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

FORM 8-K

Current Report
Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): September 15, 2011

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**1-31719**	**13-4204626**
(State of incorporation)	**(Commission File Number)**	**(I.R.S. Employer Identification Number)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

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

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

- ☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)
- ☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)
- ☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))
- ☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Item 7.01. Regulation FD Disclosure.

On September 15, 2011, Molina Healthcare, Inc. (the "Company") presented and webcast certain slides as part of the Company's presentation at its Investor Day Conference held in New York City. A copy of the Company's complete slide presentation is included as Exhibit 99.1 to this report. An audio and slide replay of the live webcast of the Company's Investor Day presentation will be available for 30 days from the date of the presentation at the Company's website, www.molinahealthcare.com, or at www.earnings.com. The information contained in such websites is not part of this current report.

The information in this Form 8-K current report and the exhibits attached hereto shall not be deemed to be "filed" for purposes of Section 18 of the Securities Exchange Act of 1934 or otherwise subject to the liabilities of that section, nor shall it be deemed incorporated by reference in any filing under the Securities Act of 1933 or the Securities Exchange Act of 1934, except as expressly set forth by specific reference in such a filing.

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits:

Exhibit No.	Description
99.1	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. on September 15, 2011.

SIGNATURE

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 hereunto duly authorized.

MOLINA HEALTHCARE, INC.

Date: September 16, 2011

By: */s/ Jeff D. Barlow*
Jeff D. Barlow
Sr. Vice President — General Counsel, and Secretary

EXHIBIT INDEX

Exhibit No.	Description
99.1	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. on September 15, 2011.

Exhibit 99.1

New York, New York
September 15, 2011

INVESTOR DAY 2011B

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Agenda

Time	Topic	Speaker
12:30pm-12:35pm	Opening Remarks	Juan José Orellana, VP Investor Relations
12:35pm-1:10pm	Business Overview	J. Mario Molina, MD, Chief Executive Officer
1:10pm-1:30pm	Q&A	
1:30pm-1:40pm	Break	
1:40pm-2:15pm	Health Plan Update	Terry Bayer, Chief Operating Officer
2:15pm-2:40pm	Financial Update	John Molina, Chief Financial Officer
2:40pm-3:00pm	Q&A	
3:00pm-3:15pm	Break	
3:15pm-3:50pm	The Dual Eligible Opportunity	J. Mario Molina, MD, Chief Executive Officer
3:50pm-4:30pm	Q&A	
4:30pm	End of Program	

MOLINA HEALTHCARE

Cautionary statement

"Safe Harbor" Statement under the Private Securities Litigation Reform Act of 1995: This slide presentation, as well as our accompanying oral remarks, contain numerous "forward-looking statements" regarding our business operations, membership levels, RFPs, benefit changes, rates, business expansion opportunities, and other matters. All of our forward-looking statements are subject to numerous risks, uncertainties, and other factors that could cause our actual results to differ materially. Anyone viewing or listening to this presentation is urged to read the risk factors and cautionary statements found under Item 1A in our 2010 Annual Report on Form 10-K filed on March 8, 2011, our first quarter and second quarter 2011 Quarterly Reports filed on May 9, 2011 and July 27, 2011 respectively, and the risk factors and cautionary statements found in our other reports and filings with the Securities and Exchange Commission and available for viewing on its website at www.sec.gov. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results.

MOLINA HEALTHCARE

New York, New York
September 15, 2011

Business Overview

J. Mario Molina, MD
President & Chief Executive Officer

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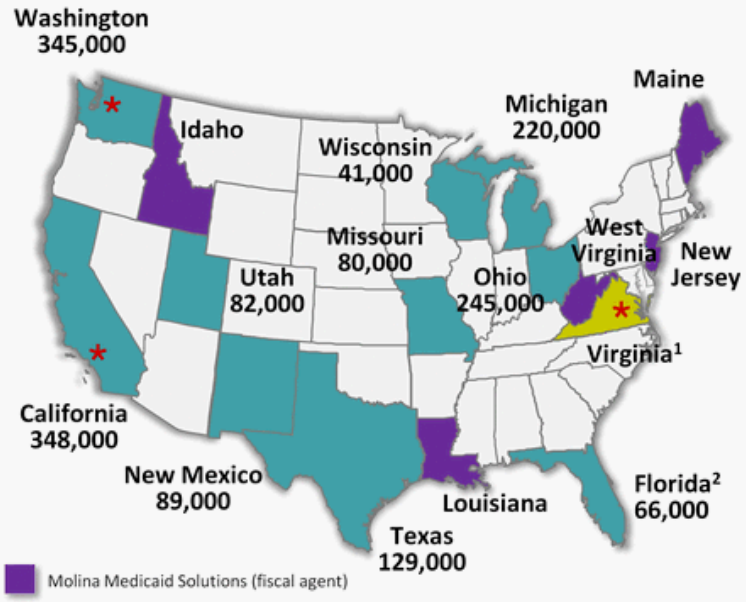
Business snapshot

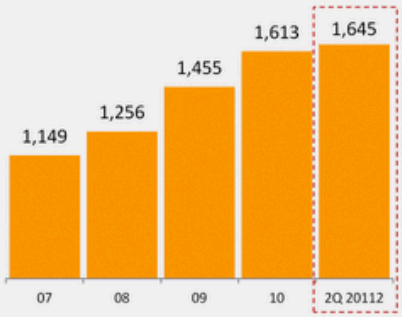
Markets and members served – 2Q 2011



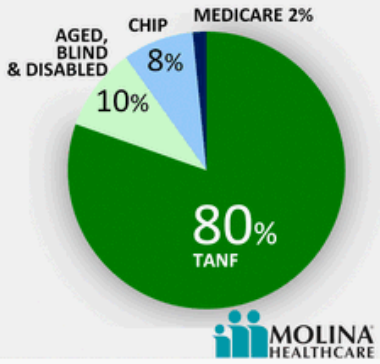
1. Virginia clinics provide Direct Delivery.
2. Florida has a managed care program as well as a pharmacy rebate program.

Health plan enrollment

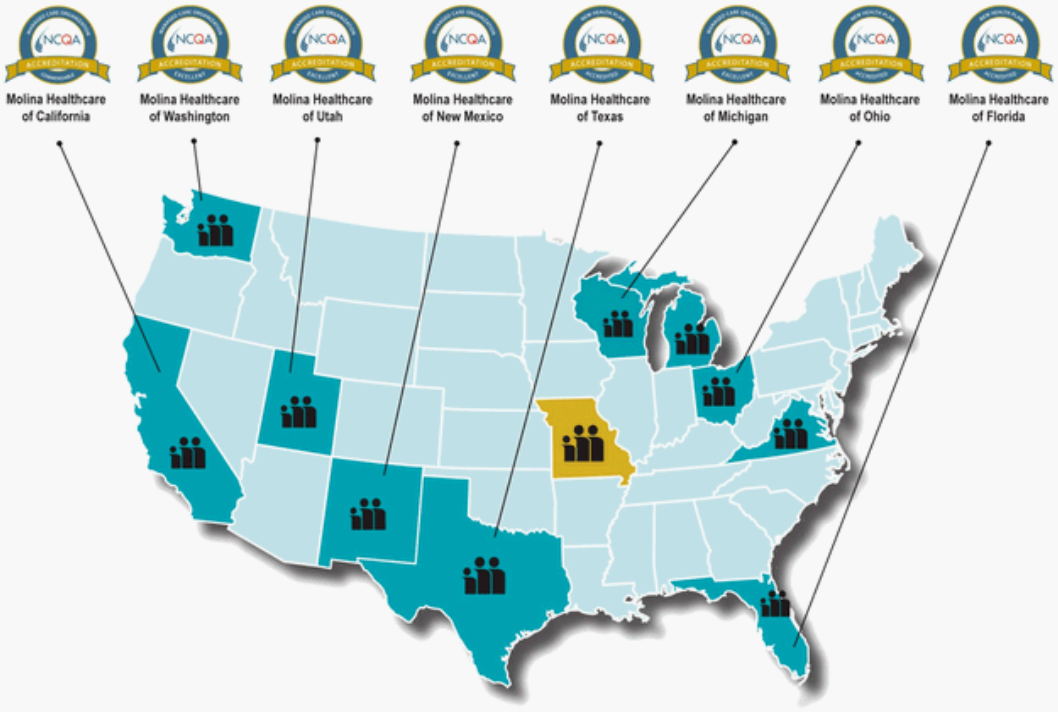
(in thousands)



Health plan membership profile



Quality and value



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Health care reform update

18 of 21 of the 2011 provisions of the Affordable Care Act (ACA) are in effect

Medicaid Provisions (all in effect) include:

- Center for Medicare and Medicaid Innovation
- Medicaid Health Homes
- Chronic Disease Prevention
- Medicaid Payments for Hospital-Acquired Infections
- Medicaid Long-Term Care Services

Source: Kaiser Family Foundation (http://healthreform.kff.org/timeline.aspx)

MOLINA HEALTHCARE

Health care reform update

- CMS issued draft regulations on the creation of state-based health insurance exchanges, giving states broad flexibility to create their insurance marketplace by 2014.
- Only three Molina MCO states have enacted legislation regarding health insurance exchanges as of today. West Virginia is the only Molina Medicaid Solutions state to have enacted authorizing Exchange legislation.
- Under the Affordable Care Act (ACA), eligibility determinations for both the Exchange and Medicaid must be seamless and the portals will operate in tandem beginning in 2014.
- Federal district and circuit courts are divided regarding individual mandate. U.S. Supreme Court review next summer appears likely. (11th Circuit ruled the individual mandate unconstitutional and the 4th and 6th Circuits ruled to uphold the individual mandate.)

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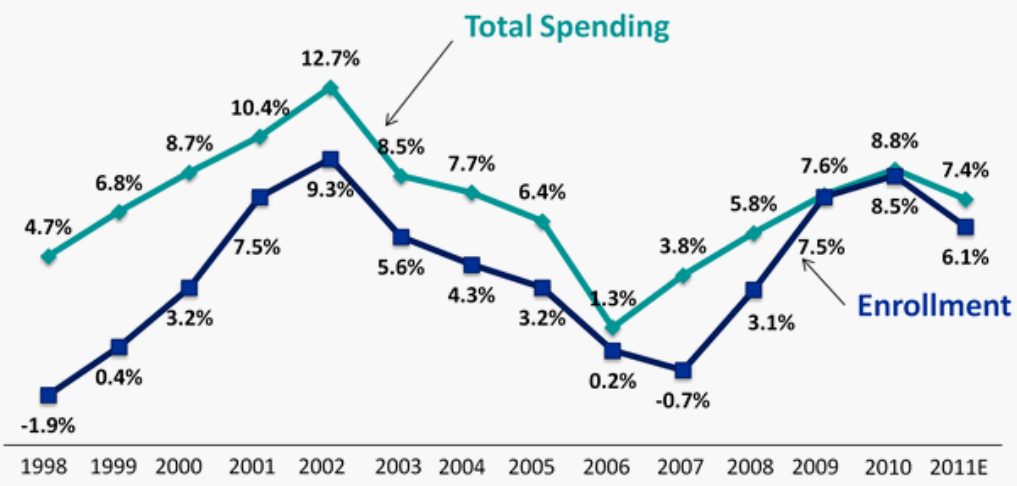
U.S. Medicaid spending and enrollment



Source: Kaiser Commission on Medicaid and the Uninsured, September 2010. http://www.kff.org/medicaid/8105.cfm //
Note: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

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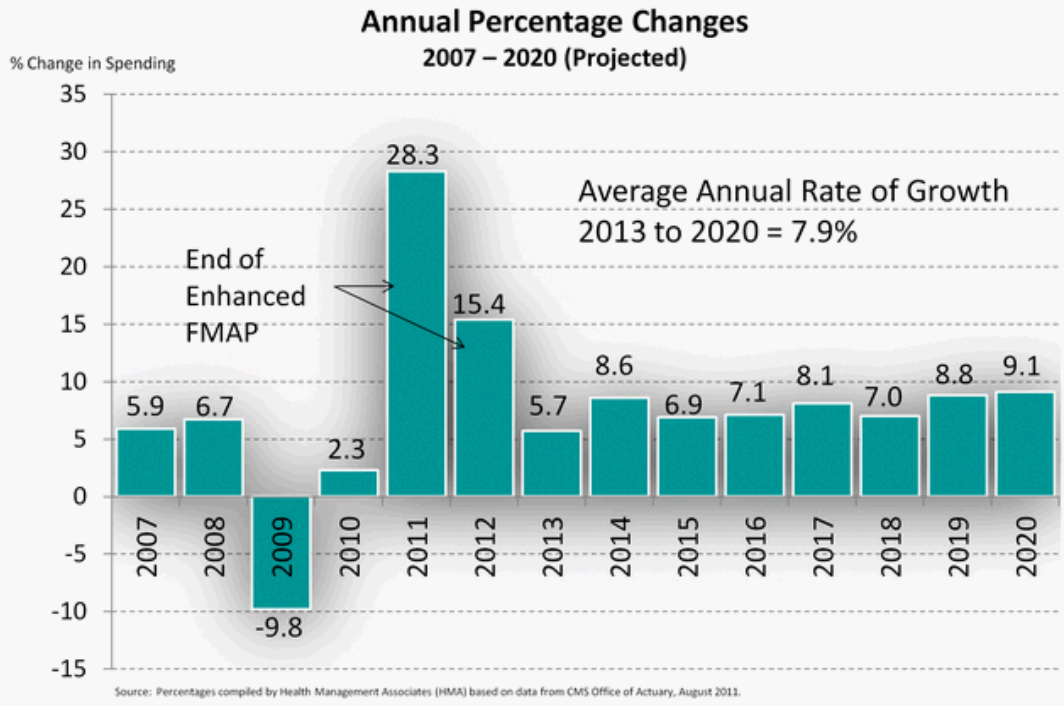
State share of Medicaid spending is growing



Source: Percentages compiled by Health Management Associates (HMA) based on data from CMS Office of Actuary, August 2011.

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State budgets have yet to recover

Poor economic conditions over the last few years have required a perennial focus on cost containment.

- Medicaid monthly enrollment increased by nearly six million (13.6%) from December 2007 to December 2009.
- Medicaid spending, both in medical services and overall, has risen faster than growth in national health expenditures and the gross domestic product (GDP), both in the last two years as well as throughout the past decade.
- However, on a per person basis, growth in Medicaid spending is slower than the growth in national health care spending per capita and slower than the growth in private health insurance premiums.
- The enhanced federal Medicaid matching funds from the American Recovery and Reinvestment Act (ARRA) expired on June 30, 2011.

Source: Kaiser Commission on Medicaid and the Uninsured, "Medicaid Spending Growth over the Last Decade and the Great Recession, 2000-2009." February 2011.

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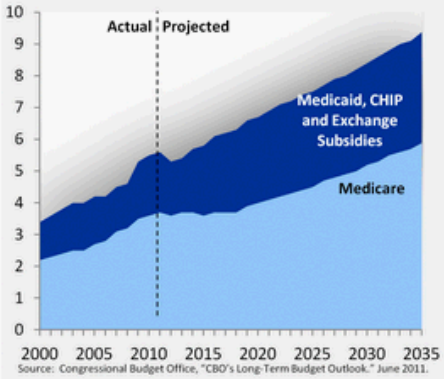
Federal fiscal pressure on Medicaid is intensifying

Debt limit negotiations brought Medicaid back into the federal spotlight. Medicaid is exempt from cuts – for now.

Mandatory Federal Spending on Health Care, by Category, Under CBO's Extended-Baseline Scenario
(Percentage of gross domestic product)



Source: Congressional Budget Office, "CBO's Long-Term Budget Outlook." June 2011.

- Federal spending on Medicaid and the Children's Health Insurance Program would increase from 1.9% of GDP in 2011 to almost 4% of GDP in 2035.

- States are concerned the drive to balance federal budget could shift costs to states
- New 12-Member Bi-Partisan Committee will look at several options
- Other considerations:
  - Block grants
  - Blended/lower federal Medicaid matching rates
  - Limits on state taxes on providers

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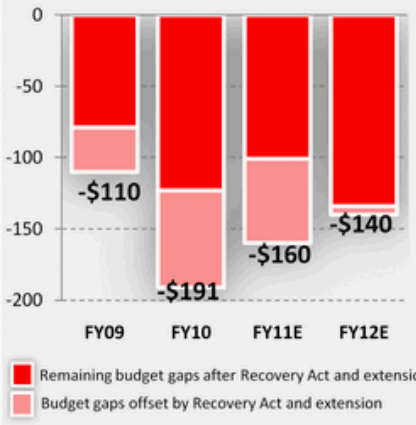
Why managed care is a viable solution

Although some states project improved cash flows over the next few years as the economy recovers, states' fiscal conditions remain very weak.

State Budget Shortfalls After Use of Recovery Act Funds
Budget shortfalls in billions



Source: Center on Budget and Policy Priorities. Analysis using data from U.S. Department of Health and Human Services, U.S. Department of Education, Congressional Budget Office, and state budget documents. December 2010

Medicaid health plans can provide:

- **Budget certainty (capitation), cost savings and flexible financing mechanisms**
- **Better information on best practices and performance**
  - MCO performance report cards
  - Embracing best practices that improve care
- **Quality Initiatives**
  - Care management programs for high risk/high cost patients
  - High performance on selected HEDIS® or CAHPS® quality performance measures that change annually
  - Penalties for poor performance

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Q&A

MOLINA HEALTHCARE

New York, New York
September 15, 2011

Health Plan Update

Terry P. Bayer
Chief Operating Officer

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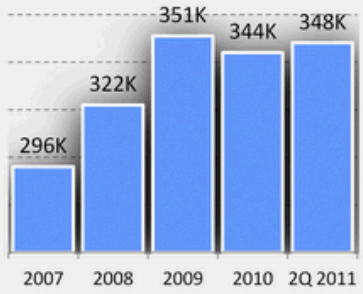
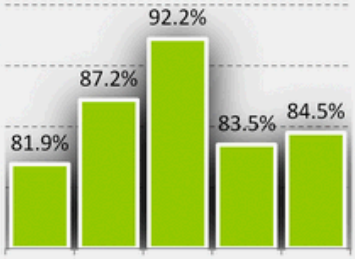
California

Molina Healthcare of California
Historical and YTD Enrollment
2007-2Q2011



Molina Healthcare of California
Historical and MCR
2007-2Q2011

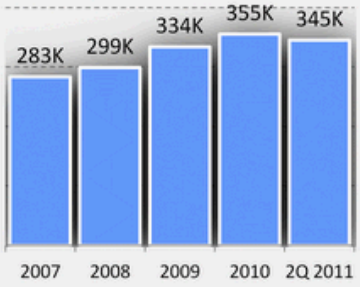


- Good performance continues
- Consolidated and redirected services to lower cost, more efficient providers
- Continued growth in Special Persons with Disabilities (California term for ABDs)
  - Enrollment in mandatory managed care began in June 2011
- State budget – provider rate cut pending

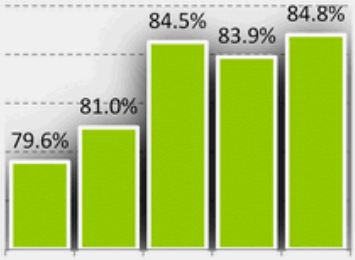
MOLINA HEALTHCARE

Washington

Molina Healthcare of Washington
Historical and YTD Enrollment
2007-2Q2011



Molina Healthcare of Washington
Historical and MCR
2007-2Q2011

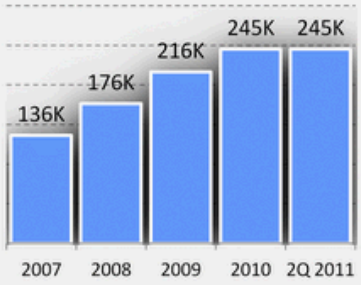


- Stable performance continues
- Re-procurement pending

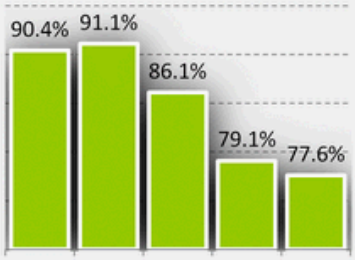
MOLINA HEALTHCARE

Ohio

Molina Healthcare of Ohio
Historical and YTD Enrollment
2007-2Q2011



Molina Healthcare of Ohio
Historical and MCR
2007-2Q2011

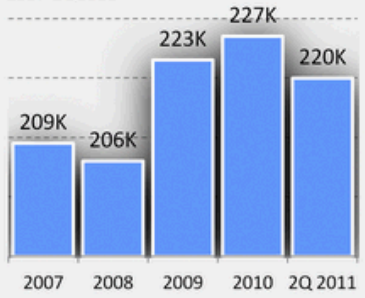


- Excellent performance continues
- Pharmacy carve-in October 1, 2011
- Re-procurement pending

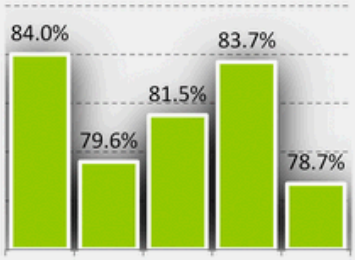
MOLINA HEALTHCARE

Michigan

Molina Healthcare of Michigan
Historical and YTD Enrollment
2007-2Q2011



Molina Healthcare of Michigan
Historical and MCR
2007-2Q2011

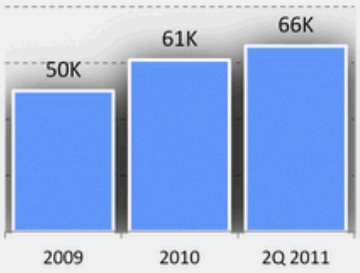


- Medical cost control continues
- "Excellent" NCQA accreditation
- 6,500 Medicare SNP members as foundation for future dual eligible expansion

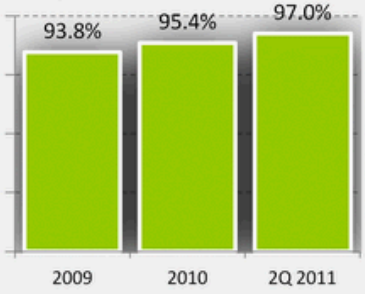
MOLINA HEALTHCARE

Florida

Molina Healthcare of Florida
Historical and YTD Enrollment
2009-2Q2011



Molina Healthcare of Florida
Historical and MCR
2009-2Q2011

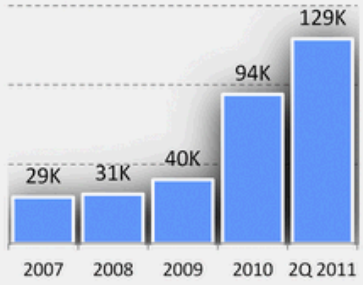


- Medical cost reduction plan in place
- Reductions in lab and behavioral health effective 7/1/11
- Pharmacy PMPM reduction
- Biggest challenges:
  - Rates
  - Contract renegotiation

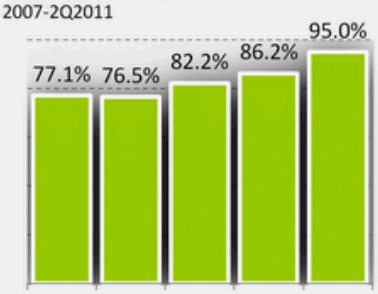
MOLINA HEALTHCARE

Texas

Molina Healthcare of Texas
Historical and YTD Enrollment
2007-2Q2011



Molina Healthcare of Texas
Historical and MCR
2007-2Q2011



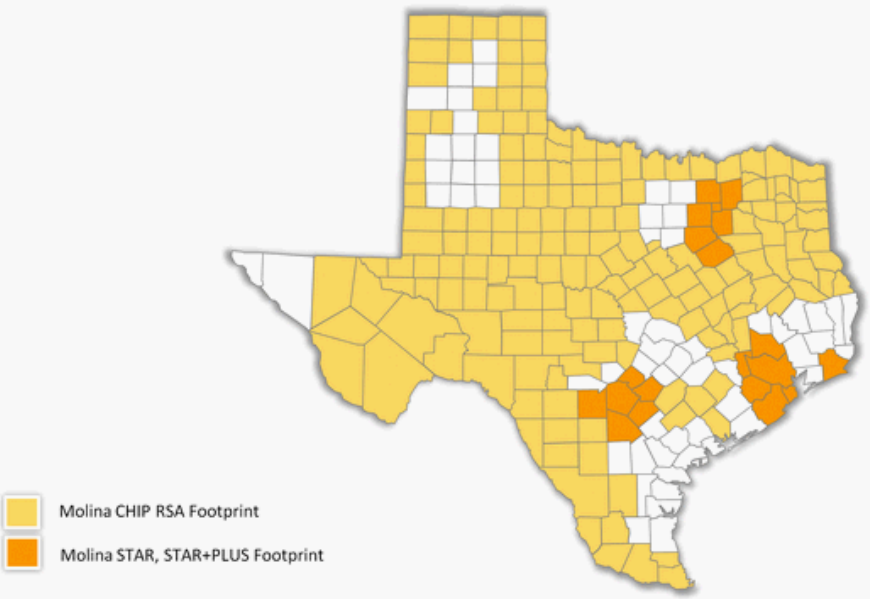
- Medical cost reduction plan in place
- Contract renegotiation
- Jefferson Service Area expansion 9/1/11
- Expansion award effective 3/1/12

MOLINA HEALTHCARE

Texas today

Through our current STAR, STAR+PLUS and CHIP RSA contracts, we already have a strong network on which to build in order to accommodate the expansion.

Molina STAR, STAR+PLUS, and CHIP RSA Footprint
(as of 9/1/2011)



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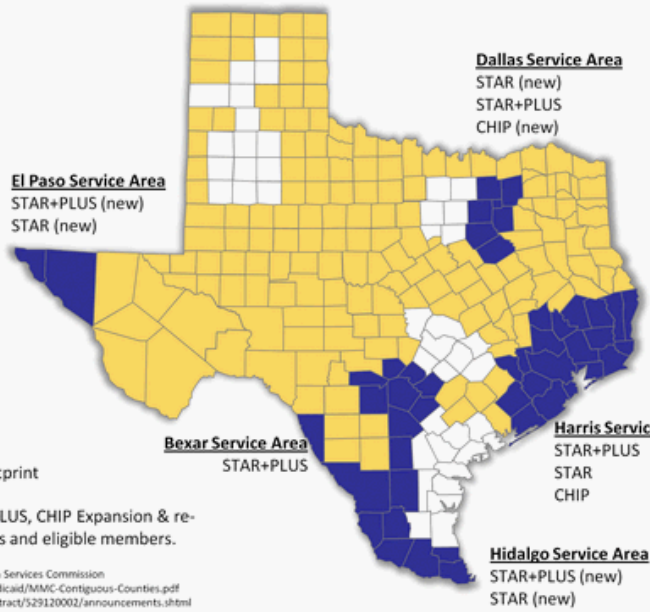
Texas win overview

Molina has been awarded a tentative contract by the State of Texas for a re-procurement and expansion of its STAR (TANF), STAR+PLUS (ABD), and CHIP Medicaid programs covering 3.4 million eligibles.

Molina Footprint After 2011 Re-procurement Awards



Dallas Service Area
STAR (new)
STAR+PLUS
CHIP (new)

El Paso Service Area
STAR+PLUS (new)
STAR (new)

Jefferson Service Area
STAR+PLUS (new)
STAR (new)
CHIP (new)

Bexar Service Area
STAR+PLUS

Harris Service Area
STAR+PLUS
STAR
CHIP

Hidalgo Service Area
STAR+PLUS (new)
STAR (new)
CHIP RSA

Molina CHIP RSA Footprint

Molina STAR, STAR+PLUS, CHIP Expansion & re-procurement counties and eligible members.

Source: Texas Health and Human Services Commission
http://www.hhsc.state.tx.us/medicaid/MMC-Contiguous-Counties.pdf
http://www.hhsc.state.tx.us/contract/529120002/announcements.shtml

MOLINA HEALTHCARE

Texas win overview

	MOH IR Day Jan 2011	Revised Sept 2011
Total Covered Population	3.4M	3.4M
Population Up for Bid	3.2M	3.2M
Effective Date	3/12	3/12
MOH Expected Membership Prior to Expansion[1]	125K	150K
MOH Expected Additional Membership[2]	220K	220K
Total Expected MOH Membership[2]	**345K**	**370K**
MOH Expected Market Penetration[2]	10%	11%
MOH Expected Incremental Annualized Revenue[3]	**$663M**	**$660M**

1. Denotes estimated membership at 12/31/11
2. Denotes estimated membership at 3/1/12
3. Excludes impact of Rx and Inpatient carve in effective 3/1/12

Note: Amounts are estimates and subject to change

MOLINA HEALTHCARE

RFP update

Please refer to the Company's cautionary statement.

	FL*	GA	IL	OH*	WA*
Total Covered Population	3.2M	1.8M	2.6M	1.8M	.8M
Population Up for Bid	1.6M	1.5M	1.8M	1.8M	.8M
Effective Date	>2012	7/2013	>2012	7/2012	7/2012
RFP Process	TBD	Delayed	TBD	≈Sept.	≈Sept.
Potential New Populations	TBD	TBD	TBD	ABD Kids	ABD

*Current Molina Health Plan states

MOLINA HEALTHCARE

Managed care carve-ins

In October 2011, Ohio pharmacy benefits are expected to be carved in. Texas pharmacy and inpatient benefits are expected to be carved in starting in March 2012. Upon carve-in, members will receive their benefits through their providers rather than through the state's fee-for-service Medicaid program. Other states are also considering carve-ins.

	Ohio	Texas
Rx carve-in	10/1/11	3/1/12
Inpatient carve-in	n/a	3/1/12
2011 profit impact	Minimal	n/a

MOLINA HEALTHCARE

New York, New York
September 15, 2011

Financial Update

John C. Molina
Chief Financial Officer

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Rate update

Please refer to the Company's cautionary statement.

Health Plan	Date	Revenue Impact[1]
California (10% provider rate cut)	7/1/2011	(≈6.0%)
Florida	9/1/2011	unknown
Michigan	10/1/2011	unknown
Missouri	7/1/2011	≈5.0%
New Mexico	7/1/2011	(≈2.5%)
Ohio	1/1/2012	unknown
Texas	9/1/2011	(≈2.0%)
Utah	7/1/2011	(≈2.0%)
Washington	10/1/2011	unknown
Wisconsin	1/1/2012	unknown

1. "( )" indicates a negative revenue impact

MOLINA HEALTHCARE

Financial results

Please refer to the Company's cautionary statement.

	2Q 2010	2Q 2011	Change
Premium Revenue	$977M	$1.1B	$123M
Service Revenue	$21M	$37M	$16M
Investment Income	$1.6M	$1.4M	($0.4M)
Medical Care Costs	$839.6M	$949.4M	$109.8M
Medical Care Ratio	86.0%	84.1%	(1.9%)
Service Costs	$14.3M	$39.2M	$24.9M
G&A Expense	$78M	$97M	$19M
G&A Ratio	7.8%	8.3%	0.5%
Premium Tax Expense	$35.0M	$37.7M	$2.2M
Depreciation and Amortization	$11.2M	$12.5M	$1.3M
Interest Expense	$4M	$4M	$0M
Income Before Tax	$17.1M	$27.7M	$10.6M
Income Tax	$6.5M	$10.3M	$3.8M
Net Income	$10.6M	$17.4M	$6.8M
Diluted EPS	$0.27	$0.38	$0.11
Weighted Average Diluted Shares Outstanding	38.9M	46.5M	7.6M
EBITDA	$35.0M	$47.9M	$12.9M
Effective Tax Rate	38%	37%	(1%)

MOLINA HEALTHCARE

2011 guidance

Please refer to the Company's cautionary statement.

$1.55 **Guidance Issued Jul 21, 2011**

- ↑ Strong performance of established health plans & fiscal agents
- ↑ Earlier than anticipated utilization improvements
- ↑ Improvement in fiscal agent business expected in second half of 2011
- ↓ Premium rate reductions
- ↓ Cost challenges in Texas and Florida health plans

$1.47* **Guidance Issued Jan 26, 2011**

* Note: EPS guidance issued 1/26/11 has been adjusted to reflect 3 for 2 stock split effective 5/9/11

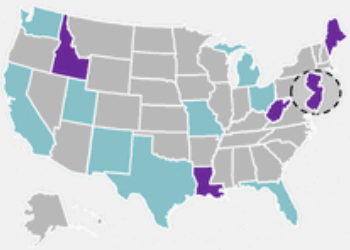
MOLINA HEALTHCARE

New credit facility discussion

- **Size: $170 Million**
- **Right sized for Molina's needs, balancing:**
  - Need for readily available cash
  - Commitment fees
  - Size of bank group
- **Terms:**
  - Five year maturity
  - Market rates
  - Simpler covenants
- **Smaller, manageable bank group:**
  - Focus on long-term relationships
  - Cash management and depository relationships
  - Aligning economic interests

MOLINA HEALTHCARE

Strategic fit of fiscal agent & health plan business



MMS footprint (fiscal agent)

Molina footprint

- Focused on Government Patient Base
- Health Care Information Technology Firm in Fiscal Agent Market
- Leverage Health Plans' Care Management Offerings for Fiscal Agent Business
- Leverage Health Plans' Cost Containment Methodologies for Clients

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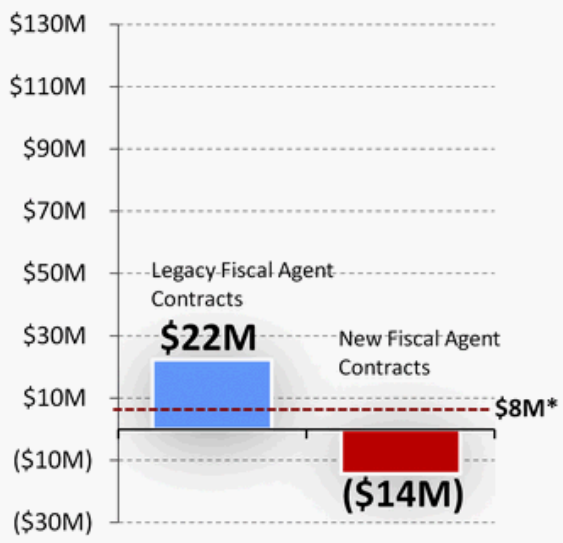
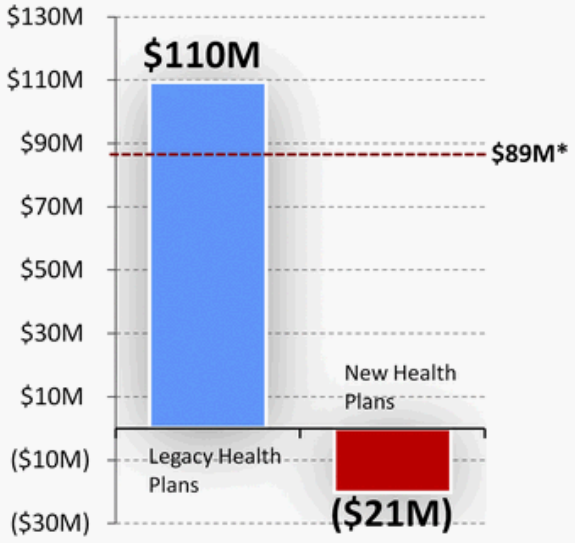
Experience matters

MMS EBITDA
(six months as of June 30, 2011)



Health Plans EBITDA
(six months as of June 30, 2011)



Total EBITDA (Legacy + New)

*Total EBITDA
Legacy Fiscal Agent contracts include: Louisiana, New Jersey, West Virginia, Florida; New Fiscal Agent contracts include: Idaho, Maine; Legacy Health Plans include: California, Michigan, Missouri, New Mexico, Ohio, Utah, Washington, Virginia; New Health Plans include: Florida, Texas, Wisconsin; Note: Non-GAAP Reconciliation slide in Appendix

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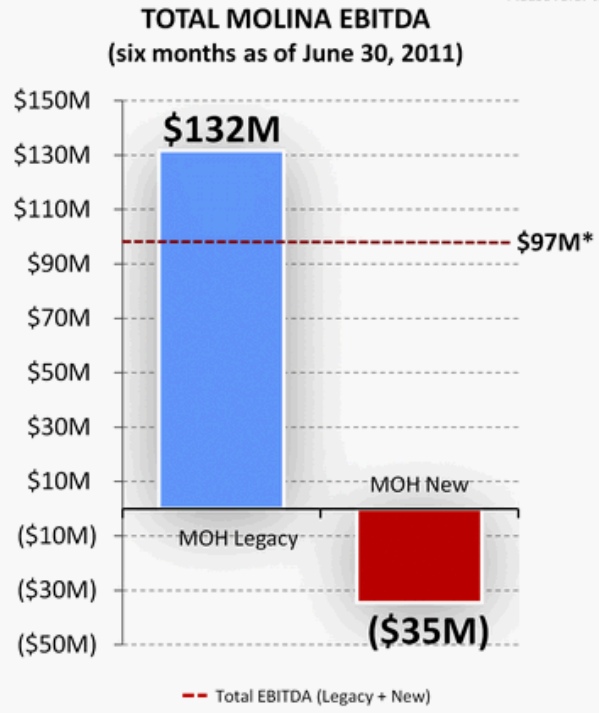
Experience matters

Please refer to the Company's cautionary statement.



*Total EBITDA
MOH Legacy includes: Health Plans in California, Michigan, Missouri, New Mexico, Ohio, Utah, Washington, Virginia, & Fiscal Agents contracts in Louisiana, New Jersey, West Virginia, and Florida; MOH New includes: Health Plans in Florida, Texas, Wisconsin & Fiscal Agent contracts in Idaho and Maine ; Note: Non-GAAP Reconciliation slide in Appendix

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Molina Medicaid Solutions

Idaho Status Update

- "Out-of-pilot" releases DDI payments
- Agreement reached on operational revenue

Maine Status Update

- CMS September certification visit
- Key stabilization metrics have been achieved (call center, enrollment and prior authorizations)

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Molina Medicaid Solutions upsells

Our fiscal agent business has pursued various new revenue opportunities (upgrades, add-ons, new services and products), producing $40M in additional sales in 2011.

West Virginia

Item	Narrative	When Sold (Qtr/Yr)
Provider Incentive Payments	Incentive payments made to the medical community	3Q 2011
Provider Enrollment Application	Enhancement of provider portal application	3Q 2011
5010	HIPAA standards for installation of 5010	3Q 2011

Louisiana

Item	Narrative	When Sold (Qtr/Yr)
InterQual	Application of InterQual criteria to state operated facilities	1Q 2011
5010/ ICD-10	10th Revision of the International Code of Diagnoses Compliance Project	1Q 2011/3Q 2011

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Q&A

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New York, New York
September 15, 2011

The Dual Eligible Opportunity

J. Mario Molina, MD
President & Chief Executive Officer

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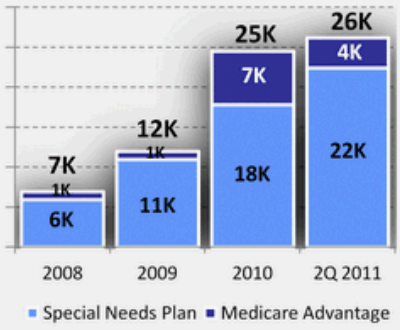
Unprecedented new focus on dual eligibles

Nearly 9 million Medicaid beneficiaries are dual eligibles: low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs.

Medicare Enrollment[1]

2008-YTD 2Q 2011



Source: 1. CMS Special Needs Plan Data
https://www.cms.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage
2. Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles" fact sheet, December 2010.
http://www.kff.org/medicaid/upload/4091-07.pdf

- Recognition that duals are the most costly group of beneficiaries for both Medicaid and Medicare
- Duals account for approximately 15% of Medicaid enrollees but contribute to 39% of all Medicaid spending[2]
- Medicaid/Medicare spending averages $20K per dual per year, 5X greater than other Medicare beneficiaries
- Dual population will highly benefit from managed care

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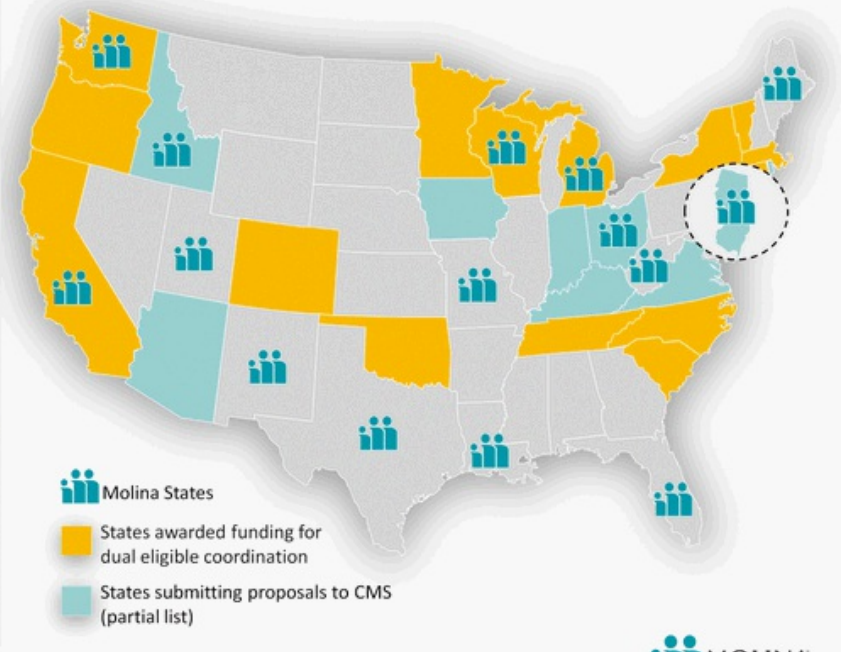
Unprecedented new focus on dual eligibles

CMS awarded 15 states to receive up to $1 million to support the design of programs to integrate care and to design shared savings initiatives.

New recognition that duals are the most costly group of beneficiaries for both Medicaid and Medicare

Source: CMS, http://www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummaries.asp.



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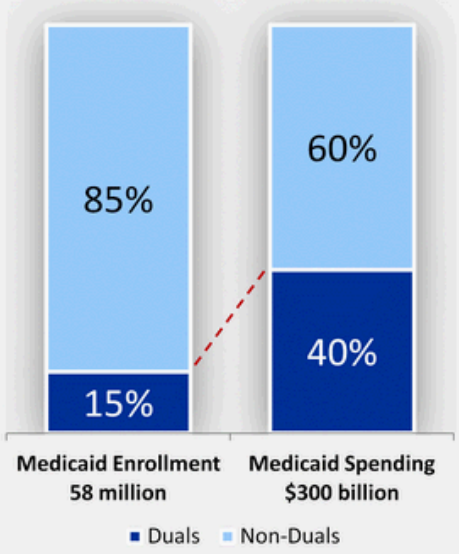
Dual eligibles enrollment and Medicaid spending

Duals make up 15% of the Medicaid population, but account for nearly 40% of Medicaid spending.

Dual Eligibles' Share of Medicaid Enrollment and Spending, FY 2007



Source: Medicaid spending and enrollment estimates from Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

- 8.7 million duals drive nearly half of Medicaid and one quarter of Medicare spending, roughly $300 billion combined.
- 1.6 million duals with annual Medicaid costs of more than $25,000 account for more than 70% of all dual spending.

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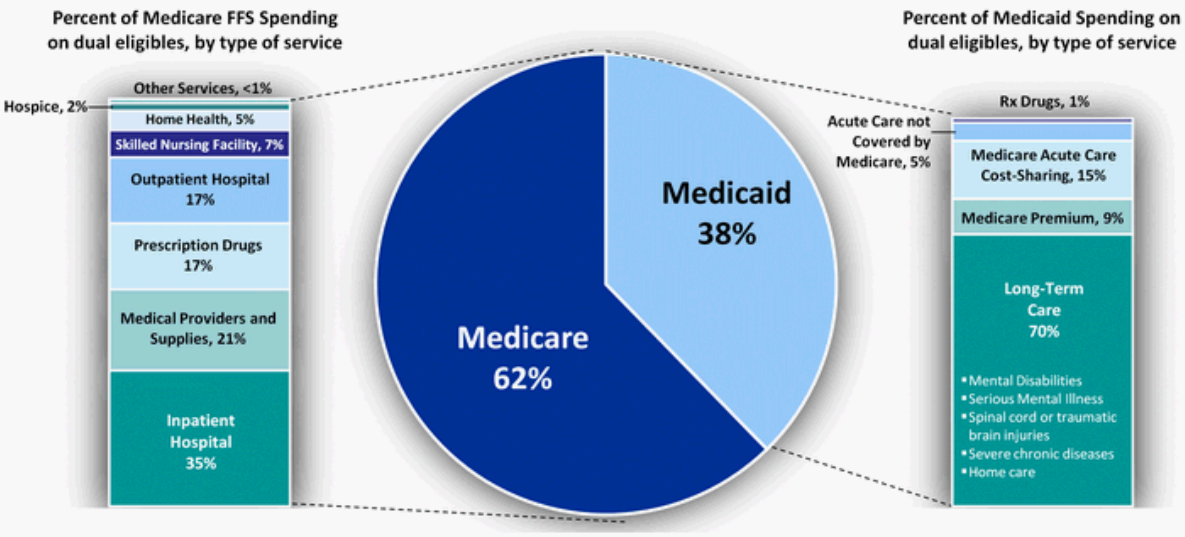
Dual eligible spending

Percent of Dual Spending by Program



Total Dual Spending, 2009: $321 Billion

Sources:
1. Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, Medicare Chartbook, 2010.
2. Kaiser State Health Facts
3. Medicare Payment Advisory Commission (http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf)

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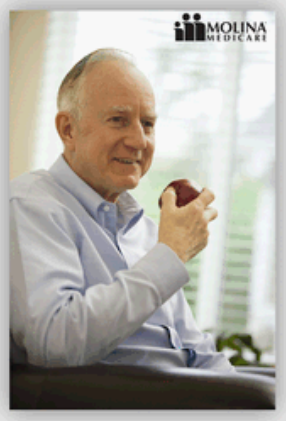
Dual eligibles



- **87% of duals have more than one chronic condition**
- **70% of Medicaid spending on duals is for Long-Term Care (LTC)**
- **Molina's experience with LTC**
  - WMIP program since 2005
  - STAR+PLUS since 2008
- **Molina's SNP experience**
  - Molina's SNP dual eligible plan is ranked number 8 nationwide

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Long-Term Care and Medicaid

Medicare covers skilled nursing facilities up to 100 days. After that, Medicaid covers custodial care, otherwise known as Long-Term Care.

Long-Term Care includes:

- Mental disabilities
- Spinal cord or traumatic brain injuries
- Severe chronic illnesses
- Nursing home care
- Home health care
- Assisted living facility
- Adult day care
- Alternate care
- Respite care

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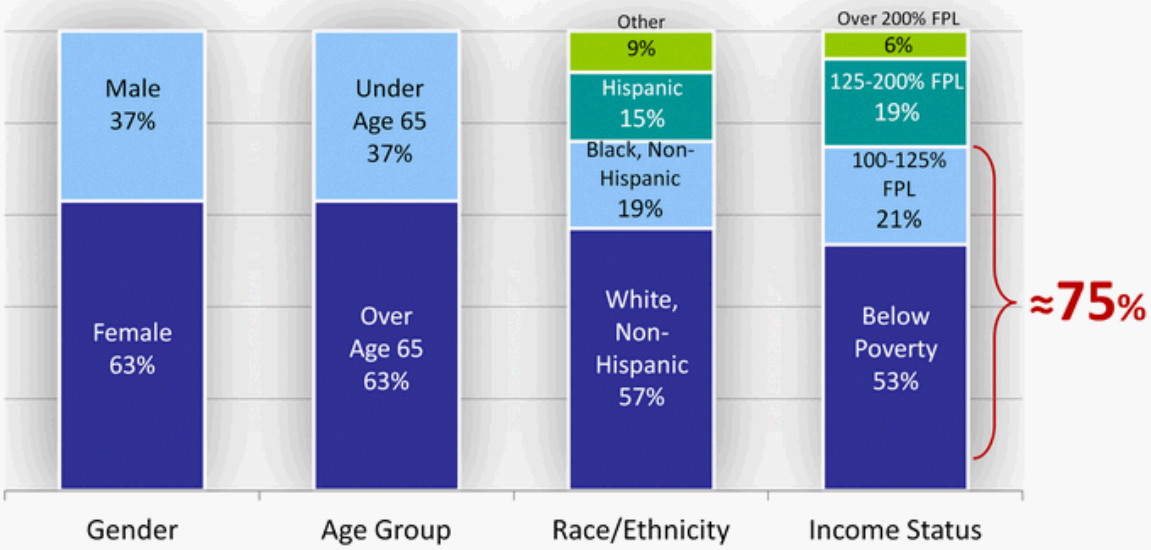
Dual eligibles demographics



Nearly 75% below Medicaid eligibility threshold

Source: Kaiser Commission on Medicaid and the Uninsured report, "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending" July 2010.

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Dual eligibles in Molina states

Approximately 40% of all duals in the United States reside in Molina states.

State	Total Dual Enrollment	As % of Total Medicaid Enrollment	Total Medicaid Expenditures for Duals (millions)	As % of Total Medicaid Spending	Per Person Spending for Duals	Per Person Medicaid Spending for Non-Disabled Adults
U.S.	8,896,020	15%	$120,520	39%	$15,459	$2,541
California	1,167,865	11%	$13,952	40%	$13,304	$969
Florida	560,967	20%	$5,253	38%	$10,935	$2,854
Michigan	257,837	14%	$3,285	37%	$14,826	$3,036
Missouri	169,391	17%	$2,253	37%	$15,864	$3,370
New Mexico	53,342	11%	$682	26%	$14,537	$3,356
Ohio	290,634	14%	$4,873	40%	$19,677	$2,844
Texas	609,468	15%	$6,014	30%	$10,797	$3,185
Utah	30,280	10%	$361	26%	$14,129	$2,940
Washington	144,224	12%	$1,920	34%	$15,722	$2,741
Wisconsin	215,227	22%	$2,748	55%	$14,542	$2,123

Source: CMS Fact Sheet, "People Enrolled in Medicare and Medicaid," May 2011.

Established programs position Molina to serve duals

Molina overview of duals

All duals are ABDs, but not all ABDs are duals.

State	ABD in Managed Care	Duals in Medicaid Managed MCO	Molina SNP
California	Yes	Yes	Yes
Florida	Yes	Yes	Yes
Michigan	Yes	No	Yes
Missouri	No	No	No
New Mexico	Yes	CoLTS (not all MCOs)	Yes
Ohio	Yes	No	Yes
Texas	Yes STAR+PLUS	Yes	Yes
Utah	Yes	Yes	Yes
Washington	No	No (only WMIP pilot)	Yes
Wisconsin	Yes	Yes	No

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Duals programs

- Fragmented programs
- Even under managed care the programs are fragmented
- Goal is to streamline and simplify programs
- Recommend managed care for duals
- Examples of proposals include:
  - Bowles-Simpson proposal
  - Domenici proposal
  - The Heritage Foundation proposal
  - Wyden-Brown proposal

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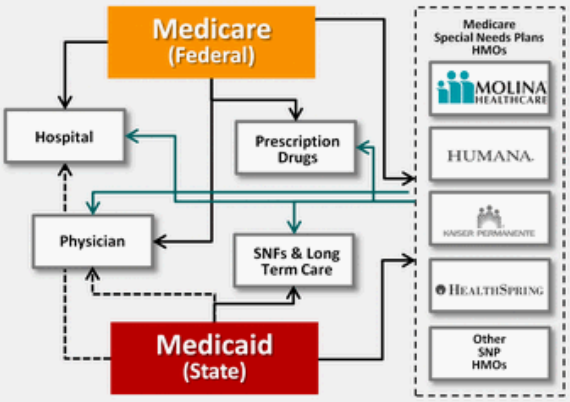
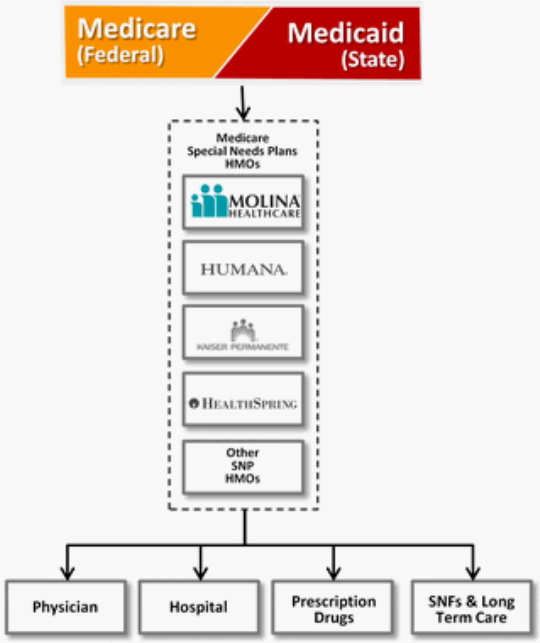
Fragmentation in current SNP model

Today



for illustrative purposes only; not a complete depiction of payments sources and destinations

Future State



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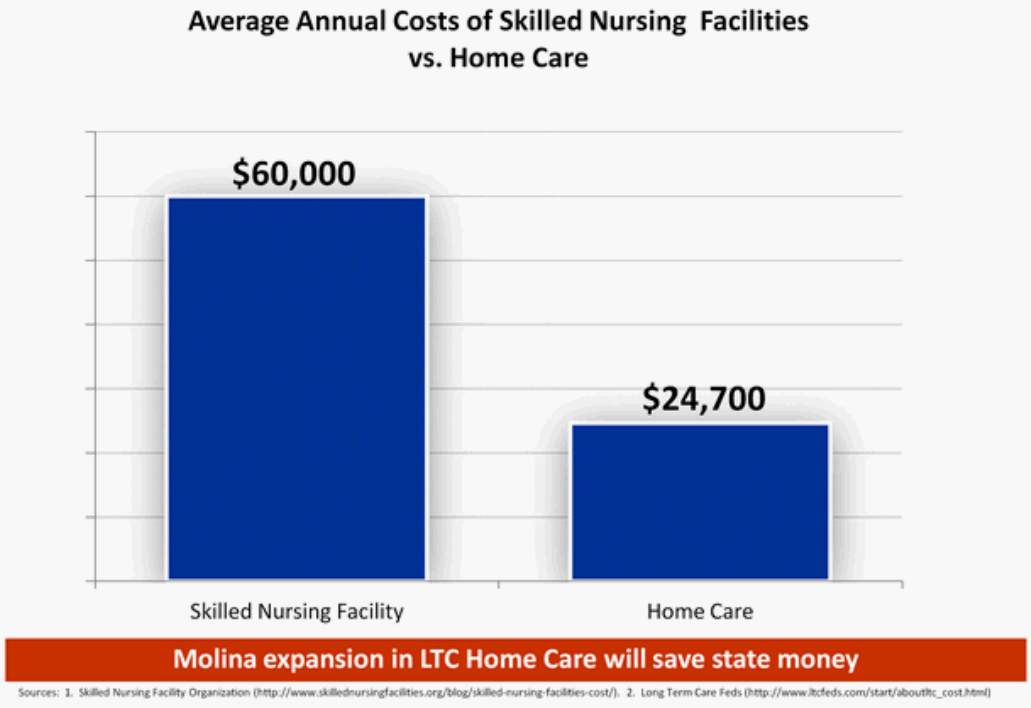
Long-Term Care costs



Molina expansion in LTC Home Care will save state money

Sources: 1. Skilled Nursing Facility Organization (http://www.skillednursingfacilities.org/blog/skilled-nursing-facilities-cost/). 2. Long Term Care Feds (http://www.ltcfeds.com/start/aboutltc_cost.html)

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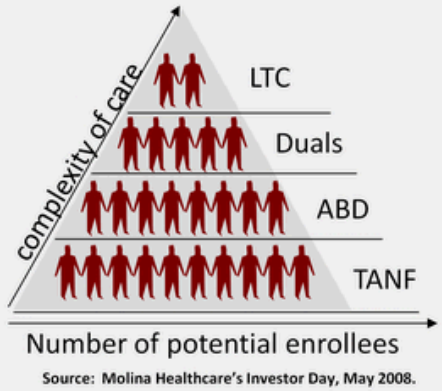
Dual eligible care coordination



Source: Molina Healthcare's Investor Day, May 2008.

Coordinating Medical Care

- Allows states to choose the locus and level of integration that meets their needs and goals
- Capitated models provide states greater budget predictability (although consideration needs to be given to the degree of financial risk)
- Allows for some streamlining of administrative processes (e.g., enrollment, marketing, quality measures and reports, etc.)
- SNPs are required to have a multi-disciplinary care team that works together to develop individual care plans for beneficiaries

Molina has extensive experience in coordinating care

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Molina's membership ranking

Top 10 SNP Dual Eligible Plans Nationwide*		
Rank	Plan	Membership
1	United[1]	178k
2	Health Spring/Bravo	73k
3	Kaiser	66k
4	Health 1st (NY)	51k
5	WellCare	33k
6	Gateway (PA)	28k
7	Care Plus (FL)	25k
8	**MOLINA MEDICARE**	**22k**
9	Humana	21k
10	HealthNet	18k

1. United includes PacifiCare, Evercare, APIPA and Secure Horizons products
Note: Molina's SNP plan is ranked #3 in the markets Molina serves.

Molina has well established SNPs serving the financially vulnerable

*Information sourced quarterly
Source: CMS Health Plan Management System as of 8/2011 (updated 9/5/11).

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Case Study: Michigan

There are 234,000 dual eligibles in Michigan, none of whom are enrolled in managed care[1].

Overview of proposed approach	To integrate Medicare and Medicaid funds to deliver all covered services for dually eligible beneficiaries
Target population	All dually eligible individuals
Estimated enrollment[2]	Current statewide enrollment is for duals: 207,594 Estimated enrollment April 1, 2012 (with 6% trend): 220,050
Planned geographic service area	Statewide, but likely a phased implementation
Proposed implementation Date and related milestones	Proposed milestones: ▪ *May 2011 and ongoing*: Obtain Medicare data and link to Medicaid data; perform data analysis for overall population ▪ *September – December 2011*: Write and submit necessary waivers and address any necessary legislation. Create an enrollment process. ▪ *November 2011*: Draft Request for Proposal (RFP) ▪ *December 2011-February 2012*: Conduct RFP Process ▪ *February-March 2012*: Contracting process with selected entities ▪ *April 2012*: Implement Integrated Care for Dual Eligibles

Source: CMS State Demonstrations for Integrate Care for Dual Eligible Individuals, MI Summary

1. Kaiser State Health Facts, "Total dual Eligible Enrollment in Managed Care as of June 30, 2009" (http://www.cms.gov/medicare-medicaid-coordination/downloads/CMSMMCODualsDemoStateSummaryMI.pdf_)
2. Estimated enrollment in 2012 at full implementation.

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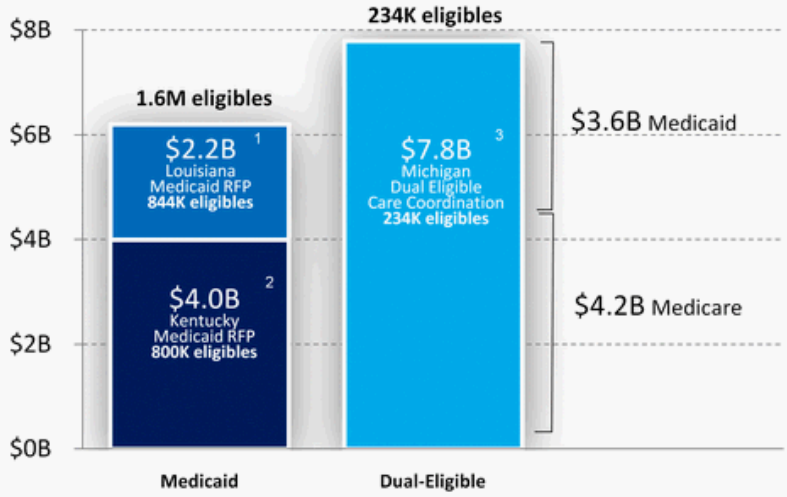
Opportunities in perspective

Michigan is among the 15 states selected to receive up to $1 million to support the design of programs to integrate care for the dual-eligible.

Select Expansion Opportunities



Molina already serving over 6,500 SNP members in Michigan

1. The Advocate, "Contract Winners want to protect data." August 2, 2011
2. Insider Louisville, Multiple mega firms pursue Kentucky's $4 billion Medicaid contract ." June 23, 2011
3. CMS document, "Michigan's Response to CMS Solicitation State Demonstrations to Integrate Care for Dual Eligible Individuals ."

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Investment highlights

- Attractive sector growth prospects driven by government policies and economic conditions
- Proven flexible health care services portfolio (risk-based, fee-based and direct delivery)
- Diversified geographic exposure with significant presence in high growth regions
- Focus on government-sponsored health care programs
- Seasoned management team with strong track record of delivering earnings growth
- Over 30 years of experience

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Q&A

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Appendix

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Reconciliation of Non-GAAP to GAAP Financial Measures

Please refer to the Company's cautionary statement.

(in millions)	Six Months Ended June 30, 2011
EBITDA [2]	
Health Plans EBITDA:	
Legacy Health Plans	$ 110
New Health Plans	(21)
	89
MMS EBITDA:	
Legacy Fiscal Agent Contracts	22
New Fiscal Agent Contracts	(14)
	8
Consolidated EBITDA	97
Less: Depreciation and Amortization	(34)
Consolidated Operating Income	$ 63

[1] GAAP stands for U.S. generally accepted accounting principles.

[2] We calculate EBITDA consistently on a quarterly and annual basis by adding back depreciation and amortization to operating income. Operating income includes investment income. EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

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