With Three Months Ended June 30, 2005**

*Net Income or Loss*

Net income for the quarter ended June 30, 2006 was $13.2 million, or $0.47 per diluted share, compared with net loss of $4.7 million, or $0.17 per diluted share, for the quarter ended June 30, 2005. Comparability between the second quarter of 2006 and the second quarter of 2005 was affected by:

- Approximately $5.0 million in positive prior period claims development recorded in the second quarter of 2006 related to the Company's claims liability at December 31, 2005. The effect of this item was to increase earnings in the second quarter of 2006 by $0.11 per diluted share.
- The previously disclosed $13.4 million in adverse prior period claims development recorded in the second quarter of 2005. The effect of this item was to decrease earnings in the second quarter of 2005 by $0.30 per diluted share.

*Premium Revenue*

Premium revenue for the quarter ended June 30, 2006 was $479.8 million, representing an increase of $77.9 million, or 19.4%, over 2005 premium revenue of $401.9 million. Increased membership provided $62.2 million of the increase in premium revenue, while the remainder of the increase was due to higher per member per month (PMPM) premium revenue. Acquisitions in California in June 2005 and in Michigan in May 2006, start-up operations in Indiana and Ohio, and enrollment growth in Utah were the primary drivers of the increase in premium revenue. Membership growth was partially offset by declines in membership in California and Michigan (exclusive of acquisitions) and in New Mexico.

*Investment Income*

Investment income increased by $2.5 million, or 103.9%, in the second quarter of 2006 compared with the second quarter of 2005 as a result of higher invested balances and higher rates of return.

*Medical Care Costs*

Medical care costs as a percentage of premium revenue (the medical care ratio) decreased to 83.7% in the second quarter of 2006 from 91.9% in the second quarter of 2005. The medical care costs for the second quarter of 2006 included approximately $5 million in favorable prior period claims development related to our claims liability at December 31, 2005. The medical care costs for the second quarter of 2005 included approximately $13.4 million in adverse prior period claims development related to claims incurred for the first quarter of 2005. Excluding the respective adjustment for both quarters, the medical care ratio would have been 84.8% and 88.6% for the second quarter ended June 30, 2006 and 2005, respectively.

Medical care costs increased in absolute terms to $401.7 million in the second quarter of 2006 from $369.5 million in the second quarter of 2005. Medical services costs increased as a percentage of premium revenue in the second quarter of 2006 when compared with the same period in 2005 due to higher capitation costs. Hospital and specialty services and pharmacy costs decreased as a percentage of premium revenue in the second quarter of 2006 when compared with the second quarter of 2005.

We believe that the medical cost control initiatives undertaken since the second quarter of 2005 have begun to have a positive impact upon our medical care ratio. In particular, we believe that the following actions have contributed to lower medical care cost trends since the second quarter of 2005:

- Recontracting efforts in New Mexico, Michigan, and Washington;
- Utilization of more cost-effective hospitals where such facilities are available;
- Enhanced monitoring of utilization at hospitals where more cost-effective alternatives are not available;
- Increased investment in medical and utilization management resources;

- Implementation of a risk sharing arrangement with the state of Washington for high cost hemophiliac care;
- Withdrawal from two counties (located in Michigan and Washington) where premium rates were not adequate to cover medical care costs;
- Adjustment of premium rates to reflect the increased cost of providing care to specific member populations; and
- Increased oversight and improvements in the quality of our claims payment process.

Nevertheless, we can give no assurances that the improved performance is not at least partially the result of factors beyond our control, nor can we give any assurances that the improved medical care cost trends will continue.

Furthermore, progress has not been uniform among our health plan subsidiaries. For example, our results during the first half of 2006 were adversely affected by the financial performance of our California HMO, principally due to profitability issues in San Diego County.

*Salary, General and Administrative Expenses*

Salary, general and administrative expenses were $56.3 million for the second quarter of 2006, representing 11.6% of total revenue, compared with $37.1 million, or 9.2% of total revenue, for the second quarter of 2005.

Core G&A (defined as SG&A expenses less premium taxes) increased to 8.6% of total revenue in the second quarter of 2006 compared with 6.7% in the second quarter of 2005. The increase in core G&A was primarily due to investments in infrastructure to support our medical care cost control initiatives, our information technology initiatives, our expansion into Ohio and Texas, and the launch of our Medicare Advantage Special Needs Plans. Expensing of stock option, effective January 1, 2006, reduced earnings per diluted share by approximately $0.02 in the second quarter of 2006.

*Interest Expense*

Interest expense increased to $0.6 million in the second quarter of 2006 from $0.4 million for the same period in 2005 due to increased credit facility fees, increased borrowings and higher interest rates.

*Depreciation and Amortization*

Depreciation and amortization expense increased to $4.9 million for the three month period ended June 30, 2006 from $3.6 million for the same period in 2005. Increased amortization expense due to our acquisitions in California (which closed on June 1, 2005) and Michigan (which closed on May 15, 2006) contributed $0.6 million and $0.1 million in additional amortization, respectively. Depreciation expense increased as a result of investment in infrastructure, principally at our corporate offices.

*Income Taxes*

Income taxes were recognized in the second quarter of 2006 based upon an effective tax rate of 37.9% compared with an effective tax rate of 38.0% in the second quarter of 2005. We believe that the most significant factor affecting our effective tax rate is the proportion of consolidated income earned by subsidiaries operating in states that impose premium taxes rather than income taxes.

**Six Months Ended June 30, 2006 Compared With Six Months Ended June 30, 2005**

*Net Income*

Net income for the six months ended June 30, 2006, was $21.7 million, or $0.77 per diluted share, compared with $10.1 million, or $0.36 per diluted share, for the six months ended June 30, 2005. The increase in net income was primarily the result of a lower medical care ratio in the first half of 2006. The $5.0 million of positive prior period claims development that we experienced in the first half of 2006 contributed to our lower medical care ratio.

*Premium Revenue*

Premium revenue for the six months ended June 30, 2006 was $929.1 million, representing an increase of $135.0 million, or 17.0%, over premium revenue of $794.1 million for the same period of 2005. Increased membership added $117.9

million to our premium revenue, while increases in the amount of revenue received per member per month provided the remainder of the increase. The acquisitions in California and Michigan, the start-ups in Indiana and Ohio and enrollment growth in Utah were the primary drivers of the increase in premium revenue. Membership growth was partially offset by declines in membership in California and Michigan (exclusive of acquisitions) and New Mexico.

*Investment Income*

Investment income for the six months ended June 30, 2006 increased to $8.9 million from $4.1 million for the same period of 2005, an increase of 115.6%, principally as a result of larger invested balances as well as higher rates of return.

*Medical Care Costs*

The medical care ratio decreased to 84.5% in the first half of 2006 from 88.5% in the same six-month period of 2005. Medical care costs increased in absolute terms to $785.0 million in the six months ended June 30, 2006 from $702.6 million in the same period of 2005.

The decrease in our medical care ratio for the six months ended June 30, 2006 compared with the six months ended June 30, 2005 was due to the same factors as identified above regarding the improvement in our medical care ratio for the second quarter of 2006.

*Salary, General and Administrative Expenses*

SG&A expenses were $107.5 million for the first half of 2006, representing 11.5% of total revenue, compared with $70.6 million, or 8.8% of total revenue, for the first half of 2005.

Core G&A (defined as SG&A expenses less premium taxes) increased to 8.6% of total revenue in the second quarter of 2006 compared with 6.2% in the first half of 2005. The increase in core G&A during the six months ended June 30, 2006 compared with the same period in 2005 was due to the same factors identified above regarding the increase in core G&A for the second quarter of 2006. Expensing of stock options, effective January 1, 2006, reduced earnings per diluted share by approximately $0.04 in the first half of 2006.

*Interest Expense*

Interest expense increased to $1.0 million for the six months ended June 30, 2006 from $0.7 million for the first half of 2005 due to increased credit facility fees, increased borrowings and higher interest rates.

*Depreciation and Amortization*

Depreciation and amortization expense for the six months ended June 30, 2006 increased to $9.6 million from $6.8 million for the same period of the prior year. Increased amortization expense was principally due to our California and Michigan (CAPE) acquisitions. Depreciation expense increased as a result of investments in infrastructure, principally at our corporate offices.

*Income Taxes*

Income tax expense increased to $13.2 million in the six months ended June 30, 2006 from $6.2 million in the prior year period due to higher operating profit in 2006. Our effective tax rate was 37.7% for the six months ended June 30, 2006, compared with 38.0% for the six months ended June 30, 2005.

**Liquidity and Capital Resources**

We generate cash from premium revenue and investment income. Our primary uses of cash include the payment of expenses related to medical care services and SG&A expenses. We generally receive premium revenue in advance of payment of claims for related health care services.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets. At June 30, 2006, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities.

At June 30, 2006, our investments (all of which are classified as current assets) consisted solely of investment grade debt securities. Our investment policies require that all of 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. Two professional portfolio managers operating under documented investment guidelines manage our investments. The average annualized portfolio yield for the six months ended June 30, 2006 and 2005 was approximately 4.7% and 2.5%, respectively.

The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. Our restricted investments are invested principally in certificates of deposit and treasury securities.

Net cash provided by operating activities was $38.6 million for the six months ended June 30, 2006 and $8.4 million for the six months ended June 30, 2005. Net income and the timing of payments for medical claims and benefits payable were the primary sources of cash provided by operating activities for the six months ended June 30, 2006. Cash provided by operating activities for the first half of 2005 was less than the same period in 2006 due to lower operating profit and an increase in tax receivable of $17.8 million, partially offset by the timing of payments for medical claims and benefits payable.

At June 30, 2006, we had working capital of $206.9 million compared with $189.2 million at December 31, 2005. At June 30, 2006 and December 31, 2005, cash and cash equivalents were $312.1 million and $249.2 million, respectively. At June 30, 2006 and December 31, 2005, investments (all classified as current assets) were $94.6 million and $103.4 million, respectively.

At June 30, 2006, we owed $15.0 million under our $180.0 million credit facility.

**Regulatory Capital and Dividend Restrictions**

Our principal operations are conducted through our seven HMO subsidiaries operating in California, Indiana, Michigan, New Mexico, Ohio, Utah, and Washington. The HMOs are subject to state laws that, among other things, may 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 their stockholders.

The National Association of Insurance Commissioners, or NAIC, has established rules which, if adopted by a particular state, set minimum capitalization requirements for HMOs 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 in their final adopted form vary slightly from state to state, have been adopted in Indiana, Michigan, Ohio, Utah, and Washington. While New Mexico has not formally adopted the RBC rules, that state holds our New Mexico HMO to those rules. California has not adopted RBC rules and has not given notice of any intention to do so. The RBC rules, if adopted by California, may increase the minimum capital required by that state.

At June 30, 2006, our HMOs had aggregate statutory capital and surplus of approximately $178.4 million, compared with the required minimum aggregate statutory capital and surplus of approximately $118.6 million. All of our HMOs were in compliance with the minimum capital requirements at June 30, 2006. We have the ability and commitment to provide additional working capital to each of our HMOs 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 at least through 2006. We also 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.

**Contractual Obligations**

In our Annual Report on Form 10-K for the year ended December 31, 2005, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report other than the draw down of $15 million on the credit facility which is due in year 2010.

**Critical Accounting Policies**

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations and requires the application of significant judgment by our management and, as a result, is subject to an inherent degree of uncertainty.

Our medical care costs include actual historical claims experience and estimates for medical care costs incurred but not reported to us, or IBNR. We, together with our in-house actuaries, estimate medical claims liabilities using actuarial methods based upon historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care

services, information provided by our providers, and other relevant factors. The estimation methods and the resulting reserves are frequently reviewed and updated, and adjustments, if necessary, are reflected in the relevant period.

While we believe our current estimates are adequate, we have in the past been required to make a significant adjustment to these estimates and it is possible that we will be required to make significant adjustments or revisions to these estimates in the future. The most significant estimates involved in determining our claims liability concern the determination of claims payment completion factors and trended per member per month cost estimates.

For the five months of service prior to the reporting date and earlier, we estimate our outstanding claims liability based upon 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 June 30, 2006 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding June 30, 2006 by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Our Utah HMO is excluded from these calculations because the majority of its business is conducted under a cost reimbursement contract. Our recent acquisition, Cape Health Plan, is excluded from these calculations because our statement of operations only includes Cape Health Plan for the period subsequent to May 15, 2006. Dollar amounts are in thousands.

| (Decrease) increase in estimated completion factors | Increase (decrease) in medical claims and benefits payable |
|---|---|
| (3)% | $ 18,156 |
| (2)% | 12,104 |
| (1)% | 6,052 |
| 1% | (6,052) |
| 2% | (12,104) |
| 3% | (18,156) |

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability because of the inherent delay between the patient/physician encounter and the actual submission of a claim. For these months of service, we estimate our claims liability based upon trended per member per month (PMPM) cost estimates. These estimates 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 June 30, 2006 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Our Utah HMO is excluded from these calculations because the majority of its business is conducted under a cost reimbursement contract. Our recent acquisition, Cape Health Plan, is excluded from these calculations because our statement of operations only includes Cape Health Plan for the period subsequent to May 15, 2006. Dollar amounts are in thousands.

| (Decrease) increase in trended per member per month cost estimates | (Decrease) increase in medical claims and benefits payable |
|---|---|
| (3)% | $ (9,729) |
| (2)% | (6,486) |
| (1)% | (3,243) |
| 1% | 3,243 |
| 2% | 6,486 |
| 3% | 9,729 |

Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNR at June 30, 2006, net income for the six months ended June 30, 2006 would increase or decrease by approximately $3.8 million, or $0.13 per diluted share, net of tax. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNR at June 30, 2006, net income for the six months ended June 30, 2006 would increase or decrease by approximately $2.0 million, or $0.07 per diluted share, net of tax.

The following table shows the components of the change in medical claims and benefits payable for the six months ended June 30, 2006 and 2005. Dollar amounts are in thousands.

| | Six months ended June 30, | |
|---|---|---|
| | 2006 | 2005 |
| Balances at beginning of period | $217,354 | $160,210 |
| Medical claims and benefits payable from business acquired during the period | 22,516 | — |
| Components of medical care costs related to: | | |
| Current year | 819,466 | 702,454 |
| Prior years | (34,504) | 150 |
| Total medical care costs | 784,962 | 702,604 |
| Payments for medical care costs related to: | | |
| Current year | 603,585 | 538,999 |
| Prior years | 171,458 | 144,478 |
| Total paid | 775,043 | 683,477 |
| Balances at end of period | $249,789 | $179,337 |

Our claims liability includes an allowance for adverse claims development based on historical experience and other factors including, but not limited to, variation in claims payment patterns, changes in utilization and cost trends, known outbreaks of disease, and large claims. Our reserving methodology is consistently applied across all periods presented. Accordingly, any benefit recognized in medical care costs resulting from favorable development of an estimated liability at the start of the period (captured as a component of "*medical care costs related to prior years*") may be offset by the addition of an allowance for adverse claims development when estimating the liability at the end of the period (captured as a component of "*medical care costs related to current year*"). During the second quarter of 2006, we recognized a net benefit in medical care costs of approximately $5.0 million due to favorable development of our medical claims liability at December 31, 2005.

**Inflation**

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

**Compliance Costs**

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

## Item 3. Quantitative and Qualitative Disclosures About Market Risk.

### 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 CADRE Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. Two professional portfolio managers operating under documented investment guidelines manage our investments. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

As of June 30, 2006, we had cash and cash equivalents of $312.1 million, investments of $94.6 million, and restricted investments of $18.3 million. Cash equivalents consist of highly liquid securities with original maturities of up to three months. At June 30, 2006, our investments (all of which are classified as current assets) consisted solely of investment grade debt securities. Our investment policies require that all of 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. The restricted investments consist of interest-bearing deposits required by the respective states in which we operate. These investments are subject to interest rate risk and will decrease in value if market rates increase. All non-restricted investments are maintained at fair market value on the condensed consolidated balance sheet. Declines in interest rates over time will reduce our investment income.

## Item 4. Controls and Procedures

***Evaluation of Disclosure Controls and Procedures:*** Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective 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.

***Changes in Internal Control Over Financial Reporting:*** There has been no change in our internal control over financial reporting during the three months ended June 30, 2006 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

## PART II - OTHER INFORMATION

### Item 1. Legal Proceedings

Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired Company stock between November 3, 2004 and July 20, 2005. The class action complaints were consolidated into a single consolidated action, Case No. CV 05-5460 GPS (SHx) (the "Class Action"), and a lead plaintiff was appointed. On March 13, 2006, the lead plaintiff filed its consolidated complaint. The consolidated complaint purports to allege claims against Molina Healthcare, Inc., J. Mario Molina, John C. Molina, and Joseph W. White for alleged violations of the Securities Exchange Act of 1934 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On May 1, 2006, the defendants filed a motion to dismiss the consolidated complaint for failure to state a claim upon which relief can be granted, and the motion has been fully briefed by the parties. On July 27, 2006, the federal court judge vacated the hearing on the motion and took the motion under submission. The Class Action is in the early stages, and no prediction can be made as to the outcome.

On August 8, 2005, a shareholder derivative complaint was filed in the Superior Court of the State of California for the County of Los Angeles, BC 337912 (the "Derivative Action"). The Derivative Action purports to allege claims on behalf of Molina Healthcare, Inc. against certain current and former officers and directors for breach of fiduciary duty, breach of the duty of loyalty, gross negligence, and violation of California Corporations Code Section 25402 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On February 7, 2006, the Superior Court ordered that the Derivative Action be stayed pending the outcome of the Class Action. The Derivative Action is in the early stages, and no prediction can be made as to the outcome.

*Arbitration with Tenet Hospital.* In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital, or Tenet, seeking damages of approximately $4.5 million involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospital claimants and to increase its damage claim to approximately $8.0 million. The parties have agreed to present their arguments in phases. The first phase of the arbitration, comprising approximately $3.0 million of the total demand, concluded in December 2005. At that time, Tenet was awarded approximately $1.7 million by the arbitrator. We paid the award in January 2006. This amount is in addition to approximately $0.33 million we paid earlier in the fourth quarter of 2005 to settle a portion of the claims included in the first phase of the arbitration. The parties are currently conducting the second phase of the arbitration. We believe that the California HMO has meritorious defenses to Tenet's claims and we intend to vigorously defend this matter. Nevertheless, at December 31, 2005, we had recorded additional expense beyond the amount of $2.03 million discussed above in connection with this matter; and the liability associated with that additional expense remains on our consolidated balance sheet at June 30, 2006. We do not believe that the ultimate resolution of this matter will materially affect our consolidated financial position, results of operations, or cash flows beyond the impact of the liability recorded in connection with this matter.

*Starko.* Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named HMOs participating in the New Mexico Medicaid program as defendants, including the predecessor of the New Mexico HMO. Plaintiff asserts that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. Discovery has recently commenced. It is not currently possible to assess the amount or range of potential loss or probability of a favorable or unfavorable outcome. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to the New Mexico HMO, an indemnification escrow account was established and funded with $6,000 in order indemnify our New Mexico HMO against the costs of such litigation and any eventual liability or settlement costs. Currently, $4,456 remains in the indemnification escrow fund.

*Antelope Valley*. On May 1, 2006, Antelope Valley Healthcare District ("Antelope Valley") filed a complaint in Los Angeles County Superior Court against our California HMO, Case No. BC351590. To date, our California HMO has not been served with the complaint, and upon information and belief the complaint was filed by Antelope Valley at this stage in order to toll the applicable statute of limitations. The complaint alleges claims for breach of contract, breach of implied contract, quantum meruit, unfair business practice, and declaratory relief related to the payment of emergency room claims for Molina members who sought treatment at Antelope Valley facilities from January 2002 to the present. Antelope Valley alleges that the emergency room claims, which our California HMO paid in accordance with its Medicaid contract with the California Department of Health Services and Title 22 of the California Code of Regulations, Section 53855, were underpaid. The complaint seeks damages in the amount of $2.0 million, plus interest and attorney fees. An administrative hearing currently pending before a California Department of Health Services (DHS) hearing officer involves the same parties and the same general subject matter as the complaint, but the amount at issue in that hearing is considerably less than the damage amount alleged in the complaint. The parties are currently awaiting the ruling of the DHS hearing officer in the administrative matter. The Antelope Valley matter is in the early stages, and no prediction can be made either as to its outcome or the circumstances under which Antelope Valley would serve the complaint on our California HMO.

We are involved in other legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

## Item 1A. Risk Factors

In addition to the other information set forth in this report and the risk factor discussed below, you should carefully consider the factors discussed in Part I, "Item 1A. Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2005, which could materially affect our business, financial condition, or future results. The risks described in our Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, and/or operating results.

**The New Medicaid Citizenship Documentation Requirements May Adversely Impact The Enrollment Levels Of Our Health Plans.**

American citizenship or legal immigration status has always been a requirement for Medicaid eligibility. However, beneficiaries could assert their status by simply checking a box on a form. The United States Department of Health and Human Services has recently issued guidelines for states to implement a new requirement, effective July 1, 2006, that persons applying for Medicaid document their citizenship. The new documentation requirement is outlined in Section 6036 of the Deficit Reduction Act of 2005 and is intended to ensure that Medicaid beneficiaries are United States citizens without imposing undue burdens on them or the states.

The new rule requires actual documentary evidence before Medicaid eligibility is granted or renewed. The provision requires that a person provide both evidence of citizenship and identity. In many cases, a single document will be enough to establish both citizenship and identity, such as a passport. However, if secondary documentation is used, such as a birth certificate, the individual will also need evidence of his or her identity. Affidavits can only be used in rare circumstances. Additional types of documentation, such as school records, may be used for children. Once citizenship has been proven, it need not be documented again with each eligibility renewal unless later evidence raises a question. Current Medicaid beneficiaries should not lose benefits during the period in which they are undertaking a good-faith effort to provide documentation to the state.

As with other Medicaid program requirements, states must implement an effective process for assuring compliance with documentation of citizenship in order to obtain federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring. In particular, audit processes will track the extent to which states rely on lower categories of documentation, and on affidavits, with the expectation that such categories would be used relatively infrequently and less over time, as state processes and beneficiary documentation improves.

Because this rule is new, it is unclear what impact it will have on the enrollment levels of our various state HMOs. The new rule may result in the disenrollment of a material number of our members, thereby decreasing our premium revenues. As a result, this new proof of citizenship requirement could have a material adverse effect on our business, financial condition, or results of operations.

## Item 5. Other Information

On August 4, 2006, the Procurement Division of the Indiana Department of Administration notified our Indiana HMO that it has not been selected to proceed with contract negotiations to provide Medicaid services in calendar year 2007 to Indiana Medicaid (Hoosier Healthwise) members. As a result of its not being selected as a participating plan, our Indiana HMO's existing Medicaid contract with the state will expire on December 31, 2006.

On August 8, 2006, our Utah HMO received back from the state a fully executed version of an agreement effective July 1, 2006 extending through June 30, 2007 our Utah HMO's Medicaid and CHIP contract with the Utah Department of Health. A copy of the new contract is included with this quarterly report as Exhibit 10.1.

Attached as Exhibit 10.2 to this quarterly report is an amendment to the employment agreement between the Company and J. Mario Molina, our president and chief executive officer. The amendment memorializes the previously-disclosed annual salary of Dr. Molina in the amount of $775,000 for 2006, and reflects the performance benchmarks of Dr. Molina to obtain bonus awards for 2006 under the Company's 2005 Incentive Compensation Plan.

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**Item 6. Exhibits**

| Exhibit No. | Title |
|---|---|
| 10.1 | Contract between Molina Healthcare of Utah and Utah Department of Health extending contract term through June 30, 2007. |
| 10.2 | Amendment to Employment Agreement with Joseph M. Molina. |
| 31.1 | Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended. |
| 31.2 | Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended. |
| 32.1 | Certification 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. |
| 32.2 | Certification 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. |

**SIGNATURES**

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: August 8, 2006

/s/ JOSEPH M. MOLINA, M.D.

**Joseph M. Molina, M.D.**
**Chairman of the Board,**
**Chief Executive Officer and President**
**(Principal Executive Officer)**

Dated: August 8, 2006

/s/ JOHN C. MOLINA, J.D.

**John C. Molina, J.D.**
**Chief Financial Officer and Treasurer**
**(Principal Financial Officer)**

**Exhibit 10.1**

**UTAH DEPARTMENT OF HEALTH**

Box 143104
288 North 1460 West, Salt Lake City, Utah 84114-3104

**CONTRACT AMENDMENT**

H0535503 — Department Log Number

066222 — State Contract Number

Amendment Number 01

1. CONTRACT NAME:

   The name of this Contract is Health Plan - Molina.

2. CONTRACTING PARTIES:

   This Contract Amendment is between the Utah Department of Health (DEPARTMENT), and Molina Healthcare of Utah (CONTRACTOR).

3. PURPOSE OF CONTRACT AMENDMENT:

   To extend the Contract Period for 12 months; to increase the Contract Amount to cover the additional 12 months; and to replace "Attachment F: Payment Methodology" dated January 1, 2006 with "Attachment F: Payment Methodology" dated July 1, 2006.

4. CHANGES TO CONTRACT:

   A. On page 1, paragraph 3, CONTRACT PERIOD, is changed to read as follows:

   "The service period of this contract will be January 1, 2006 through June 30, 2007, unless terminated or extended by agreement in accordance with the terms and conditions of this Contact. This Contract may be extended annually 1 time, at the option of the DEPARTMENT, by means of an amendment to this contract. Such extension must be in writing."

   B. On page 1, paragraph 4, CONTRACT AMOUNT, is changed to read as follows:

   "The CONTRACTOR will be paid up to a maximum amount of $144,000,000.00 in accordance with the provisions in this Contract. This contract is funded with 70.76% Federal funds and with 29.24% State funds. The CFDA # is 93.778 and relates to the federal funds provided.

   C. Effective July 1, 2006, "Attachment F: Payment Methodology" dated January 1, 2006 is replaced with "Attachment F: Payment Methodology" dated July 1, 2006.

   D. All other provisions of the Agreement remain unchanged.

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective July 1, 2006.

6. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA § 63-56-5), this Contract Amendment must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract Amendment.

7. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract Amendment.

CONTRACTOR: Molina Healthcare of Utah

By: _____ Date
Signature of Authorized Individual

Print Name: G. Kirk Olsen

Title: Chief Executive Officer

UTAH DEPARTMENT OF HEALTH

By: _____ Date
Shari A. Watkins, C.P.A.
Director
Office of Fiscal Operations

_____ Date
State Finance:

_____ Date
State Purchasing:

**ATTACHMENT "A"**

**UTAH DEPARTMENT OF HEALTH**

**General Provisions**

**ATTACHMENT "A"**

**UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS**

## I. CONTRACT DEFINITIONS

The following definitions apply in these general provisions:

"**Assign**" or **"Assignment"** means the transfer of all rights and delegation of all duties in the contract to another person.

"**Business**" means any corporation, partnership, individual, sole proprietorship, joint stock company, joint venture, or any other private legal entity.

"**This Contract**" means this agreement between the Department and the Contractor, including both the General Provisions and the Special Provisions.

"**The Contractor**" means the person who delivers the services or goods described in this Contract, other than the state or the Department.

"**The Department**" means the Utah Department of Health.

"**Director**" means the Executive Director of the Department or authorized representative.

"**Equipment**" means capital equipment which costs at least $1,000 and has a useful life of one year or more unless a different definition or amount is set forth in the Special Provisions or specific Department Program policy as described in writing to Contractor.

"**Federal law**" means the constitution, orders, case law, statutes, rules, and regulations of the federal government.

"**General provisions**" means those provisions of this Contract which are set forth under the heading "General Provisions."

"**Governmental entity**" means a federal, state, local, or federally-recognized Indian tribal government, or any subdivision thereof.

"**Individual**" means a living human being.

"**Local health department**" means a local health department as defined in § 26A-1-102, Utah Code Annotated, 1953 as amended (UCA.).

"**Non-governmental entity**" means privately held non-profit or for profit organization not classified as a "Governmental entity."

"**Person**" means any governmental entity, business, individual, union, committee, club, other organization, or group of individuals.

"**Recipient**" means an individual who is eligible for services provided by the Department or by an authorized Contractor of the Department under the terms of this Contract.

"**Services**" means the furnishing of labor, time, or effort by a Contractor, not involving the delivery of a specific end product other than reports which are merely incidental to the required performance.

"**Special provisions**" means those provisions of this Contract which are in addition to the General Provisions and which more fully describe the goods or services covered by this Contract.

"**State**" means the State of Utah.

"**State law**" means the constitution, orders, case law, statutes, and rules, of the state.

"**Subcontract**" means any signed agreement between the Contractor and a third party to provide goods or services for which the Contractor is obligated, except purchase orders for standard commercial equipment, products, or services.

"**Subcontractor**" means the person who performs the services or delivers the goods described in a subcontract.

## II. AUTHORITY

1. The Department's authority to enter into this Contract is derived from Chapter 56, Title 63, UCA; Titles 26 and 26A, UCA; and from related statutes.

2. The Contractor represents that it has the institutional, managerial, and financial capability to ensure proper planning, management, and completion of the project or services described in this Contract.

**ATTACHMENT "A"**

**III. MISCELLANEOUS PROVISIONS**

1. For reference clarity, as used in these General Provisions: "ARTICLE" refers to a major topic designated by capitalized roman numerals; "SECTION" refers to the next lower numbered heading designated by arabic numerals, and "SUBSECTIONS" refers to the next two lower headings designated by lower case letters and lower case roman numerals.

2. If the General Provisions and the special provisions of this Contract conflict, the special provisions govern.

3. These provisions distinguish between two Contractor types: Governmental and Non-governmental. Unspecified text applies to both types. Type-specific statements appear in bold print (*e.g.*, **Non-governmental entities only**).

4. Once signed by the Director and the State Division of Finance, when applicable, and the State Division of Purchasing, when applicable, this Contract becomes effective on the date specified in this Contract. Changes made to the unsigned Contract document shall be initialed by both persons signing this Contract on page one. Changes made to this Contract after the signatures are made on page one may only be made by a separate written amendment signed by persons authorized to amend this Contract.

5. Neither party may enlarge, modify, or reduce the terms, scope of work, or dollar amount in this Contract, except by written amendment as provided in section 4.

6. This Contract and the contracts that incorporate its provisions contain the entire agreement between the Department and the Contractor. Any statements, promises, or inducements made by either party or the agent of either party which are not contained in the written Contract or other contracts are not valid or binding.

7. The Contractor shall comply with all applicable laws regarding federal and state taxes, unemployment insurance, disability insurance, and workers' compensation.

8. The Contractor is an independent Contractor, having no authorization, express or implied, to bind the Department to any agreement, settlement, liability, or understanding whatsoever, and agrees not to perform any acts as agent for the Department unless expressly set forth herein. Compensation stated herein shall be the total amount payable to the Contractor by the Department. The Contractor shall be responsible for the payment of all income tax and social security amounts due as a result of payments received from the Department for these contract services.

9. The Contractor shall maintain all licenses, permits, and authority required to accomplish its obligations under this Contract.

10. The Contractor shall obtain prior written Department approval before purchasing any equipment with contract funds.

11. Notice shall be in writing, directed to the contact person on page one of this Contract, and delivered by certified mail or by hand to the other party's most currently known address. The notice shall be effective when placed in the U.S. mail or hand-delivered.

12. The Department and the Contractor shall attempt to resolve contract disputes through available administrative remedies prior to initiating any court action.

13. This Contract shall be construed and governed by the laws of the State of Utah. The Contractor submits to the jurisdiction of the courts of the State of Utah for any dispute arising out of this Contract or the breach thereof. The proper venue of any legal action arising under this contract shall be in Salt Lake City, Utah.

14. Any court ruling or other binding legal declaration which declares that any provision of this Contract is illegal or void, shall not affect the legality and enforceability of any other provision of this Contract, unless the provisions are mutually dependent.

15. The Contractor agrees to maintain the confidentiality of records that it holds as agent for the Department as required by the Government Records Access and Management Act, Title 63, Chapter 2, UCA and the confidentiality of records requirements of Title 26, UCA.

16. The Contractor agrees to abide by the State of Utah's executive order, dated March 17,1993, which prohibits sexual harassment in the workplace.

17. The waiver by either party of any provision, term, covenant or condition of this Contract shall not be deemed to be a waiver of any other provision, covenant or condition of this Contract nor any subsequent breach of the same or any other provision, term, covenant or condition of this Contract.

18. The Contractor agrees to warrant and assume responsibility for each hardware, firmware, and/or software product (hereafter called the product) that it licenses, or sells, to the Department under this Contract. The Contractor

acknowledges that the Uniform Commercial Code applies to this Contract. In general, the Contractor warrants that:

(a) the product will do what the salesperson said it would do, (b) the product will live up to all specific claims that the manufacturer makes in their advertisements, (c) the product will be suitable for the ordinary purposes for which such product is used, (d) the product will be suitable for any *special purposes* that the Department has relied on the Contractor's skill or judgement to consider when it advised the Department about the product, (e) the product has been properly designed and manufactured, and (f) the product is free of significant defects or unusual problems about which the Department has not been warned.

19. The State of Utah's sales and use tax exemption number is E33399. The tangible personal property or services being purchased are being paid for from State funds and used in the exercise of that entity's essential functions. If the items purchased are construction materials, they will be converted into real property by employees of this government entity, unless otherwise stated in the contract.

20. The Contractor agrees that the Contract will be a public document, and may be available for distribution. Contractor gives the Department express permission to make copies of the Contract and/or of the response to the solicitation in accordance with State of Utah Government Records Access and Management Act. The permission to make copies as noted will take precedence over any statements of confidentiality, proprietary information, copyright information, or similar notation.

21. This Contract may be amended, modified, or supplemented only by written amendment to the Contract, executed by the parties hereto, and attached to the original, signed copy of the Contract..

22. Unless otherwise specified in this Contract, all deliveries will be F.O.B. destination with all transportation and handling charges paid by the Contractor. Responsibility and liability for loss or damage will remain with Contractor until final inspection and acceptance, when responsibility will pass to the Department, except as to latent defects, fraud and Contractor's warranty obligations.

23. All orders will be shipped promptly in accordance with the delivery schedule. The Contractor will promptly submit invoices (within 30 days of shipment or delivery of services) to the Department. The State contract number and/or the agency purchase order number shall be listed on all invoices, freight tickets, and correspondence relating to the Contract order. The prices paid by the Department will be those prices listed in the Contract. The Department has the right to adjust or return any invoice reflecting incorrect pricing.

24. The Contractor will release, indemnify, and hold the State, its officers, agents, and employees harmless from liability of any kind or nature, including the Contractor's use of any copyrighted or un-copyrighted composition, secret process, patented or un-patented invention, article, or appliance furnished or used in the performance of this Contract.

25. Neither party to this Contract will be held responsible for delay or default caused by fire, riot, acts of God, and/or war which is beyond that party's reasonable control. The Department may terminate this Contract after determining that such delay or default will reasonably prevent successful performance of the Contract.

26. The Contractor understands that a person who is interested in any way in the sale of any supplies, services, construction, or insurance to the State of Utah is violating the law if the person gives or offers to give any compensation, gratuity, contribution, loan, or reward, or any promise thereof to any person acting as a procurement officer on behalf of the State, or who in any official capacity participates in the procurement of such supplies, services, construction, or insurance, whether it is given for their own use or for the use or benefit of any other person or organization (63-56-73, Utah Code Annotated, 1953 as amended).

27. Contractor Terms and Conditions that apply must be in writing and attached to the Contract. No other Terms and Conditions will apply to this Contract, including terms listed or referenced on a Contractor's website, terms listed in a Contractor quotation/sales order, etc. In the event of any conflict in the contract terms and conditions, the order of precedence shall be: a. Department General Provisions; b. Department Special Provisions; c. Contractor Terms and Conditions.

## IV. UTAH INDOOR CLEAN AIR ACT

The Contractor, for all personnel operating within the State of Utah, shall comply with the Utah Indoor Clean Air Act, Title 26, Chapter 38, UCA, which prohibits smoking in public places.

**ATTACHMENT "A"**

## V. RELATED PARTIES & CONFLICTS OF INTEREST

1. The Contractor may not pay related parties for goods, services, facilities, leases, salaries, wages, professional fees, or the like for contract expenses without the prior written consent of the Department. The Department may consider the payments to the related parties as disallowed expenditures and accordingly adjust the Department's payment to the Contractor for all related party payments made without the Department's consent. As used in this section, "related parties" means any person related to the Contractor by blood, marriage, partnership, common directors or officers, or 10% or greater direct or indirect ownership in a common entity.

2. The Contractor shall comply with the Public Officers' and Employees' Ethics Act, § 67-16-10, UCA, which prohibits actions that may create or that are actual or potential conflicts of interest. It also provides that "no person shall induce or seek to induce any public officer or public employee to violate any of the provisions of this act." The Contractor represents that none of its officers or employees are officers or employees of the State of Utah, unless disclosure has been made in accordance with § 67-16-8, UCA.

## VI. OTHER CONTRACTS

1. The Department may perform additional work related to this Contract or award other contracts for such work. The Contractor shall cooperate fully with other contractors, public officers, and public employees in scheduling and coordinating contract work. The Contractor shall give other contractors reasonable opportunity to execute their work and shall not interfere with the scheduled work of other contractors, public officers, and public employees.

2. The Department shall not unreasonably interfere with the Contractor's performance of its obligations under this Contract.

## VII. SUBCONTRACTS & ASSIGNMENTS

The Contractor shall not assign, sell, transfer, subcontract, or sublet rights or delegate responsibilities under this Agreement, in whole or part, without the prior written consent of the Department. The Department agrees that the Contractor may partially subcontract services, provided that the Contractor retains ultimate responsibility for performance of all terms, conditions and provisions of this Agreement. When subcontracting, the Contractor agrees to use written subcontracts that conform with Federal and State laws. The Contractor shall request Department approval for any assignment at least 20 days prior to its effective date.

## VIII. FURTHER WARRANTY

The Contractor warrants that (a) all services shall be performed in conformity with the requirements of this Contract by qualified personnel in accordance with generally recognized standards; and (b) all goods or products furnished pursuant to this Contract shall be free from defects and shall conform to contract requirements. For any item that the Department determines does not conform with the warranty, the Department may arrange to have the item repaired or replaced, either by the Contractor or by a third party at the Department's option, at the Contractor's expense.

## IX. INFORMATION OWNERSHIP

Except for confidential medical records held by direct care providers, the Department shall own exclusive title to all information gathered, reports developed, and conclusions reached in performance of this Contract. The Contractor may not use, except in meeting its obligations under this Contract, information gathered, reports developed, or conclusions reached in performance of this Contract without the express written consent of the Department.

## X. SOFTWARE OWNERSHIP

1. If the Contractor develops or pays to have developed computer software exclusively with funds or proceeds from this Contract to perform its obligations under this Contract, or to perform computerized tasks that it was not previously performing to meet its obligations under this Contract, the computer software shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this Contract.

2. If the Contractor develops or pays to have developed computer software which is an addition to existing software owned by or licensed exclusively with funds or proceeds from this Contract, or to modify software to perform computerized tasks in a manner different than previously performed, to meet its obligations under this Contract, the addition shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this Contract.

3. If the Contractor uses computer software licensed to it which it does not modify or program to handle the specific tasks required by this Contract, then to the extent allowed by the license agreement between the Contractor and the owner of the software, the Contractor grants to the Department a continuing nonexclusive license to use the software, either by the Department or by a different Contractor, to perform work substantially identical to the work performed by the Contractor under this Contract. If the Contractor cannot grant the license as required by this section, then the Contractor shall reveal the input screens, report formats, data structures, linkages, and relations used in performing its obligations under this Contract in such a manner to allow the Department or another Contractor to continue the work performed by the Contractor under this Contract.

4. The Contractor shall deliver to the Department a copy of the software or information required by this Article within 90 days after the commencement of this Contract and thereafter immediately upon making a modification to any of the software which is the subject of this Contract.

## XI. INFORMATION PRACTICES

1. (**Governmental entities only**) The Contractor shall establish, maintain, and practice information procedures and controls that comply with Federal and State law. The Contractor assures that any information about an individual that it receives or requests from the Department pursuant to this Contract is necessary to the performance of its duties and functions and that the information will be used only for the purposes set forth in this Contract. The Department shall inform the Contractor of any non-public designation of any information it provides to the Contractor.

2. (**Non-governmental entities only**) The Contractor shall establish, maintain, and practice information procedures and controls that comply with Federal and State law. The Contractor may not release any information regarding any person from any information provided by the Department, unless the Department first consents in writing to the release.

## XII. INDEMNIFICATION

1. (**Governmental entities only**) It is mutually agreed that each party assumes liability for the negligent or wrongful acts committed by its own agents, officials, or employees, regardless of the source of funding for this Contract. Neither party waives any rights or defenses otherwise available under the Governmental Immunity Act.

2. **(Non-governmental entities only)** To the extent authorized by law, the Contractor shall indemnify and hold harmless the Department and any of its agents, officers, and employees, from any claims, demands, suits, actions, proceedings, loss, injury, death, and damages of every kind and description, including any attorney's fees and litigation expenses, which may be brought, made against, or incurred by that party on account of loss or damage to any property, or for injuries to or death of any person, caused by, arising directly or indirectly out of, or contributed to in whole or in part, by reason of any alleged act, omission, professional error, fault, mistake, or negligence of the Contractor or its employees, agents, or representatives, or subcontractors or their employees, agents, or representatives, in connection with, incident to, or arising directly or indirectly out of this Contract, or arising out of workers' compensation claims, unemployment, or claims under similar such laws or obligations.

## XIII. SUBMISSION OF REPORTS

If the Contractor is a Local Health Department, it shall submit monthly expenditure reports to the Department in a format approved by the Department. All other Contractors shall submit monthly summarized billing statements to the Department. Expenditure reports and billing statements must be submitted to the Department within 30 days following the last day of the month in which the expenditures were incurred or the services provided.

## XIV. PAYMENT

1. If a recipient, a recipient's insurance, or any third-party is responsible to pay for services rendered pursuant to this Contract, the Contractor shall bill and collect for the goods or services provided to the recipient. The Department shall reimburse total actual expenditures, less amounts collected as required by this section.

2. Under no circumstances shall the Department authorize payment to the Contractor that exceeds the amount specified in this Contract without an amendment to the Contract.

3. The Department agrees to make every effort to pay for completed services, and payments are conditioned upon receipt of applicable, accurate, and completed reports prepared by the Contractor and delivered to the Department. The Department may delay or deny payment for final expenditure reports received more than 20 days after the Contractor has satisfied all Contract requirements.

4. In the case that funds are not appropriated or are reduced, the Department will reimburse Contractor for products delivered or services performed through the date of cancellation or reduction, and the Department will not be liable for any future commitments, penalties, or liquidated damages.

## XV. RECORD KEEPING, AUDITS, & INSPECTIONS

1. The Contractor shall use an accrual or a modified accrual basis for reporting annual fiscal data, as required by Generally Accepted Accounting Principles (GAAP). Required monthly or quarterly reports may be reported using a cash basis.

2. The Contractor and any subcontractors shall maintain financial and operation records relating to contract services, requirements, collections, and expenditures in sufficient detail to document all contract fund transactions. The Contractor and any subcontractors shall maintain and make all records necessary and reasonable for a full and complete audit, inspection, and monitoring of services by state and federal auditors, and Department staff during normal business hours or by appointment, until all audits and reviews initiated by federal and state auditors are completed, or for a period of four years from the date of termination of this Contract, whichever is longer, or for any period required elsewhere in this Contract.

3. The Contractor shall retain all records which relate to disputes, litigations, claim settlements arising from contract performance, or cost/expense exceptions initiated by the Director, until all disputes, litigations, claims, or exceptions are resolved.

4. The Contractor shall comply with federal and state regulations concerning cost principles, audit requirements, and grant administration requirements, cited in Table 1. Unless specifically exempted in this Contract's special provisions, the Contractor must comply with applicable federal cost principles and grant administration requirements if state funds are received. The Contractor shall also provide the Department with a copy of all reports required by the State Legal Compliance Audit Guide (SLCAG) as defined in Chapter 2, Title 51, UCA. All federal and state principles and requirements cited in Table 1 are available for inspection at the Utah Department of Health during normal business hours. A Contractor who receives $100,000 or more in a year from all federal or from all state sources may be subject to federal and state audit requirements. A Contractor who receives $500,000 for fiscal years ending after December 31, 2003 or more per year from federal sources may be subject to the federal single audit requirement. Counties, cities, towns, school districts, and all non-profit corporations that receive 50 percent or more of its funds from federal, state or local governmental entities are subject to the State of Utah Legal Compliance Audit Guide. Copies of required audit reports shall be sent to the Utah Department of Health, Bureau of Financial Audit, Box 144002, Salt Lake City, Utah 84114-4002.

**ATTACHMENT "A"**

**Federal and State Principles and Requirements**

| Contractor | Cost Principles | Federal Audit Requirements | State Audit Requirements | Grant Admin. Requirements |
|---|---|---|---|---|
| State or Local Govt. & Indian Tribal Govts. | OMB Circular A-87 | OMB Circular A-133 | SLCAG | OMB Common Rule |
| Hospitals | 45 CFR 74, App. E | OMB Circular A-133 | SLCAG | OMB Common Rule or Circular A-110 |
| College or University | OMB Circular A-21 | OMB Circular A-133 | SLCAG | OMB Circular A-110 |
| Non-Profit Organization | OMB Circular A-122 | OMB Circular A-133 | SLCAG | OMB Circular A-110 |
| For-Profit Organization | 48 CFR 31 | n/a | n/a | OMB Circular A-110 |

| Documents | Web Address |
|---|---|
| OMB Circulars | http://www.whitehouse.gov/omb/circulars/index.html |
| OMB Common Rule | http://www.whitehouse.gov/omb/grants/attach.html |
| CFRs | http://www.access.gpo.gov/nara/cfr/cfr-table-search.html |
| SLCAG | http://www.sao.state.ut.us/resources/resources-lg.htm |

**Table 1**

## XVI. CONTRACT ADMINISTRATION REQUIREMENTS

The Contractor agrees to administer this Contract in compliance with either OMB Common Rule or OMB Circular A-110 depending upon the legal status of the of the Contractor as shown in Table 1. Financial management, procurement, and affirmative step requirements specify that:

1. the Contractor must have fiscal control and accounting procedures sufficient to:
    a. permit preparation of reports required by this Contract, and
    b. permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.
2. the Contractor's financial management systems must meet the following standards:
    a. *financial reporting.* Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of this Contract.
    b. *accounting records.* The Contractor must maintain records which adequately identify the source and application of funds provided for federally financially-assisted activities. These records must contain information pertaining to the Contract's awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.
    c. *internal control.* Effective control and accountability must be maintained for all Contract cash, real and personal property, and other assets. The Contractor must adequately safeguard all such property and must assure that it is used solely for authorized purposes.
    d. *budget control*. Actual expenditures or outlays must be compared with budgeted amounts for the Contract Financial information must be related to performance or productivity data, including the development of unit cost information whenever appropriate or specifically required in this Contract. If unit cost data are required, estimates based on available documentation will be accepted whenever possible.
3. Federal OMB cost principles, federal agency program regulations, and the terms of grant and subgrant, and contract agreements will be followed in determining the reasonableness, allowability, and allocability of costs.
    a. *source documentation.* Accounting records must be supported by such source documentation as canceled checks, paid bills, payrolls, time and attendance records, contract and subcontract award documents, etc.
    b. *cash management.* Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by the Department and the Contractor must be followed whenever advance payment procedures are used.

4. the Contractor shall use its own procurement procedures which reflect applicable State and local laws, rules, and regulations, provided that the procurements conform to applicable Federal law and the standards identified in this Contract.

a. The Contractor will maintain a contract administration system which ensures that subcontractors perform in accordance with the terms, conditions, and specifications of its contracts or purchase orders.

b. The Contractor will maintain a written code of standards of conduct governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Department or the Contractor shall participate in selection, or in the award or administration of a contract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:

i. the employee, officer or agent,

ii. any member of his immediate family,

iii. his or her partner; or

iv. an organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The Department's or the Contractor's officer, employees or agents will neither solicit nor accept gratuities, favors or anything of monetary value from contractors, potential contractors, or parties to subagreements. The Department and the Contractor may set minimum rules where the financial interest is not substantial or the gift is an unsolicited item of nominal intrinsic value. To the extent permitted by State or local law or regulations, such standards or conduct will provide for penalties, sanctions, or other disciplinary actions for violations of such standards by the Department's or the Contractor's officers, employees, or agents, or by subcontractors or their agents.

c. The Contractor's procedures will provide for a review of proposed procurements to avoid purchase of unnecessary or duplicative items. Consideration should be given to consolidating or breaking out procurements to obtain a more economical purchase. Where appropriate, an analysis will be made of lease versus purchase alternatives, and any other appropriate analysis to determine the most economical approach.

d. To foster greater economy and efficiency, the Contractor, if a governmental entity, is encouraged to enter into State and local intergovernmental agreements for procurement or use of common goods and services.

e. If allowed by law, the Contractor is encouraged to use Federal excess and surplus property in lieu of purchasing new equipment and property whenever such use is feasible and reduces project costs.

f. The Contractor may contract only with responsible contractors possessing the ability to perform successfully under the terms and conditions of a proposed procurement.

g. The Contractor shall maintain records sufficient to detail the significant history of a procurement. These records shall include, but are not necessarily limited to the following:

i. the rationale for the method of procurement,

ii. selection of contract type,

iii. contractor selection or rejection, and

iv. the basis for the contract price.

h. The Contractor may use time and material type contracts only:

i. after a determination that no other contract is suitable, and

ii. if the Contract includes a ceiling price that the Contractor exceeds at its own risk.

i. The Contractor alone will be responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements. These issues include, but are not limited to source evaluation, protests, disputes, and claims. These standards do not relieve the Contractor of any contractual responsibilities under its contracts.

j. The Contractor shall have protest procedures to handle and resolve disputes relating to its procurements and shall in all instances disclose information regarding the protest to the federal funding agency. A protestor must exhaust all administrative remedies with the Department and the Contractor before pursuing a protest with the federal funding agency.

5. the Contractor shall take all necessary affirmative steps to assure that minority firms, women's business enterprises, and labor surplus area firms are used when possible. Affirmative steps shall include:

a. placing qualified small and minority businesses and women's business enterprises on solicitation lists;

b. assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;

c. dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority business, and women's business enterprises;

d. establishing delivery schedules, where the requirement permits, which encourage participation by small and minority business, and women's business enterprises;

e. using the services and assistance of the Small Business Administration, and the Minority Business Development Agency of the Department of Commerce; and

f. requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in Article XVI, section 5, subsections a - e.

## XVII. DEFAULT, TERMINATION, & PAYMENT ADJUSTMENT

1. Each party may terminate this Contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall send a notice, which meets the notice requirements of this Contract, citing the default and giving notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within fifteen days of the notice. If the default is not cured within the fifteen days, the party giving notice may terminate this Contract 45 days from the date of the initial notice of default or at a later date specified in the notice.

2. The Department may terminate this Contract without cause, in advance of the specified termination date, upon 30 days written notice.

3. The Department agrees to use its best efforts to obtain funding for multi-year contracts. If continued funding for this Contract is not appropriated or budgeted at any time throughout the multi-year contract period, the Department may terminate this Contract upon 30 days notice.

4. If funding to the Department is reduced due to an order by the Legislature or the Governor, or is required by federal or state law, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 days written notice. If the specific funding source for the subject matter of this Contract is reduced, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 written notice being given to the Contractor.

5. If the Department terminates this Contract, the Department may procure replacement goods or services upon terms and conditions necessary to replace the Contractor's obligations. If the termination is due to the Contractor's failure to perform, and the Department procures replacement goods or services, the Contractor agrees to pay the excess costs associated with obtaining the replacement goods or services.

6. If the Contractor terminates this Contract without cause, the Department may treat the Contractor's action as a default under this Contract.

7. The Department may terminate this Contract if the Contractor becomes debarred, insolvent, files bankruptcy or reorganization proceedings, sells 30% or more of the company's assets or corporate stock, or gives notice of its inability to perform its obligations under this Contract.

8. If the Contractor defaults in any manner in the performance of any obligation under this Contract, or if audit exceptions are identified, the Department may, at its option, either adjust the amount of payment or withhold payment until satisfactory resolution of the default or exception. Default and audit exceptions for which payment may be adjusted or withheld include disallowed expenditures of federal or state funds as a result of the Contractor's failure to comply with federal regulations or state rules. In addition, the Department may withhold amounts due the Contractor under this Contract, any other current contract between the Department and the Contractor, or any future payments due the Contractor to recover the funds. The Department shall notify the Contractor of the Department's action in adjusting the amount of payment or withholding payment. This Contract is executory until such repayment is made.

9. The rights and remedies of the Department enumerated in this article are in addition to any other rights or remedies provided in this Contract or available in law or equity.

10. Upon termination of the Contract, all accounts and payments for services rendered to the date of termination will be processed according to the financial arrangements set forth herein for approved services rendered to date of termination. If the Department terminates this Contract, the Contractor shall stop all work as specified in the notice of termination. The Department shall not be liable for work or services performed beyond the termination date as specified in the notice of termination.

11. Any of the following events will constitute cause for the Department to declare Contractor in default of the Contract: a. Nonperformance of contractual requirements; b. A material breach of any term or condition of this contract. The Department will issue a written notice of default providing a ten (10) day period in which Contractor will have an opportunity to cure. Time allowed for cure will not diminish or eliminate Contractor's liability for damages. If the default remains, after Contractor has been provided the opportunity to cure, the Department may do one or more of the following: c. Exercise any remedy provided by law; d. Terminate this Contract and any related Contracts or portions thereof; e. Impose liquidated damages, if liquidated damages are listed in the Contract; f. Suspend Contractor from receiving future solicitations.

## XVIII. FEDERAL REQUIREMENTS

The Contractor shall comply with all applicable federal requirements. To the extent that the Department is able, the Department shall give further clarification of federal requirements upon the Contractor's request. If the Contractor is receiving federal funds under this Contract, certain federal requirements apply. The Contractor agrees to comply with the federal requirements to the extent that they are applicable to the subject matter of this Contract and are required by the amount of federal funds involved in this Contract.

**1. Civil Rights Requirements:**

a. The Civil Rights Act of 1964, Title VI, provides that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Health and Human Services regulation implementing this requirement is 45 CFR Part 80.

b. The Civil Rights Act of 1964, Title VII, (P.L. 88-352 & 42 U.S.C. § 2000e) prohibits employers from discriminating against employees on the basis of race, color, religion, national origin, and sex. Title VII applies to employers of fifteen or more employees, and prohibits all discriminatory employment practices.

c. The Rehabilitation Act of 1973, as amended, section 504, provides that no otherwise qualified handicapped individual in the United States shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Health and Human Services regulation 45 CFR Part 84 implements this requirement.

d. The Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), prohibits unreasonable discrimination on the basis of age in any program or activity receiving federal financial assistance. The Health and Human Services regulation implementing the provisions of the Age Discrimination Act is 45 CFR
Part 91.

e. The Education Amendments of 1972, Title IX, (20 U.S.C. §§ 1681-1683 and 1685-1686), section 901, provides that no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving federal financial assistance. Health and Human Services regulation 45 CFR Part 86 implements this requirement.

f. Executive Order No. 11246, as amended by Executive Order 11375 relates to "Equal Employment Opportunity," (all construction contracts and subcontracts in excess of $10,000)

g. Americans with Disabilities Act of 1990, (P.L.101-336), section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), prohibits discrimination on the basis of disability.

h. The Public Health Service Act, as amended, Title VII, section 704 and TITLE VIII, section 855, forbids the extension of federal support for health manpower and nurse training programs authorized under those titles to any entity that discriminates on the basis of sex in the admission of individuals to its training programs. Health and Human Services regulation implementing this requirement is 45 CFR Part 83.

i. The Public Health Service Act, as amended, section 526, provides that drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment because of their drug abuse or drug dependence, by any private or public general hospital that receives support in any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefitting from federal financial assistance by 45 CFR Part 84.

j. The Public Health Service Act, as amended, section 522, provides that alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse or alcoholism, by any private or public general hospital that receives support in any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefitting from federal financial assistance by 45 CFR Part 84.

2. **Confidentiality:** The Public Health Service Act, as amended, sections 301(d) and 543, require that certain records be kept confidential except under certain specified circumstances and for specified purposes. Confidential records include records of the identity, diagnosis, prognosis, or treatment of any patient that are maintained in connection with the performance of any activity or program relating to drug abuse prevention, i.e., drug abuse education, training, treatment, or research, or alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research that is directly or indirectly assisted by the federal government. Public Health Service regulations 42 CFR Parts 2 and 2a implement these requirements.

3. **Lobbying Restrictions:** Lobbying restrictions as required by 31 U.S.C. § 1352, requires the Contractor to abide by this section and to place it's language in all of it's contracts:

a. No federal funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Federal Standard Form LLL, "Disclosure Form to report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this article be included in the award documents for all subcontracts and that subcontractors shall certify and disclose accordingly.

4. **Debarment, suspension or other ineligibility:** The Contractor certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in this Contract by any governmental department or agency. The Contractor must notify the Department within 30 days in accordance with the notification requirements specified in Article III, section 11 of this Contract if the Contractor has been debarred by any governmental entity within the contract period. Debarment regulations are stated in Health and Human Services regulation 45 CFR Part 76.

5. **Environmental Impact:** The National Environmental Policy Act of 1969 (NEPA) (Public Law 91-190) establishes national policy goals and procedures to protect and enhance the environment. NEPA applies to all federal agencies and requires them to consider the probable environmental consequences of any major federal activity, including activities of other organizations operating with the concurrence or support of a federal agency. This includes grant-supported activities under this Contract if federal funds are involved. Additional environmental requirements include:

a. the institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order 11514;

b. the notification of violating facilities pursuant to Executive Order 11738 (all contracts, subcontracts, and subgrants in excess of $100,000);

c. the protection of wetlands pursuant to Executive Order 11990;

d. the evaluation of flood hazards in floodplains in accordance with Executive Order 11988;

e. the assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.);

f. the conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176 (c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§ 7401 et seq.);

g. the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523),

h. the protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205) and;

i. the protection of the national wild and scenic rivers system under the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 *et seq.*).

6. **Human Subjects:** The Public Health Service Act, section 474(a), implemented by 45 CFR Part 46, requires basic protection for human subjects involved in Public Health Service grant supported research activities. Human subject is defined in the regulation as "a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual or identifiable private information." The regulation extends to the use of human organs, tissues, and body fluids from individually identifiable human subjects as well as to graphic, written, or recorded information derived from individually identifiable human subjects. The regulation also specifies additional protection for certain classes of human research involving fetuses, pregnant women, human in vitro fertilization, and prisoners. However, the regulation exempts certain categories of research involving human subjects which normally involve little or no risk. The exemptions are listed in 45 CFR Part 46.101(b). The protection of human subjects involved in research, development, and related activities is found in P.L. 93-348.

7. **Sterilization:** Health and Human Services and Public Health Service have established certain limitations on the performance of nonemergency sterilizations by Public Health Service grant-supported programs or projects that are otherwise authorized to perform such sterilizations. Public Health Service has issued regulations that establish safeguards to ensure that such sterilizations are performed on the basis of informed consent and that the solicitation of consent is not based on the withholding of benefits. These regulations, published at 42 CFR Part 50, Subpart B, apply to the performance of nonemergency sterilizations on persons legally capable of consenting to the sterilization. Federal financial participation is not available for any sterilization procedure performed on an individual who is under the age of 21, legally incapable of consenting to the sterilization, declared mentally incompetent, or is institutionalized.

8. **Abortions and Related Medical Services:** Federal financial participation is generally not available for the performance of an abortion in a grant-supported health services project. For further information on this subject, consult the regulation at 42 CFR Part 50, Subpart C.

9. **Recombinant DNA and Institutional Biosafety Committees:** Each institution where research involving recombinant DNA technology is being or will be conducted must establish a standing Biosafety Committee. Requirements for the composition of such a committee are given in Section IV of *Guidelines for Research Involving Recombinant DNA Molecules*, (49 FR 46266 or latest revision), which also discusses the roles and responsibilities of principal investigators and contractor institutions. *Guidelines for Research Involving Recombinant DNA Molecules and Administrative Practices Supplement* should be consulted for complete requirements for the conduct of projects involving recombinant DNA technology.

10. **Animal Welfare:** The *Public Health Service Policy on Humane Care and Use of Laboratory Animals By Awardee Institutions* requires that applicant organizations establish and maintain appropriate policies and procedures to ensure the humane care and use of live vertebrate animals involved in research activities supported by Public Health Service. This policy implements and supplements the U.S. *Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research, and Training* and requires that institutions use the *Guide for the Care and Use of Laboratory Animals* as a basis for developing and implementing an institutional animal care and use program. This policy does not affect applicable State or local laws or regulations which impose more stringent standards for the care and use of laboratory animals. All institutions are required to comply, as applicable, with the Animal Welfare Act as amended (7 U.S.C. 2131 et seq.) and other federal statutes and regulations relating to animals. These documents are available from the Office for Protection from Research Risks (OPRR), National Institutes of Health, Bethesda, MD 20892, (301) 496-7005.

11. **Contract Provisions:** The Contractor must include the following provisions in its contracts, as limited by the statements enclosed within the parentheses following each provision:

a. administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provides for such sanctions and penalties as may be appropriate. (Contracts other than small purchases. Small purchase involve relatively simple and informal procurement methods that do not cost more than $100,000 in aggregate.)

b. termination for cause and for convenience by the contractor or subgrantee including the manner by which it will be effected and the basis for settlement. (All contracts in excess of $10,000)

c. compliance with Executive Order 11246 of September 24, 1965 entitled "Equal Employment Opportunity," as amended by Executive Order 11375 of October 13, 1967 and as supplemented in Department of Labor regulations (41 CFR Chapter 60). (All construction contracts awarded in excess of $10,000 by the Contractor and its contractors or subgrantees)

d. compliance with the Copeland "Anti-Kickback" Act (18 U.S.C. 874) as supplemented in Department of Labor regulations (29 CFR Part 3). (All contracts and subgrants for construction or repair)

e. compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) as supplemented by Department of Labor regulations (29 CFR Part 5). (Construction contracts in excess of $2,000 awarded when required by Federal grant program legislation)

f. compliance with the Contract Work Hours and Safety Standards Act, sections 103 and 107, (40 U.S.C. 327-330) as supplemented by Department of Labor regulations (29 CFR Part 5). (Construction contracts awarded in excess of $2,000, and in excess of $2,500 for other contracts which involve the employment of mechanics or laborers)

g. notice of the federal awarding agency requirements and regulations pertaining to reporting.

h. notice of federal awarding agency requirements and regulations pertaining to patent rights with respect to any discovery or invention which arises or is developed in the course of or under such contract.

i. federal awarding agency requirements and regulations pertaining to copyrights and rights in data.

j. access by the Department, the Contractor, the Federal funding agency, the Comptroller General of the United States, or any of their duly authorized representatives to any books, documents, papers, and records of the Contractor which are directly pertinent to that specific contract for the purpose of making audit, examination, excerpts, and transcriptions.

k. compliance with all applicable standards, orders, or requirements of the Clear Air Act, section 306, (42 U.S.C. 1857(h)), the Clean Water Act, section 508, (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15). (Contracts, subcontracts, and subgrants of amounts in excess of $100,000)

l. mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-163).

12. **(Governmental entities only) Merit System Standards:** The Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763), requires adherence to prescribed standards for merit systems funded with federal funds.

13. **Misconduct in Science:** The United States Public Health Service requires certain levels of ethical standards for all PHS grant-supported projects and requires recipient institutions to inquire into, investigate and resolve all instances of alleged or apparent misconduct in science. Issues involving potential criminal violations must be promptly reported to the HHS Office of Inspector General. (See regulations in 42 CFR Part 50, Subpart A)

END OF GENERAL PROVISIONS

**ATTACHMENT B**
**SPECIAL PROVISIONS**

**TABLE OF CONTENTS**

**Covered Services**
**Limitations & Exclusions**
**Co-payment & Co-insurance Requirements**

Covered Services are the same under both the Traditional and Non-Traditional Medicaid Plans unless otherwise indicated. Co-payments and co-insurances are listed if required. **Pregnant women and children under age 18 are exempt from all co-payment and co-insurance requirements. Services related to family planning are excluded from all co-payment and co-insurance requirements.** Medicaid Provider Manuals provide detailed information regarding covered services and are available to the CONTRACTOR upon request.

A. In General

The CONTRACTOR will provide the following benefits to Enrollees in accordance with Medicaid benefits as defined in the Utah State Plan subject to the exception or limitations as noted below. The DEPARTMENT reserves the right to interpret what is in the State plan. Medicaid services can only be limited through utilization criteria based on Medical Necessity. The CONTRACTOR will provide at least the following benefits to Enrollees.

The CONTRACTOR is responsible to provide or arrange for all Medically Necessary Covered Services on an emergency basis 24 hours each day, seven days a week. The CONTRACTOR is responsible for payment for all covered Emergency Services furnished by providers that do not have arrangements with the CONTRACTOR.

**B. Hospital Services**

**1. Inpatient Hospital**

Services furnished in a licensed, certified hospital are Covered Services.

**Non-Traditional Medicaid Plan excludes the following revenue codes:**

430 - 439 (Occupational Therapy)
380 - 382, and 391 (Whole Blood)
390 and 399 (Autologous or self blood storage for future use)
811 - 813 (Organ Donor charges)

**CO-INSURANCE**

**Traditional Medicaid:** $220.00 for non-emergency admissions. Limited to $220.00 per Enrollee per calender year.

**Non-Traditional Medicaid:** $220.00 for each non-emergency admission per Enrollee. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

**2. Outpatient Hospital**

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital are Covered Services.

**CO-PAYMENT**

**Traditional Medicaid:** $2.00 co-payment per visit. Limited to one co-payment per date of service per provider. The facility fees associated with services provided in an outpatient hospital or free-standing ambulatory surgical centers are subject to $2.00 co-payment per date of service per provider. Annual calendar year maximum for any combination of physician, podiatry, outpatient hospital, and surgical centers is $100.00 per Enrollee.

**Non-Traditional Medicaid:** $3.00 co-payment per visit. Limited to one co-payment per date of service per provider. The facility fees associated with services provided in an outpatient hospital or a free standing ambulatory surgical centers are subject to $3.00 co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

**3. Emergency Department Services**

Emergency Services provided to Enrollees in designated hospital emergency departments are Covered Services.

**CO-PAYMENT**

**Traditional Medicaid:** Co-payment is $6.00 for non-emergency use of the emergency room.

**Non-Traditional Medicaid:** Co-payment is $6.00 for non-emergency use of the emergency room. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

C. Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision are covered Services.

**Non-Traditional Medicaid excludes** office visits in conjunction with allergy injections (CPT codes 95115 through 95134 and 95144 through 95199).

**CO-PAYMENT**

**Traditional Medicaid**: Co-pay is $3.00 per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 per Enrollee for any combination of physician, osteopath, podiatry, outpatient hospital, freestanding emergency centers, and surgical centers. Co-payment required for preventive services and immunizations.

**Non-Traditional Medicaid:** Co-payment is $3.00 per visit. Limited to one co-payment per date of service per provider. No co-payment for preventive services and immunizations. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

**D. General Preventive Services**

The CONTRACTOR must develop or adopt practice guidelines consistent with current standards of care, as recommended by professional groups such as the American Academy of Pediatric and the U.S. Task Force on Preventive Care.

A minimum of three screening programs for prevention or early intervention (e.g. Pap Smear, diabetes, hypertension).

**E. Vision Care**

Services provided by licensed ophthalmologists or licensed optometrists, and opticians within their scope of practice are Covered Services. Services include, but are not limited to, the following:

1. Eye examinations and care to identify and treat medical problems
2. Eye refractions, examinations
3. Laboratory work
4. Lenses
5. Eyeglass Frames
6. Repair of Frames
7. Repair or Replacement of Lenses
8. Contact Lenses (when Medically Necessary)

**Traditional Medicaid Plan:** Full coverage for all Non-Traditional clients.

**Non-Traditional Medicaid Plan is limited to the following services and limitations:** Non- Traditional Medicaid clients have coverage for vision screening in conjunction with determining refractions. Providers may bill using procedure codes 92002, 92004, 92012, and 92014. There is a maximum Medicaid benefit of $31.21 for screening services. Charges above the $31.21 are non-covered Medicaid services and are considered the patient's responsibility. Eye refraction/examination is limited to one eye examination every 12 months.

Eyeglasses (lenses and frames) are not covered.

Services to identify and treat medical problems such as diabetic retinopathy, glaucoma, cataracts, etc., may be billed by ophthalmologists and optometrists using procedure codes

92020, 92083, 92135, 95930, 99201-99205, 99211-99215, 65210, 65220, 65222, 67820, 68761, and 68801. Ophthalmologists may bill additional procedure codes within their scope of service that are covered by Medicaid. These services are paid based on the Medicaid fee schedule and are considered payment in full.

**F. Lab and Radiology Services**

Professional and technical laboratory and X-ray services furnished by licensed and certified providers are Covered Services. All laboratory testing sites, including physician office labs, providing services under this Contract will have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

**G. Physical and Occupational Therapy**

**1. Physical Therapy**

Treatment and services provided by a licensed physical therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

**2. Occupational Therapy**

Treatment of services provided by a licensed occupational therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified occupational therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

**Non-Traditional Medicaid:** Physical therapy and occupational therapy (in combination) are limited to 10 visits per calendar year.

**CO-PAYMENT**

**Non-Traditional Medicaid:** $3.00 co-payment per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

H. Speech and Hearing Services

Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss are Covered Services.

**Non-Traditional Medicaid Plan:** Full coverage except hearing aids are limited to congenital (birth defect) hearing losses only.

I. Podiatry Services

Services provided by a licensed podiatrist are Covered Services.

**Traditional Medicaid Plan:** Full coverage is limited to children up to age 21 and pregnant women. Limited podiatry benefits are covered for adults.

**Non-Traditional Medicaid Plan:** Limited podiatry benefits are covered.

**CO-PAYMENT**

**Traditional Medicaid**: Co-pay is $3.00 per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 per Enrollee for any combination of physician, podiatry, outpatient hospital, freestanding emergency centers, and surgical centers. Co-payment required for preventive services and immunizations.

**Non-Traditional Medicaid:** Co-payment is $3.00 per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

J. End Stage Renal Disease - Dialysis

Treatment of end stage renal dialysis for kidney failure is a Covered Service. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

K. Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client’s home when the client is homebound or semi-homebound are Covered Services. Home health care must be rendered by a Medicare-certified Home Health Agency. The CONTRACTOR agrees to comply with all federal regulations regarding surety bonds. The CONTRACTOR agrees to contract with only Medicare-certified Home Health Agencies who carry a surety bond if federal regulations regarding this requirement are reinstated. The DEPARTMENT agrees to notify the CONTRACTOR if such federal regulations are reinstated.

Personal care services as defined in the DEPARTMENT's Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

L. Hospice Services

Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care are Covered Services. Hospice care must be rendered by a Medicare-certified hospice. When an Enrollee is receiving hospice in a nursing facility, ICF/MR or freestanding hospice facility, the CONTRACTOR is responsible for up to 30 days of hospice care.

**M. Private Duty Nursing**

Services provided by licensed nurses for ventilator-dependent children and technology-dependent adults in their home in lieu of hospitalization if Medically Necessary, feasible, and safe to be provided in the patient's home are Covered Services. Requests for continuous care will be evaluated on a case by case basis and must be approved by the CONTRACTOR.

**Non-Traditional Medicaid Plan**: Private Duty Nursing is not a covered service.

N. Medical Supplies and Medical Equipment

This Covered Service includes any necessary supplies and equipment used to assist the Enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the Enrollee to his or her best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but should be ordered by a physician. Durable medical equipment (DME) includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies must be provided by a DME supplier that has a surety bond. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 of the Utah Administrative Code, with the exception of criteria concerning long term care since long term care services are not covered under the Contract.

**Non-Traditional Medicaid Plan** excludes blood pressure monitors, and replacement of lost, damaged, or stolen durable medical equipment or prosthesis.

**O. Abortions and Sterilizations**

These Covered Services are provided to the extent permitted by Federal and State law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. These requirements must be met regardless of whether Medicaid is primary or secondary payer.

P. Treatment for Substance Abuse and Dependency

Treatment will cover medical detoxification for alcohol or substance abuse conditions is a Covered Service. Medical services including hospital services will be provided for the medical non-psychiatric aspects of the conditions of alcohol/drug abuse.

Q. Organ Transplants

The following transplantations are Covered Services for all Enrollees: kidney, liver, cornea, bone marrow, stem cell, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 2 of this Contract.

**Non-Traditional Medicaid Plan** is limited to kidney, liver, cornea, bone marrow, stem cell, heart, and lung transplantations.

**R. Other Outside Medical Services**

The CONTRACTOR, at its discretion and without compromising quality of care, may choose to provide services in Freestanding Emergency Centers, Surgical Centers and Birthing Centers.

**CO-PAYMENT**

**Traditional Medicaid**: $2.00 co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 per Enrollee for any combination of physician, podiatry, outpatient hospital, freestanding emergency centers, and surgical centers. (Co-payment does not apply to birthing centers.)

**Non-Traditional Medicaid:** $3.00 co-payment per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

**S. Long Term Care**

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within thirty (30) days or less. When the prognosis of an Enrollee indicates that long term care (over 30 days) will be required, the CONTRACTOR will notify the DEPARTMENT and the skilled nursing facility of the prognosis determination and will initiate disenrollment. Skilled nursing care is to be rendered in a skilled nursing facility which meets federal regulations of participation.

**T. Services to CHEC Enrollees**

**1. CHEC Services**

The CONTRACTOR will provide to CHEC Enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan. The CONTRACTOR is not responsible for home and community-based services available through Utah's Home and Community-Based waiver programs.

The CONTRACTOR will provide the full early and periodic screening, diagnosis, and treatment services to all eligible children and young adults up to age 21 in accordance with the periodicity schedule as described in the Utah CHEC Provider Manual. All children between six months and 72 months must be screened for blood lead levels.

**Non-Traditional Medicaid:** CHEC services are not covered. Enrollees who are 19 or 20 years of age receive the adult scope of services.

**2. CHEC Policies and Procedures**

The CONTRACTOR agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the CHEC periodicity schedules. These policies and procedures will emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHEC Enrollees.

**U. Family Planning Services**

These Covered Services includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah law.

Birth control services include information and instructions related to the following:

1. Birth control pills;
2. Norplant (removal only);
3. Depo Provera;
4. IUDs;
5. Barrier methods including diaphragms, male and female condoms, and cervical caps;

6. Vasectomy or tubal ligations;
7. Nuvaring; and
8. Office calls, examinations or counseling related to contraceptive devices.

**Non-Traditional Medicaid:** Norplant is not a covered service.

## V. High-Risk Prenatal Services

### 1. In General - Ensure Services are Appropriate and Coordinated

The CONTRACTOR must ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive, preventive, and continuous either by direct service or referral to an appropriate provider or facility. In the determination of the provider and facility to which a high risk prenatal Enrollee will be referred, care must be taken to ensure that the provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling must be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others.

### 2. Risk Assessment

#### a. General

Enrollees who are pregnant should be risk assessed at their first prenatal visit, preferably in the first trimester, and later in pregnancy as low, moderate or high risk for medical and psychosocial conditions which may contribute to poor birth outcomes. Women found to not be moderate or high risk should be evaluated for change in risk status throughout their pregnancy.

#### b. Assessment tools

The CONTRACTOR must have a mechanism to assure that prenatal care providers conduct risk assessments on all pregnant Enrollees on entry into prenatal care and, as needed, on an ongoing basis to re-assess risk status throughout pregnancy. Assessment tools used by prenatal care providers should be consistent with standards of practice and linked to the CONTRACTOR’s care coordination/case management programs for those Enrollees who have a moderate or high risk status. All prenatal health care providers should be able to identify the full range of medical and psychosocial risk factors and either provide appropriate care or initiate referrals to the appropriate level of care/consultation throughout pregnancy.

The CONTRACTOR’s healthy pregnancy programs must also include assessment of risk for all pregnant Enrollees as soon as a pregnancy is identified and as needed, on an ongoing basis. The CONTRACTOR shall refer to and coordinate care with the prenatal care providers concerning the treatment plan and risk factors. The CONTRACTOR’s risk assessments shall be overseen by the CONTRACTOR’s Medical Director.

Assessment tools used by prenatal care providers and the CONTRACTOR should include a means of identifying prenatal risk factors based on medical and psychosocial conditions that may contribute to poor birth outcomes and that will assist the CONTRACTOR and prenatal care providers in determining the level and intensity of care coordination/case management required to ensure the appropriate level of perinatal care.

The DEPARTMENT recommends "Guidelines for Perinatal Care by American Academy of Pediatrics, and American College of Obstetricians and Gynecologists" as a resource for evaluating and classification of risk, the level of care and consultation recommended based on risk status, and the level of care coordination required. The DEPARTMENT recommends that Enrollees be identified with a status of no risk, low risk, moderate risk, or high risk and that at a minimum, Enrollees who are classified as moderate or high risk should receive care coordination/case management services.

**c. Recommended Prenatal Screening**

**(1) Hepatitis B surface antigen**

The DEPARTMENT recommends routine prenatal screening of every woman for hepatitis B surface antigen (HBsAg) early in prenatal care to identify all those at high risk for transmitting the virus to their newborns and later in pregnancy for women who tested negative for HbsAg during early pregnancy but who are at high risk based on:

(a) evidence of clinical hepatitis during pregnancy;

(b) injection drug use;

(c) occurrence during pregnancy or a history of STDs; or

(d) judgement of the health care provider.

When a woman is found to be HBsAg-positive, the CONTRACTOR will provide HBIG and HB vaccine at birth. Initial treatments should be given during the first 12 hours of life. The CONTRACTOR will comply with all other requirements as specified in Utah Law R386-702-9.

**(2) Sexually Transmitted Diseases (STDs)**

The DEPARTMENT recommends prenatal screening including sexually transmitted diseases such as gonorrhea, chlamydia, and standard serological testing for syphilis as required by Utah Law 26-6-20. Testing for STDs should be repeated in the 3rd trimester for Enrollees at high risk for exposure.

**(3) HIV testing**

The DEPARTMENT also recommends testing of all pregnant Enrollees for HIV and testing and treatment at labor and delivery for women who have not received testing during pregnancy. The CONTRACTOR should encourage providers to develop policies that are consistent with the American College of Obstetricians and Gynecologists, including but not limited to:

(a) universal testing with an opt-out approach (testing of all pregnant women and not just those who appear to be at high risk for HIV;

(b) flexibility in the consent process; and

(c) prevention and referral through education during prenatal care.

Prenatal care providers should have a mechanism to document in medical records when pregnant Enrollees are offered HIV tests and when tests are refused. Pregnant Enrollees who refuse HIV testing earlier in pregnancy should be offered HIV testing again later in pregnancy. Pregnant Enrollees who test positive should receive treatment throughout their pregnancy and labor and delivery to reduce the risk of HIV transmission to their newborns.

**3. Prenatal Initiative Program**

Prenatal services provided directly or through agreements with appropriate providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:

a. perinatal care coordination

b. prenatal and postnatal home visits

c. group prenatal and postnatal education

d. nutritional assessment and counseling

e. prenatal and postnatal psychosocial counseling

Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness should be referred to an appropriate mental health care provider.

**W. Services for Children with Special Needs**

**1. In General**

In addition to primary care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care must be provided in a timely manner. The specialized care must comprehensively address all areas of need to be most effective and must be coordinated with primary care and other services to be most efficient. The children's families must be involved in the planning and delivery of the care for it to be acceptable and successful.

**2. Services Requiring Timely Access**

All children with special health care needs must have timely access to the following services:

a. Comprehensive evaluation for the condition.

b. Pediatric subspecialty consultation and care appropriate to the condition.

c. Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.

d. Durable medical equipment appropriate for the condition.

e. Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

In addition, children with the conditions marked by * below must have timely access to coordinated multispecialty clinics, when Medically Necessary, for their disorder.

**3. Definition of Children with Special Health Care Needs**

The definition of children with special health needs includes, but is not limited to, the following conditions:

a. Nervous System Defects such as
Spina Bifida*
Sacral Agenesis*
Hydrocephalus

b. Craniofacial Defects such as
Cleft Lip and Palate*
Treacher - Collins Syndrome

c. Complex Skeletal Defects such as
Arthrogryposis*
Osteogenesis Imperfecta*
Phocomelia*

d. Inborn Metabolic Disorders such as
Phenylketonuria*
Galactosemia*

e. Neuromotor Disabilities such as
Cerebral palsy*
Muscular Dystrophy*
Complex Seizure Disorders

f. Congenital Heart Defects

g. Genetic Disorders such as
Chromosome Disorders
Genetic Disorders

h. Chronic Illnesses such as
Cystic Fibrosis
Hemophilia
Rheumatoid Arthritis
Bronchopulmonary Dysplasia
Cancer
Diabetes
Nephritis
Immune Disorders

i. Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

The CONTRACTOR agrees to cover all Medically Necessary services for children with special health care needs such as the ones listed above. The CONTRACTOR further agrees to cooperate with the DEPARTMENT's quality assurance monitoring for this population by providing requested information.

**X. Medical and Surgical Services of a Dentist**

**1. Who May Provide Services**

Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

**2. Universe of Covered Services**

Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the Contract.

3. Services Specifically Covered

The CONTRACTOR is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider should refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital, the CONTRACTOR is responsible for coverage of the inpatient hospital stay. The CONTRACTOR is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

4. **Dental Services Not Covered**

The CONTRACTOR is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

**Y. Diabetes Education**

The CONTRACTOR shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

1. has recently been diagnosed with diabetes, or

2. is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee's self-management plan, or
3. is determined by the health care professional to require re-education or refresher training.

**Z. HIV Prevention**

The CONTRACTOR shall have in place the following:

**1. General Program**

The CONTRACTOR must have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) should must be culturally and linguistically appropriate. All Enrollees should be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah State-operated programs.

**2. Focused Program for Women**

Special attention should be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, antiretroviral therapy during pregnancy.

**SUMMARY OF CO-PAYMENT AND
CO-INSURANCE REQUIREMENTS**

Pregnant women and children under age 18 are exempt from all co-payment and co-insurance requirements. Services related to family planning are excluded from all co-payment and co-insurance requirements.

**Traditional Medicaid Plan**

**Inpatient hospital:** Each Enrollee must pay a $220.00 co-insurance for non-emergency inpatient hospital admissions. The maximum co-payment per Enrollee per calendar year is $220.00 for non-emergency inpatient hospital admissions.

**Emergency Department:** Each enrollee must pay a $6.00 co-payment for non-emergency use of the emergency room.

**Physician, osteopath, podiatrist, outpatient hospital, freestanding emergency centers, and surgical centers:** Each Enrollee must pay a $3.00 co-payment per provider per day. The maximum co-payment per Enrollee per calendar year is $100.00 for any combination of the services provided by the above providers.

**Prescription Drugs:** Each Enrollee must pay a co-payment of $3.00 per prescription. The maximum co-payment is $15.00 per Enrollee per month.*

**There is no overall out-of-pocket maximum for the above services.**

**Non-Traditional Medicaid Plan**

**Inpatient hospital:** Each Enrollee must pay a $220.00 co-insurance for each non-emergency inpatient hospital admissions.

**Emergency Department:** Each enrollee must pay a $6.00 co-payment for non-emergency use of the emergency room.

**Physician, osteopath, podiatrist, physical therapist, occupational therapist, chiropractor*, freestanding emergency centers, surgical centers:** Each Enrollee must pay a $3.00 co-payment per provider per day.

**Prescription Drugs:** Each Enrollee must pay a co-payment of $2.00 per prescription.*

**The out-of-pocket maximum for each Enrollee is $500.00 for any combination of the above co-payments and co-insurance.**

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* Pharmacy services and chiropractic services are not the responsibility of the CONTRACTOR.

**Utah's Quality Assessment and Performance Improvement Plan**
**(Utah "QAPIP")**

**For Contracted Medicaid Health Plans**

**Attachment D: Program Description**

**State of Utah**
**Department of Health**
**Division of Health Care Financing**
**Bureau of Managed Health Care**

**August 13, 2003**

Utah Dept of Health

Utah Department of Health

Table of Contents

**I. Utah Quality Assessment and Performance Improvement Monitoring Plan (QAPIP) Executive Summary:**

The Utah Department of Health (DOH), Division of Health Care Financing (DHCF), Bureau of Managed Health Care (BMHC) by authority of 42 CFR, Part 438, Subparts C, D, E, F, H (438.602, 438.608, 438.610), and Subpart I (438.700) has oversight responsibility of contracted Medicaid health plans to ensure the delivery of quality health care and compliance with state and federal regulations.

The BMHC oversight methodology consists of activities to collect and analyze data from on-site reviews, required reports, and other internal and external data sources. This information is used to determine compliance with state Medicaid requirements; federal regulations pertaining to managed care entities; to identify opportunities for improvement and areas of non-compliance. When BMHC identifies non-compliance and areas where improvement is needed, BMHC makes recommendations and requires corrective action plans (CAP's). Health plans are required to submit CAP's according to specified timeframes; BMHC reviews what is submitted and either accepts or requests a revised CAP. Health plans can request extensions to the required CAP timeframes or appeal the BMHC's findings. Once the health plan submits an acceptable action plan, the BMHC provides adequate opportunity for the plan to implement corrections and improvements. Follow up activities are conducted thereafter to assess progress toward compliance and address areas for continuous improvement.

The BMHC uses information from quality monitoring activities to assess the effectiveness of its monitoring program, implement improvements to its oversight processes, update health plan compliance requirements and develop work plans for subsequent years. The BMHC reports to Centers for Medicare and Medicaid Services (CMS) as required concerning results of quality monitoring activities and program evaluations.

## II. Utah Quality Assessment and Performance Improvement Monitoring Plan (QAPIP) Program Description

### A. Overview:

The Utah Department of Health (DOH), Division of Health Care Financing (DHCF), Bureau of Managed Health Care (BMHC) by authority of 42 CFR, Part 438, Subparts C, D, E, F, H (438.602, 438.608, 438.610), and Subpart I (438.700) has oversight responsibility of contracted Medicaid health plans to ensure the delivery of quality health care and compliance with state and federal regulations.

The UTAH QAPIP encompasses oversight of regulations pertaining to Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs) and Primary Care Case Management (PCCM) entities.

### B. Purpose:

The purpose of the Utah Quality Assessment and Performance Improvement Plan is to ensure that the Medicaid health plans provide quality health care to Medicaid enrollees, to provide a mechanism to ensure continuous improvement in the care and services provided and assess compliance to state and federal regulations required for managed care entities.

### C. Objectives:

- To establish a monitoring plan that uses experts outside of the BMHC to promote interagency cooperation and support other state DOH programs.
- To establish a monitoring plan which includes deeming provisions, in order to minimize duplication and redundancy of comparable monitoring content for organizations that have received accreditation by a nationally recognized accreditation body.
- To assess the quality, availability and access to, coordination of, and appropriateness of care and services provided to Medicaid enrollees (including those with special health care needs) under MCO, PIHP and PCCM contracts.
- To assure care and services are provided in a culturally competent manner, which respects the rights of enrollees, including those with disabilities.
- To assess compliance through regular monitoring in a way that promotes collaboration and continuous quality improvement.
- To ensure adherence to contract requirements, state and federal regulations applicable to the types of health plans contracted with Medicaid.
- To assure appropriate adherence to privacy and confidentiality rules in the provision of care and services.
- To assure the organizations structure, operations and information systems support adherence to the Utah QAPIP, program oversight needs and meet federal and state regulations.
- To assure that data and documentation necessary for quality oversight is accurate and complete.

**D. Quality Assessment and Performance Improvement (QAPI) Strategy:**

The BMHC's methods of oversight of contracted Medicaid health plans involve an integrated approach using information derived from the following four activities. These include:

1. **Health Plan Compliance Reviews**
2. **Internal Surveillance and Tracking (analysis of internal data)**
3. **External Quality Review (EQR)**
4. **Annual Program Review**

**1. Health Plan Compliance Reviews**

The BMHC conducts periodic reviews of contracted MCOs, PIHPs and PCCMs to monitor contract compliance and compliance to state and federal regulations applicable to these types of health plan entities. Reviews are done using the Utah Quality Assessment and Performance Improvement Plan (QAPIP), which is a comprehensive set of compliance Standards based on quality improvement, contract monitoring, and regulatory oversight needs. Most of the compliance Standards in the QAPIP is applicable to MCO and PIHP health plan entities. Oversight of PCCM contracts and compliance with state and federal regulations is also accomplished through the UTAH QAPIP; although, much fewer of the compliance Standards are applicable to PCCM entities.

The BMHC's conducts periodic comprehensive quality monitoring reviews (CQMRs) using the UTAH QAPIP compliance Standards. Frequency of CQMRs is determined by the level of compliance demonstrated during the on-reviews, internal surveillance and monitoring (number 2, described below), the amount of structural or operational changes made following reviews or based on other oversight needs. For all MCO or PIHP entities CQMR's will occur at least every threes years and more frequently when necessary. Annually, follow-up reviews will be done to assess progress toward recommended improvements and CAPs. The BMHC may also conduct a focused review of a particular area(s); these are Follow-up/ Focused Quality Monitoring Review's (FQMR's).

CQMRs consist of review of all UTAH QAPIP pertaining to the type of entity being reviewed and all applicable data sources for each area. The UTAH QAPIP delineates compliance areas that require detailed program narratives, any mandatory data sources needed to assess compliance, authority for particular areas of compliance, applicability of deeming status for entities who have received national accreditation, and DOH staff resources that may be used to assess each compliance area. Documentation requirements for annual monitoring will be tailored to the level of compliance from the most recent CQMR, analysis from internal surveillance, and other monitoring needed relating to quality, access to care and appropriateness of care and services, etc.

CQMRs for MCOs or PIHPs will occur "on-site" at the organization's local office(s). On-site reviews will consist of reviewing documentation, interviewing staff and conducting an exit conferencing, which outlines the organization's strengths and weaknesses. The BMHC may use on-site review, in-person meetings or teleconferencing to conduct

FQMRs. For PCCMs, an assessment of compliance to applicable regulations may be conducted less formally (telephone conference following review of applicable documentation) and therefore not require an on-site review. The BMHC's Quality Monitoring Unit staff and other DOH consultants will participate in review activities. The BMHC uses consultants from the Division of Community and Family Health Services, the Office of Health Care Statistics and other DHCF staff to conduct reviews.

Following each review, the BMHC will compile a report addressing the level of compliance to applicable Utah QAPIP Standards for the type of entity being reviewed. This report will detail findings, recommendations for improvements and general comments. Written corrective action plans (CAPs) for any areas of non-compliance will be required as necessary. The BMHC will conduct follow-up reviews annually that will assess the plan's progress toward CAPs, other recommended improvements and monitoring related to reviews and any reports required by the contract relating to quality, access to care and appropriateness of care and services since the last review. Depending on the level of compliance, BMHC may elect to repeat CQMR as often as necessary or conduct a partial/focused review annually until the required level of compliance is achieved. Quarterly progress reports (verbal or written) may be required depending on the level of non-compliance determined from CQMR or FQMRs.

The BMHC will regularly monitor areas requiring annual oversight (see compliance Standards for "crosswalk" of annual monitoring areas). Attestation statements may be permitted to satisfy part(s) of the QAPIP compliance areas after a sufficient level of performance is demonstrated through CQMR's. Attestation statements are permitted only for areas that have not changed or have changed minimally since the last review. The BMHC will determine if the attestations are acceptable on a case-by-case basis. These will permit the health plan to not have to provide full program narratives for areas that have not changed since the last review or have changed minimally. The BMHC will determine if attestations are acceptable on a case-by-case basis.

Annually, Medicaid MCOs and PIHPs are required to produce a Work Plan (WP) each new calendar year detailing all quality assessment and performance improvement (QAPI) activities; including activities related to recommended improvements from reviews/CAPs, the organization's clinical and non clinical performance improvement projects/studies, specific program activities, projects related to priority population groups, federal or state requirements, etc. Additionally, on completion of each calendar year the health plans are required to conduct a comprehensive program evaluation, called a Work Plan Evaluation (WPE), to determine the effectiveness of interventions in each area of the WP. The WPE is expected to be part of the process used to develop the WP for each new year and update the organizations overall Quality Improvement Program Description (QIPD), if necessary.

The BMHC on an ongoing basis will provide input on WP, WPE and annually updated QIPD's as part of annual monitoring activities or reviews for MCOs and PIHPs. PCCMs are not required to submit these documents since they are outside the scope of their regulations; however, may be required to submit other annual reports related to applicable regulations or compliance areas.

**a. Center for Medicare and Medicaid Services (CMS) Reporting:**

In accordance with 42 CFR, part 438, 438.202, the BMHC will submit to CMS any required repots relating to BMHC's UAPIP/quality improvement (QI) strategy, reports on the implementation and effectiveness of the QAPIP/QI strategy and of updates whenever substantial changes to the UAPIP/QI strategy are made. Additionally, CMS may require the BMHC to submit reports of findings from compliance reviews and EQR's.

**b. Documentation Requirements and Timelines:**

Each health plan will be required to submit documentation that specifically addresses all compliance Standards in the QAPIP prior to a CQMR and FQMR. This documentation is required to be organized and categorized in accordance with the sequencing of each domain and Standard within the Utah QAPIP. Process narratives (a description of the compliance area and how compliance is achieved) are mandatory for specific areas in which exhibits alone are insufficient to determine how the plan operates in the given area (see "crosswalk" section of compliance Standards).

Prior to an audit, the health plan may be required to submit pre-review documentation as early as 60 days before a CQMR or FQMR. All documentation is required to be available during the entire time of an on-site review. Organization's being reviewed are required to provide suitable, private workspace; i.e., private conference room with a phone, for the number of staff participating and make appropriate plan staff available to assist in finding necessary information during documentation review sessions or for answering questions. Prior to a CQMR or FQMR an agenda will be developed including time frames for reviewing documentation, interviews, post interview team consultation and an exit conference.

Following a CQMR or FQMR the BMHC will complete a compliance report within 60 calendar days of the date of the exit conference. The health plans, if necessary, will be required to submit a written plan of correction within 45 calendar days of the receipt of the compliance report or submit an appeal of the BMHC's findings. If an extension is required the organization may request, in writing, an extension to the due date for the CAP and the timeframes will be adjusted as appropriate. The BMHC will provide written approval as to the acceptance of the CAP within 30 calendar days of BMHC's receipt of the CAP. Within 30 calendar days of the receipt of the CAP the BMHC will provide written approval or request revisions, if not accepted.

**c. Deeming:**

The BMHC has incorporated deeming provisions in the UTAH QAPIP for areas applicable to MCOs and PIHPs. Accreditation by a nationally recognized accreditation agency that is also recognized by the State will be accepted to fulfill some compliance requirements. Examples of nationally recognized accreditation agencies include National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Utilization Review and Accreditation Commission (URAC), also known as American Accreditation HealthCare Commission. The organization must provide written verification of accreditation in areas where deeming may be applicable. The BMHC will determine areas applicable for deeming based on comparability and level of accreditation achieved.

**d. Corrective Actions and Sanctions:**

Corrective actions may be required to be submitted relating to quality monitoring activities if the BMHC determines the contracted Medicaid organization has not provided services in accordance with the contract or within expected professional standards. The BMHC will request in writing that the health plan correct deficiencies or identified problems through a corrective action plan (CAP). The contracted Medicaid health plan agrees with all applicable procedures and time frames set forth in the contract regarding compliance with CAP's. However, CAP's which are the result of non compliance findings with the Utah QAPIP, following reviews, longer time frames are granted for submitting initial CAP's and subsequent requests for revision to CAP's, until final acceptance. Additionally, longer time frames may be granted prior to implementing sanctions. Areas of non compliance related to contract requirements or the UQAMP, which are deemed more critical or urgent, may be subject to time frames associated with requests for CAP's as set forth in the contract. The BMHC will follow do-process procedures as outlined in the contract with regard to requests for CAP's, requests for extensions of CAP's, allowing opportunity to appeal findings, considering explanations of disagreement and in issuing hearing rights.

**2. Internal Surveillance and Tracking (analysis of internal MMCS and Data Warehouse data)**

Additionally, as a mechanism of quality oversight the BMHC will monitor and analyze other available internal data. These include internal MMCS data; information available through the state's Data Warehouse or reported encounter data. When possible and appropriate this information will be integrated into compliance reviews in order to address areas where further study or improvement may be needed or when additional information is needed.

**3. External Quality Reviews (EQR's):**

The BMHC uses an External Quality Review Organization (EQRO) to conduct an annual, external assessment of outcomes related to quality, access to and timeliness of care for services covered in MCO and PIHPs contracts (42 CFR Part 438, Subpart E, 438.320). External review includes mandatory and optional activities.

**Mandatory EQR activities include using information from the following activities:**

1. Validation of performance improvement projects as noted in 438.240(b)(1), validation of performance measures required by the state in accordance with 438.240(b)(2), and
2. To conduct a review within the previous 3 year period to determine MCO's or PIHP's compliance with standards related to access to care, structure and operations, and quality measurement [(438.204(g)].

**Optional activities include using information derived from the previous 12 months from the following activities:**

1. Validation of encounter data reported by an MCO or PIHP,
2. Administration or validation of consumer or provider surveys of quality of care,
3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validation
4. Conducting performance improvement projects in addition to those conducted by an MCO or PIHP.

The BMHC assures that EQROs meet the qualifications to perform external quality reviews (EQRs) as set forth in 42 CFR, Part 438, Subpart E, 438.354 (competence and independence). The state, its agent or the EQRO may perform the mandatory and optional EQR-related activities [42 CFR, Part 438, Subpart E, 438.358(a)].

The BMHC will assure that the date collection methods and tools used by the EQRO are consistent with the Medicaid managed care provisions of the Balanced Budget Act (BBA) and the compliance requirements outlined in the Utah QAPIP, which were developed to assess compliance in accordance with the BBA.

The EQRO will submit reports in accordance with requirements in 438.364. The BMHC will make available upon request information obtained from the technical report supplied by the EQRO to interested parties, such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, recipient advocacy groups and general public. This information will be supplied in alternative formats for persons with sensory impairments, when requested.

The EQRO contract may be amended as necessary in order to accommodate review activities. Study subjects will be determined collaboratively by DHCF, BMHC, EQRO and health plan staff.

**4. Annual Program Evaluation**

Annually, the BMHC will develop a Work Plan, which outlines the planned review activity (CQMR or follow up reviews), EQR activity and activities related to available systems data (MMCS/DW, grievance/appeals, hearings, exemptions, reporting, etc.,). At the end of each calendar a Work Plan Evaluation will be completed. The Work Plan Evaluation will be used to develop the Work Plan for each new year and schedule monitoring reviews. At least every 3 years the BMHC will perform a more comprehensive evaluation, which will be used to make program improvements. The BMHC will submit to CMS any required reports relating to the states quality improvement program.

**III. Table of Appendices**

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| Appendix P | Member Handbook Checklist (DRAFT) |

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MEDICAL SERVICES REVENUE AND COST DEFINITIONS FOR TABLE 2

**REVENUES** (Report all revenues received or receivable at the end-of-period date on the form)

1. Premiums

   Report premium payments received or receivable from the DEPARTMENT.

2. Delivery Fees

   Report the delivery fee received or receivable from the DEPARTMENT.

3. Reinsurance

   Report the reinsurance payments received or receivable from a reinsurance carrier other than the DEPARTMENT.

4. Stop Loss

   Report stop loss payments received or receivable from the DEPARTMENT.

5. TPL Collections - Medicare

   Report all third party collections received from Medicare.

6. TPL Collections - Other

   Report all third party collections received other than Medicare collections. (Report TPL savings because of cost avoidance as a memo amount on line 48).

7. Other (specify)

8. Other (specify)

   For lines seven and eight: Report all other revenue not included in lines one through six. (There may not be any amount to report; however, this line can be used to report revenue from total Utah operations that do not fit lines one through six.)

9. **TOTAL REVENUES**

   Total lines one through eight.

NOTE: Duplicate premiums are not considered a cost or revenue as they are collected by the CONTRACTOR and paid to the DEPARTMENT. Therefore, the payment to the DEPARTMENT would reduce or offset the revenue recorded when the duplicate premium was received. However, line 49 has been established for reporting duplicate premiums as a memo amount.

**MEDICAL COSTS:** Report all costs accrued as of the ending date on the form. In the first data column (column 3), report all costs for Utah operations per the general ledger. In the 15 Medicaid data columns (columns 4 through 18), report only costs for Medicaid Enrollees.

10. Inpatient Hospital Services

    Costs incurred in providing inpatient hospital services to Enrollees confined to a hospital.

11. Outpatient Hospital Services

    Costs incurred in providing outpatient hospital services to Enrollees, not including services provided in the emergency department.

12. Emergency Department Services

    Costs incurred in providing outpatient hospital emergency room services to Enrollees.

13. Primary Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

    All costs incurred for Enrollees as a result of providing primary care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

14. Specialty Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

    All costs incurred as a result of providing specialty care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services to Enrollees, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

15. Adult Screening Services

    Expenses associated with providing screening services to Enrollees.

16. Vision Care - Optometric Services

    Included are payroll costs, any capitation and/or contract payments, and fee-for-service payments for services and procedures performed by an optometrist and other non-payroll expenses directly related to providing optometric services for Enrollees.

17. Vision Care - Optical Services

    Included are payroll costs, any capitation and/or contract payments and fee-for-service payments for services and procedures performed by an optician and other supportive staff, cost of eyeglass frames and lenses and other non-payroll expenses directly related to providing optical services for Enrollees.

18. Laboratory (Pathology) Services

    Costs incurred as a result of providing pathological tests or services to Enrollees including payroll expenses, any capitation and/or contract payments, fee-for-service payments and other expenses directly related to in-house laboratory services. Excluded are costs associated with a hospital visit.

19. Radiology Services

Cost incurred in providing x-ray services to Enrollees, including x-ray payroll expenses, any capitation and/or contract payments, fee-for-service payments, and occupancy overhead costs. Excluded are costs associated with a hospital visit.

20. Physical and Occupational Therapy

Included are payroll costs, any capitation and/or contract payments, fee-for-service costs, and other non-payroll expenditures directly related to providing physical and occupational therapy services.

21. Speech and Hearing Services

Payroll costs, any capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing speech and hearing services for Enrollees.

22. Podiatry Services

Salary expenses or outside claims, capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing services rendered by a podiatrist to Enrollees.

23. End Stage Renal Disease (ESRD) Services - Dialysis

Costs incurred in providing renal dialysis (ESRD) services to Enrollees.

24. Home Health Services

Included are payroll costs, any capitation and/or contract payments, fee-for-service payments, and other non-payroll expenses directly related to providing home health services for Enrollees.

25. Hospice Services

Expenses related to hospice care for Enrollees including home care, general inpatient care for Enrollees suffering terminal illness and inpatient respite care for caregivers of Enrollees suffering terminal illness.

26. Private Duty Nursing

Expenses associated with private duty nursing for Enrollees.

27. Medical Supplies and Medical Equipment

This cost center contains fee-for-service cost for outside acquisition of medical requisites, special appliances as prescribed by the CONTRACTOR to Enrollees.

28. Abortions

Medical and hospital costs incurred in providing abortions for Enrollees.

29. Sterilizations

Medical and hospital costs incurred in providing sterilizations for Enrollees.

30. Detoxification

Medical and hospital costs incurred in providing treatment for substance abuse and dependency (detoxification) for Enrollees.

31. Organ Transplants

Medical and hospital costs incurred in providing transplants for Enrollees.

32. Other Outside Medical Services

The costs for specialized testing and outpatient surgical centers for Enrollees ordered by the CONTRACTOR.

33. Long Term Care

Costs incurred in providing long-term care for Enrollees required under Attachment C.

34. Transportation Services

Costs incurred in providing ambulance (ground and air) services for Enrollees.

35. Accrued Costs

Costs Incurred for services rendered to Enrollees but not yet billed.

36/37 Other

Report costs not otherwise reported.

38. **TOTAL MEDICAL COSTS**

Total lines10 through 37.

**ADMINISTRATIVE COSTS**

Report payroll costs, any capitation and/or contract payments, non-payroll costs and occupancy overhead costs for accounting services, claims processing services, health plan services, data processing services, purchasing, personnel, Medicaid marketing and regional administration.

Report the administration cost under four categories—advertising, home office indirect cost allocation, utilization and all other administrative costs. If there are no advertising costs or indirect home office cost allocations, report a zero amount in the applicable lines.

39. Administration - Advertising

40. Home Office Indirect Cost Allocations

41. Utilization

Payroll cost and any capitation and/or contract payments for utilization staff and other non-payroll costs directly associated with controlling and monitoring outside physician referral and hospital admission and discharges of Enrollees.

42. Administration - Other

43. **TOTAL ADMINISTRATIVE COSTS**
Total lines 39 through 42.

44. **TOTAL COSTS (Medical and Administrative)**
Total lines 38 and 43.

45. **NET INCOME (Gain or Loss)**
Line 9 minus line 44.

46. **ENROLLEE MONTHS**
Total Enrollee months for period of time being reported.

47. **MEDICAL COSTS PER ENROLLEE MONTH**
Line 38 divided by line 46.

48. **ADMINISTRATIVE COSTS PER ENROLLEE MONTH**
Line 43 divided by line 46.

49. **TOTAL COSTS PER ENROLLEE MONTH**
Line 44 divided by line 46.

**OTHER DATA**

50. TPL Savings - Cost Avoidance

51. Duplicate Premiums
Include all premiums received for Enrollees from all sources other than Medicaid.

52. Number of Deliveries
Total number of Enrollee deliveries when the delivery occurred at 24 weeks or later.

53. Family Planning Services
Include costs associated with family planning services as defined in Attachment C (Covered Services, Section V, Family Planning Services).

54. Reinsurance Premiums Received
Include the reinsurance premiums received or receivable that are not counted as revenue.

55. Reinsurance Premiums Paid

Include reinsurance premiums paid to a reinsurance carrier other than the DEPARTMENT.

56. Administrative Revenue Retained by the CONTRACTOR

Include the administrative revenue retained by the CONTRACTOR from the reinsurance premiums received or receivable.

MEDICAL SERVICES UTILIZATION DEFINITIONS FOR TABLE 3

**MEDICAL SERVICES**

1. Hospital Services - General Days

   Record total number of inpatient hospital days associated with inpatient medical care.

2. Hospital Services - Discharges

   Record total number of inpatient hospital discharges.

3. Hospital Services - Outpatient Visits

   Record total number of outpatient visits.

4. Emergency Department Visits

   Record total number of emergency room visits.

5. Primary Care Physician Services

   Number of services and procedures defined by CPT-4 codes provided by primary care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/ immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

6. Specialty Care Physician Services

   Number of ser services and procedures defined by CPT-4 codes provided by specialty care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/ immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

7. Adult Screening Services

   Number of adult screenings performed.

8. Vision Care - Optometric Services

   Number of optometric services and procedures performed by an optometrist.

9. Vision Care - Optical Services

Number of eye glasses and contact lenses dispensed.

10. Laboratory (Pathology) Procedures

Number of procedures defined by CPT-4 Codes under the Pathology and Laboratory section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

11. Radiology Procedures

Number of procedures defined by CPT-4 Codes under the Radiology section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

12. Physical and Occupational Therapy Services

Physical therapy refers to physical and occupational therapy services and procedures performed by a physician or physical therapist.

13. Speech and Hearing Services

Number of services and procedures.

14. Podiatry Services

Number of services and procedures.

15. End Stage Renal Disease (ESRD) Services - Dialysis

Number of ESRD procedures provided upon referral.

16. Home Health Services

Number of home health visits, such as skilled nursing, home health aide, and personal care aide visits.

17. Hospice Days

Number of days hospice care is provided, including respite care.

18. Private Duty Nursing Services

Hours of skilled care delivered.

19. Medical Supplies and Medical Equipment
Durable medical equipment such as wheelchairs, hearing aids, etc., and nondurable supplies such as oxygen etc.

20. Abortion Procedures
Number of procedures performed.

21. Sterilization Procedures
Number of procedures performed.

22. Detoxification Days
Days of inpatient detoxification.

23. Organ Transplants
Number of transplants.

24. Other Outside Medical Services
Specialized testing and outpatient surgical services ordered by IHC.

25. Long Term Care Facility Days
Total days associated with long-term care.

26. Transportation Trips
Number of ambulance trips.

27. Other (specify)

MOLINA

**Attachment F: Payment Methodology**

This Contract is classified as non-risk. Under a non-risk contract, the DEPARTMENT's total payments to Molina for medical services provided under this Contract net of third party payments may not exceed the Payment Limit. The Payment Limit is the total amount Medicaid would have paid for the same services on a fee-for-service (FFS) basis net of third party payments. In calculating payments to determine the amount the DEPARTMENT would have paid on each claim, the DEPARTMENT will use its reimbursement schedule for each claim and subtract (1) any third party payment reported on each claim and (2) any co-payment and co-insurance for which the Enrollee is responsible.

Molina may reimburse individual providers at rates different from the Medicaid fee schedule. However, the DEPARTMENT's aggregate payments to Molina for medical services provided to its Enrollees must not exceed what Medicaid would have paid in aggregate for the same services on a FFS basis.

Based on direction from the Centers for Medicare and Medicaid Services (CMS), the 9% add-on amount that the DEPARTMENT reimburses Molina will not be included when determining the total payments the DEPARTMENT paid Molina when ascertaining compliance with the Payment Limit for a non-risk contract. The 9% add-on includes administration, case management services, profit earned, etc., and any incentive payments (CHEC screenings and immunizations). The 9% add-on that the DEPARTMENT reimburses Molina for administration, case management services, and profit will be included when calculating the savings sharing payments. If CMS requires in writing that this method of calculating the Payment Limit be revised, this Contract will be amended in accordance with, and only to the extent necessary to comply with, the specific requirements of CMS.

For Molina clients enrolled in Molina's Medicare product, Molina will reimburse its providers at no less than the Medicare fee schedule.

**A. Molina Cost Plus 9% Payment Provisions Based on Molina's Encounter Records**

1. Molina will submit encounter records including any associated encounter refunds from providers or from the Office of Recovery Services to the DEPARTMENT following the Electronic Data Interchange (EDI) standards defined in the *Encounter Records 837 Institutional Companion Guide* and *Encounter Records 837 Professional Companion Guide*. Molina will not submit any encounter record in the same month in which the service to which the encounter record relates was provided. In the event Molina inadvertently does so, the DEPARTMENT will not pay for any encounter record in the same month in which the service was provided.
2. The DEPARTMENT will process Molina's encounter records and reimburse Molina for encounter records that pass the Medicaid Managed Care System

(MMCS) encounter records edits within 30 calendar days after the DEPARTMENT has received the encounter records. However, it is the intent of the DEPARTMENT to pay Molina within 15 calendar days after the DEPARTMENT has received the encounter records. The DEPARTMENT will reimburse Molina the amount Molina paid its providers as reflected in each encounter record's "paid amount" field, net of third party payments and net of any co-payment or co-insurance for which the Enrollee is responsible, for those encounters that pass the MMCS edits. In addition, the DEPARTMENT will pay to Molina an additional amount equal to 9% of the total amount of paid encounter records, net of third party payments. The 9% does not apply to the Medicaid payment on encounters for Molina's Medicaid enrollees who are also enrolled in Molina's Medicare plan.

3. The 9% add-on fee is based on the reasonable expenses of managed care plans organizations for all administrative functions, case management services, profit earned, etc. necessary to operate as an efficient and effective Medicaid managed care plan and including federal managed care requirements as described in 42 CFR Part 438-Managed Care. The DEPARTMENT will verify Molina's costs incurred for administration, case management services, profit earned, etc. using the quarterly reports submitted by Molina as defined in Section F., Quarterly Report of Costs Incurred for Administration, Case Management Services, Etc., of this Attachment F.

4. Rejected encounter records that are corrected and resubmitted and that clear the MMCS edits will be paid to Molina in the next regular payment cycle.

**B. Determination of the Amount the DEPARTMENT Would have Paid under FFS (Payment Limit)**

**1. Determination of Covered Encounters**

All encounter records not rejected in the process under Section A. above will go through a final cleansing by running said encounters through the DEPARTMENT's fee-for-service pricing process. Encounters for which the DEPARTMENT paid the CONTRACTOR under Section A. but that are not covered encounters based on the criteria in B.2. will be credited back to the DEPARTMENT and excluded from the Payment Limit calculation.

The DEPARTMENT will provide documentary support for its calculation to Molina and afford Molina a reasonable opportunity to review and comment.

**2. Covered Services Criteria**

For purposes of this Attachment F, a covered encounter record is an encounter record that is covered under this Contract, is not rejected by the rejection edits in the DEPARTMENT's Encounter Records Companion Guides and:

a. the procedure codes are either covered by Medicaid as indicated on Medicaid's Reference File, or

b. the Enrollee who received the service was a CHEC eligible, or

c. the DEPARTMENT approved the payment for services described in Attachment B (Special Provisions), under Article VI (Authorization of Services and Notices of Action), A.2. (Process for the CONTRACTOR to Request Payment Authorization of Services); or

d. the services provided are in lieu of services covered in the Utah Medicaid State Plan because they are cost-effective and of equal or higher quality.

**3. Determination of Payments Subject to the Payment Limit**

For purposes of determining whether the DEPARTMENT paid Molina more or less than the Payment Limit, the total amount the DEPARTMENT paid Molina is the total amount as determined in Section A. (net of third party payments and enrollee co-payments and co-insurance) excluding the 9% add-on fee that includes administration, case management services, profit earned, etc.

**4. Determination of Payment Limit**

The DEPARTMENT will determine the Payment Limit by pricing covered encounter records, net of third party payments and Enrollee co-payments and co-insurance.

For services that do not have a reimbursement amount in the DEPARTMENT's Reference File or the Reference File indicates that the service is manually priced, the amount the CONTRACTOR paid its provider will be the amount used in determining the Payment Limit.

The DEPARTMENT will provide documentary support for its calculation to Molina and afford Molina a reasonable opportunity to review and comment.

**5. Payment Limit Reconciliation**

The DEPARTMENT will begin a final reconciliation within 60 days following the conclusion of State Fiscal Year (SFY) 2007 to determine compliance with the Payment Limit. The DEPARTMENT will compare the total amount in B.3. with the total amount in B.4. If the amount in B.3. is greater than the amount in B.4., the DEPARTMENT will recoup the difference from Molina so that all payments to Molina equal the Payment Limit. In addition, Molina would not qualify for the Savings Sharing described in Article C. below. If the amount in B.3. is less than the amount in B.4., Molina may qualify for the Savings Sharing Provision.

**C. Savings Sharing Provision for FY2007**

For State fiscal year 2007, the DEPARTMENT will calculate the amount due to Molina, if any, under this Savings Sharing Provision, utilizing only a fee-for-service methodology. The calculations and comparisons described below will be computed separately for urban and rural Enrollees.

**1. Determination of Payments Subject to Savings Sharing**

For purposes of determining the amount due to Molina, if any, under this Savings Sharing Provision, the total amount the DEPARTMENT paid Molina is the total amount as determined in Section A. (net of third party payments and net of Enrollee co-payments and co-insurance) including the 9% add-on fee.

**2. Determination of the Amount the DEPARTMENT Would have Paid Under Fee-For-Service**

For purposes of determining the amount due to Molina, if any, under this Savings Sharing Provision, the total amount the DEPARTMENT would have paid Molina under fee-for-service is the total amount as determined in B.4. (the Payment Limit) plus a 2% administration fee applied to that Payment Limit amount.

**3. Savings Sharing Reconciliation**

The DEPARTMENT will compare the total amounts in C.1 and C.2 for each of the urban population and the rural population. Such comparisons of the two populations will be separate and independent of each other. If the amount in C.1 for urban members is less than the amount in C.2 for urban members, the DEPARTMENT will pay Molina as an incentive payment fifty percent (50%) of the difference. Likewise, if the amount in C.1 for rural members is less than the amount in C.2 for rural members, the DEPARTMENT will pay Molina as an incentive payment fifty percent (50%) of the difference.

**D. CHEC Screening Incentive Clause**

**1. CHEC Screening Goal**

Molina will ensure that Medicaid children have access to appropriate well-child visits. Molina will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The Centers for Medicare and Medicaid Services (CMS), mandates that all states have 80% of all children screened. The DEPARTMENT and Molina will work toward that goal.

**2. Calculation of CHEC Incentive Payment**

The DEPARTMENT will calculate Molina's annual participation rate based on information supplied by Molina under the CMS-416 EPSDT (CHEC) reporting requirements. Based on the CMS-416 data, Molina's well-child participation rate was 61% for Federal Fiscal Year (FFY) 2005 (October 1, 2004 through September 30, 2005). The incentive payment for the Contract year ending June 30, 2006 will be based on Molina's FFY 2006 (October 1, 2005 through September 30, 2006) CMS-416 participation rate. The DEPARTMENT will pay Molina $10,000 if a rate of 80% or higher is attained during FFY 2006.

The participation rate will be calculated no later than April 15, 2007; Molina will be notified of the incentive payment, if applicable, no later than April 30, 2007.

**3. MOLINA's Use of Incentive Payment**

The CONTRACTOR agrees to use this incentive payment to reward Molina's employees responsible for improving the EPSDT (CHEC) participation rate.

**E. Immunization Incentive Clause**

The CONTRACTOR will ensure that Enrollees have access to recommended immunizations. Molina will follow the Advisory Committee on Immunization Practices' recommendations for immunizations for children.

**1. Immunizations for two-year-olds**

The National Immunization Survey reported that in 2004 Utah had a statewide immunization level of 71.3% for two-year-olds. Molina's 2004 HEDIS rate was 72.2% for the Combination 1 immunization measure for two-year olds. Based on Molina's 2004 HEDIS result for the Combination 1 immunization measure, the DEPARTMENT will pay Molina $300 for each full percentage point above 72.2%.

The CONTRACTOR agrees to use this incentive payment to reward Molina's employees responsible for improving the HEDIS immunization rate for two-year- olds.

**2. Immunizations for adolescents**

The DEPARTMENT realizes it is important that adolescents are vaccinated according to the schedule recommended by the Advisory Committee on Immunization Practices and other professional groups. Molina's 2004 HEDIS rate was 27.3% for the Combination 1 immunization measure for adolescents. Based on Molina's 2005 HEDIS measure for adolescent immunizations, the DEPARTMENT will pay Molina $300 for each full percentage point above 27.3% up to 77.3%.

The CONTRACTOR agrees to use this incentive payment to reward Molina's employees responsible for improving the HEDIS immunization rate for adolescents.

**3. Immunizations for adults**

The DEPARTMENT will provide an incentive to Molina using an influenza measure developed by the DEPARTMENT and the Office of Health Care Statistics. The measurement is the percentage of Enrollees age 50 and older who receive an influenza immunization during the previous year's flu season (September 1 of the previous year through May 31 of the measurement year). The baseline year is September 1, 2002 through August 31, 2003. Based on Molina's percentage for the flu season ending in 2006, the DEPARTMENT will pay Molina $300 for each full percentage point above Molina's percentage in the baseline year up to 50 percentage points above the baseline year.

The CONTRACTOR agrees to use this incentive payment to reward Molina's employees responsible for improving the influenza immunization rate for adults.

**F. Quarterly Report of Costs Incurred for Administration, Case Management Services, etc.**

1. On a quarterly basis, the DEPARTMENT is required to report costs incurred for administration, case management services, etc., from non-risk managed care contracts with Federal Financial Participation (FFP). This reporting is required 30 days after the quarters ending March 31, June 30, September 30, and December 31. In order to meet this requirement, Molina must submit the cost data to the DEPARTMENT by the 25th of each month following each quarter's end.
2. The CONTRACTOR will report to the DEPARTMENT its costs incurred for administration, case management services, profit earned, etc. in an Excel spreadsheet. Molina will develop a cost reporting plan that documents methods used for reporting including direct assignment and/or allocation process. The purpose of the plan methods is to facilitate any reviews that the DEPARTMENT conducts.

   The CONTRACTOR will itemize its costs incurred into at least the following cost categories:

   a. Family Planning including Skilled Medical Professionals
   b. Claims Processing
   c. Provider Enrollment & Credentialing/Re-credentialing
   d. Prior Authorization

e. Case Management Services/Care Coordination

f. Disease Management Programs

g. Perinatal Care Programs

h. Educational Newsletters and other Outreach

i. HEDIS Reporting

j. Audit of HEDIS Performance Measures

k. Encounter Data Submitted to the DEPARTMENT

l. Grievance and Appeals Processes

m. Work related to the DEPARTMENT's External Quality Review Organization

n. Quality-related (Quality Improvement Programs, Quality Committees, Performance Improvement Projects)

o. Health Needs Assessments

p. Profit from Operations Before Taxes

q. Taxes from Operations

r. Skilled Professional Medical Personnel (physicians, registered nurses, MSWs, LCSWs, pharmacists)

s. Other General Administrative Costs

- Support Services (Accounting Services, Payroll Processing Services, Outside Services-Other, Outside Services-Translation, Software Hardware Expenses, Equipment Lease/Rental, Non-specified Payroll)
- Oral Interpretation
- Business Development (Marketing Costs)
- Fees/Taxes (Regulatory Fees, Board Fees, Bank Service Charges, Taxes/Personal Prop-unsecured, Licenses)
- Educational Expenses (Periodical Subscriptions, Membership Dues, Continuing Ed/User Training, Conferences/Seminars)
- Travel Expenses (Hotels & Lodging, Meals & Entertainment)
- HR (Employment-recruitment, Employment Relations, Employment Functions)
- Office Expenses (Common Area Maintenance, Rent, Telephone, Electric, Security, Repair & Maint-Office Equip, Copier Expenses, Office Supplies, Printing Supplies, Postage, Miscellaneous, Other Admin Expenses, Depreciation-admin)

**G. Other Payment-Related References**

Attachment A, Article III, #4, #5, and #6 - (unauthorized changes to contract)

Attachment B, Article XI - Other Requirements (Fraud & Abuse)

Article XII - Payments (Third Party Liability)

Article XIII - Records and Reporting Requirements (Accuracy of Data)

Article XIV - Compliance/Monitoring (Right to Audit)

Article XV - Termination of Contract

**AMENDMENT**

**to**

**EMPLOYMENT AGREEMENT**

This Amendment to Employment Agreement ("Amendment") is dated as of July 1, 2006, and is made by and between Joseph M. Molina, M.D. (the "Executive), and Molina Healthcare, Inc., a Delaware corporation (the "Company").

WHEREAS, the parties have previously entered into an Employment Agreement dated as of January 2, 2002 (the "Agreement");

WHEREAS, the parties wish to amend and supersede certain provisions of the Agreement;

NOW, THEREFORE, the Executive and the Company agree as follows:

**1.** Terms used in this Amendment, unless otherwise defined herein, are used as defined in the Agreement.

**2.** Section 3 of the Agreement is hereby amended to read in its entirety as follows:

(a) BASE SALARY. Executive's Base Salary shall be at a rate of not less than $775,000 on an annual basis ("Executive's Base Salary"), commencing as of March 20, 2006, and paid in accordance with the Company's regular payroll practices. The Company's Compensation Committee shall review at least annually Executive's Base Salary for possible increase and may, in its sole discretion and in accordance with applicable rules and regulations of the Securities and Exchange Commission and the New York Stock Exchange, periodically adjust Executive's Base Salary.

(b) BONUS. For the Company's fiscal year 2006, Executive shall be eligible to earn discrete performance bonuses under the Company's 2005 Incentive Compensation Plan upon the separate and independent satisfaction of the following objective performance benchmarks previously established by the Company's Compensation Committee:

(i) a bonus in the amount of $193,750 if the Company achieves earnings per fully diluted share of at least $1.94;

(ii) a bonus in the amount of $193,750 if the Company achieves a return on equity of at least fourteen percent (14%); and

(iii) a bonus in the amount of $193,750 if the Company achieves gross premium revenues of at least $1,832,000,000.

In order to receive any of the three specified bonus amounts, the Compensation Committee of the Board of Directors must first certify in

accordance with the 2005 Incentive Compensation Plan and the applicable rules and regulations of the Internal Revenue Code that the relevant objective performance benchmark has been achieved.

(iv) In addition to the above-identified bonus amounts under the 2005 Incentive Compensation Plan, the Executive shall also be eligible to receive a separate, general bonus amount of up to $193,750 in the sole discretion of the Compensation Committee.

**3.** Section 4(e)(ii) of the Agreement, the original inclusion of which in the Agreement is acknowledged by the parties to have been a typographical error and which provision *ab initio* is without force or effect, is deleted in its entirety.

**4.** The Addendum to the Agreement is deleted in its entirety and shall be without force or effect.

**5.** Except as provided herein, the Agreement remains in full force and effect without amendment. References in the Agreement to the Agreement mean the Agreement as amended by this Amendment.

**[signature page follows]**

**6.** This Amendment may be executed in two or more counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument.

**IN WITNESS WHEREOF**, the Company and the Employee have caused this Amendment to be signed as of the date that appears in its first paragraph.

**MOLINA HEALTHCARE, INC.**

/s/ John P. Szabo, Jr.

By: John P. Szabo, Jr.
Title: Director, Chairman of Compensation Committee

**EMPLOYEE**

/s/ Joseph M. Molina

By: Joseph M. Molina, M.D.

**EXHIBIT 31.1**

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended June 30, 2006 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 8, 2006

/s/ Joseph M. Molina, M.D.

**Joseph M. Molina, M.D.**
**Chairman of the Board,**
**Chief Executive Officer and President**

**EXHIBIT 31.2**

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended June 30, 2006 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 8, 2006

/s/ John C. Molina, J.D.

**John C. Molina, J.D.**
**Chief Financial Officer and Treasurer**

**EXHIBIT 32.1**

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2006 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 8, 2006

/s/ Joseph M. Molina, M.D.

**Joseph M. Molina, M.D.**
**Chairman of the Board,**
**Chief Executive Officer and President**

**EXHIBIT 32.2**

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2006 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 8, 2006

/s/ John C. Molina, J.D.

**John C. Molina, J.D.**
**Chief Financial Officer and Treasurer**