
**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): January 22, 2009

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware
(State of incorporation)

1-31719
(Commission File Number)

13-4204626
(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))
-
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Item 7.01. Regulation FD Disclosure.

On January 22, 2009, Molina Healthcare, Inc. issued a press release announcing its guidance for fiscal year 2009. The full text of the press release is included as Exhibit 99.1 to this report. The information contained in the websites cited in the press release is not part of this report.

Also on January 22, 2009, in connection with the Company's presentation at its Investor Day Conference in New York City, the Company webcast certain slides. A copy of the Company's complete slide presentation is included as Exhibit 99.2 to this report. An audio and slide replay of the live broadcast 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.

The information in this Form 8-K 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	Press release of Molina Healthcare, Inc. issued January 22, 2009, reporting guidance for fiscal year 2009.
99.2	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. held on January 22, 2009.

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.

Date: January 22, 2009

MOLINA HEALTHCARE, INC.

By: /s/ Mark L. Andrews

Mark L. Andrews
Chief Legal Officer, General Counsel,
and Corporate Secretary

EXHIBIT INDEX

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News Release

Contact:
 Juan José Orellana
 Investor Relations
 562-435-3666, ext. 111143

MOLINA HEALTHCARE ISSUES GUIDANCE FOR ITS 2009 FISCAL YEAR

Long Beach, California (January 22, 2009) – Molina Healthcare, Inc. (NYSE:MOH) today announced its guidance for 2009. For its 2009 fiscal year, the Company currently expects the financial results shown below (all amounts are approximate):

Earnings per diluted share	\$2.20 to \$2.40
Net income	\$59 to \$65 million
Investment income	\$15 million
Premium revenue	\$3.6 billion
EBITDA	\$158 to \$167 million
EBITDA as a percentage of premium revenue	4.4% to 4.7%
Medical care costs as a percentage of premium revenue	85.5%
Core G&A (administrative expenses excluding premium taxes) as a percentage of total revenue	7.5%
Administrative expenses (including premium taxes) as a percentage of total revenue	10.5%
Depreciation and amortization	\$43 million
Interest expense	14 million
Total membership	1.44 million
Diluted shares outstanding	27 million
Effective tax rate	41%

The Company's guidance for diluted shares outstanding does not include any potential dilution from its senior convertible notes.

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of healthcare services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. Molina Healthcare's ten licensed health plan subsidiaries in California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington serve approximately 1.26 million members. More information about Molina Healthcare can be obtained at www.molinahealthcare.com.

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: *This press release contains numerous "forward-looking statements" regarding our expected results for 2009. All of our forward-looking statements are based on current expectations and assumptions that are subject to numerous known and unknown risks, uncertainties, and other factors that could cause our actual results to differ materially. Such factors include, without limitation, risks related to: budgetary pressures on the federal and state governments and their resulting inability to fully fund Medicaid, Medicare, or SCHIP or to maintain current membership eligibility thresholds and criteria; the successful management of our medical costs and the achievement of our projected medical care ratios in all our health plans, including the reduction of the medical care ratio of our Ohio health plan; the success of our efforts to leverage our administrative costs to address the needs associated with increased enrollment; risks related to our limited experience operating in Florida and attendant claims estimation difficulties; growth in our Medicaid and Medicare enrollment consistent with our expectations; uncertainties regarding the impact of federal health care reform efforts and the new presidential administration; rate increases and the maintenance of existing rate levels that are consistent with our expectations; our inability to pass on to our contracted providers any rate cuts under our governmental contracts; the budget and liquidity crisis in California and the state's inability to make payment under its contracts with our California health plan; the successful resolution of pending rate litigation in California; the renewal of the provider premium tax beyond October 1, 2009; our ability to accurately estimate incurred but not reported medical costs across all health plans; the successful renewal and continuation of the government contracts of all of our health plans, including the re-selection of our Michigan and Missouri health plans in response to Medicaid RFPs in 2009; in light of the current turmoil and illiquidity in credit markets, the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs; the illiquidity of our auction rate securities; the successful and cost-effective integration of our acquisitions; earnings seasonality; interest rates on invested balances that are lower than expected; high profile qui tam matters and negative publicity regarding Medicaid managed care and Medicare Advantage; changes in funding under our contracts as a result of regulatory and programmatic adjustments and reforms; approval by state regulators of dividends and distributions by our subsidiaries; unexpected changes in member utilization patterns, healthcare practices, or healthcare technologies; high dollar claims related to catastrophic illness; changes in federal or state laws or regulations or in their interpretation; the favorable resolution of litigation or arbitration matters; and other risks and uncertainties as detailed in our reports and filings with the Securities and Exchange Commission and available on its website at www.sec.gov. All forward-looking statements in this release represent our judgment as of January 22, 2009. We disclaim any obligation to update any forward-looking statement to conform the statement to actual results or changes in our expectations.*

Note regarding EBITDA Measures: *The Company calculates EBITDA by adding back depreciation and amortization expense to operating income. EBITDA is not prepared in conformity with GAAP since it excludes depreciation and amortization expense, interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to net income, operating income, operating margin, or cash provided by operating activities. Management uses EBITDA as a supplemental metric in evaluating the Company's 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 the Company's performance and the performance of other companies in our industry.*

-END-



Your Extended Family.

2009 Molina Healthcare Investor Day
January 22, 2009
New York, NY

2009 Investor Day

Juan José Orellana
VP, Investor Relations
Molina Healthcare, Inc.



About today



- Opening remarks
- Panel I
- Panel II
 - 2009 Guidance

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.” 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 in Molina Healthcare’s most recent annual report on Form 10-K, its quarterly reports on Form 10-Q, its current reports on Form 8-K, and its other reports and filings with the Securities and Exchange Commission and available for viewing on its website at www.sec.gov.



Your Extended Family.

2009 Molina Healthcare Investor Day
January 22, 2009
New York, NY

Business Overview

J. Mario Molina, MD

Chief Executive Officer
Molina Healthcare, Inc.



Topics



- Strategic plan
- Molina markets
- Macroeconomic trends
- Management

Mission statement

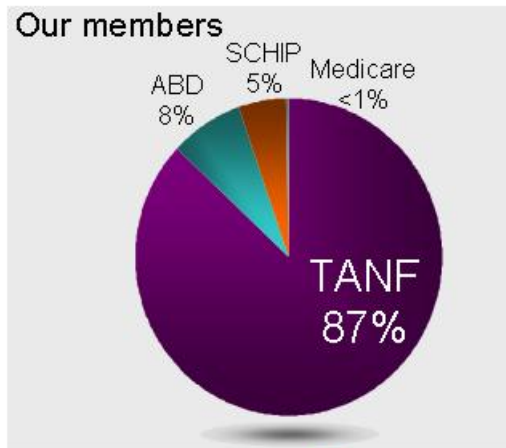
"I want this to be an exemplary organization."

*Mary R. Molina
Founder*

Our mission is to provide healthcare services to low-income families and individuals covered by government programs

Growth

- Focus on government programs for poor & uninsured
- Goal: Revenues of \$4 billion by end of 2010
- Increase ABD enrollment
- Increase Medicare enrollment
- Acquisitions will continue to play an important role



* Approximate revenue amount based on most recent guidance -- final reported revenue amount may vary.

Other financial objectives

- We must use the most cost-effective alternatives
- Lead our industry in limiting administrative costs
- No state to contribute more than 15% of revenue
- Keep a nickel from every dollar of revenue – EBITDA margin 5% of revenue
- We are the stewards of the public's money

Core Administrative Expense
as % of total revenue



*"This is a
business of
nickels."*

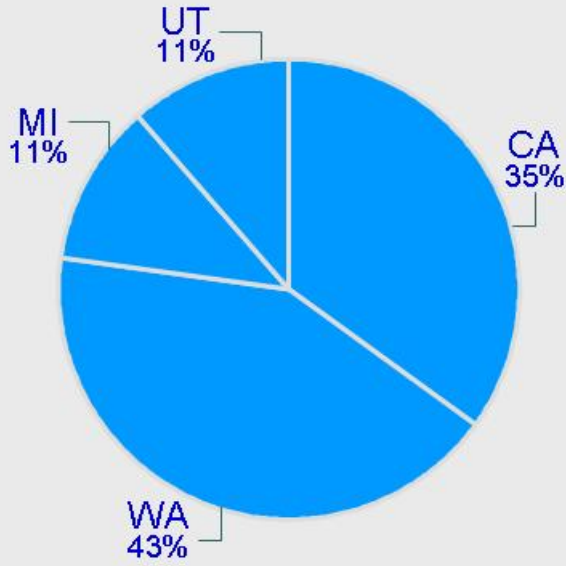
*C. David
Molina, MD
Founder*



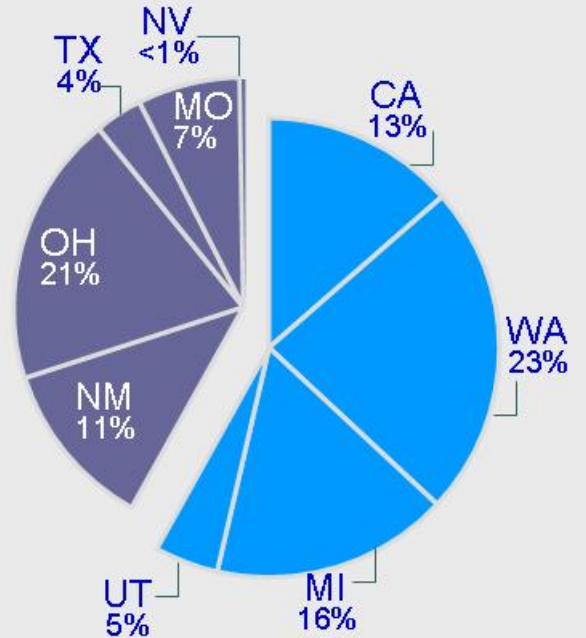
Growth: revenue diversification

Significant revenue diversification since going public in 2003

Revenue Share by State FY 2003



Revenue Share by State 3Q 2008



Commitment to quality



- ALL of Molina's eligible health plans ranked by US News & World Report
- New Mexico, Utah, and Washington health plans ranked as the top Medicaid plan in their state
- Texas and Ohio to undergo NCQA accreditation in 2009

"Quality is everyone's responsibility."

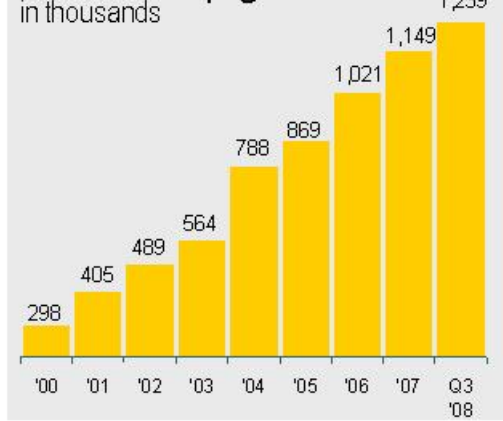
*W. Edwards Deming
(1900-1993)
American Statistician*

Business Snapshot

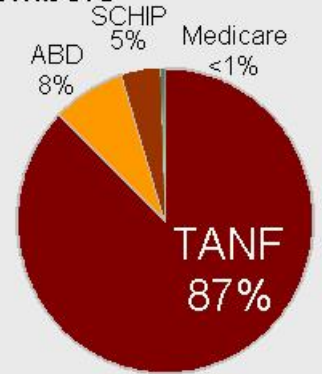
Markets and members served – Q3 '08



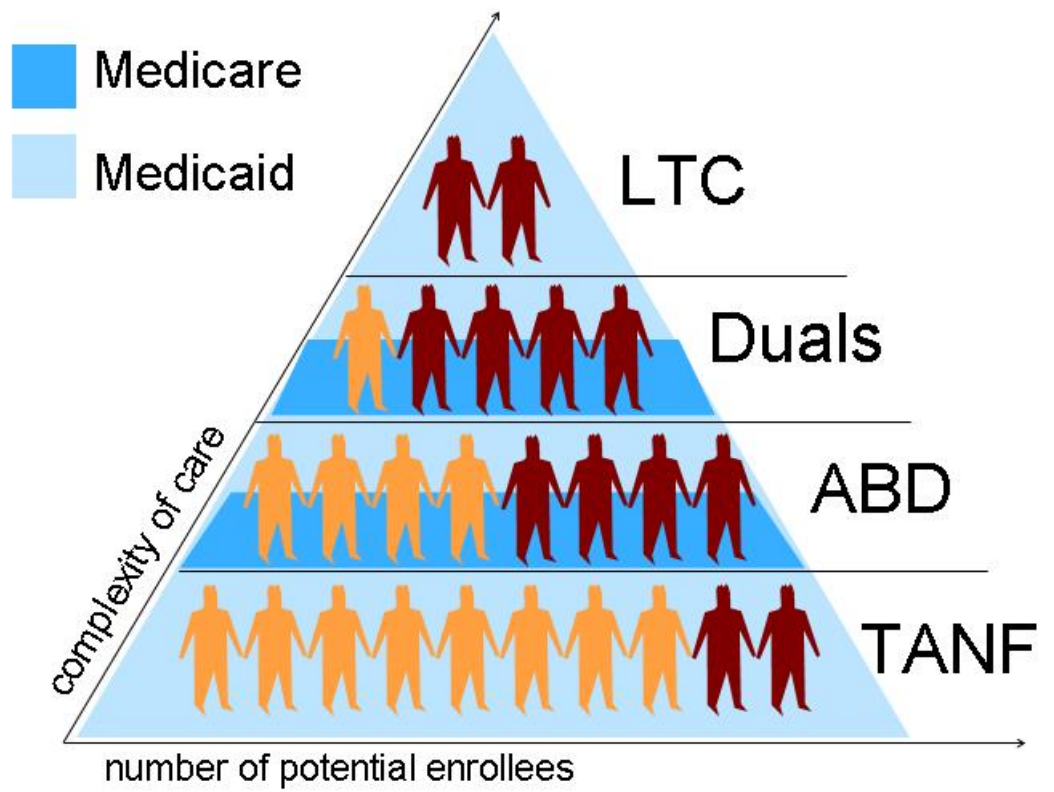
Membership growth in thousands




Our members



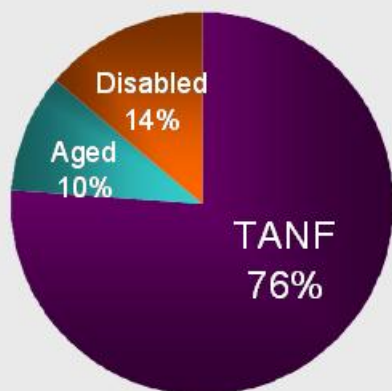
Segmentation



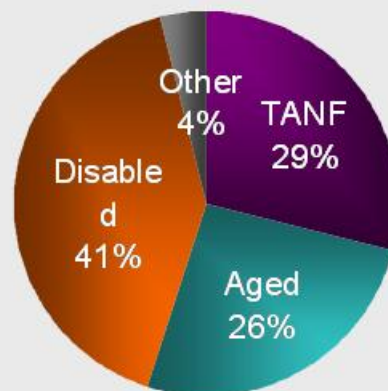
 = patients in need of more complex care
(for illustrative purposes only - not an actual percentage)

Sizeable market continues to grow

Medicaid Enrollment
≈ 59M¹



Medicaid Expenditures:
≈ \$304B¹



- Managed care is an alternative to state's rising Medicaid costs
- Migration of new populations to managed care
- Growing diversity and complexity of social and healthcare needs

1. Medicaid: A Primer. Key Information on the Nation's Health Program for Low Income People. Kaiser Commission on Medicaid and the Uninsured (January 2009)

Competencies



- 29+ years of Medicaid experience
- Documented Quality: NCQA accreditation
- Management: experience and stability
- Industry leading administrative efficiency
- Recognized cultural & linguistic competency
- “Our roots are in the clinics.”

Stimulating the economy



Medicaid delivers a good return on investment:

<i>\$1 spent on:</i>	<i>= 1 year change in GDP</i>
UI benefit extension	= \$1.63
Increase in Food Stamps	= \$1.73
Aid to State Governments (i.e. Medicaid FMAP increase)	= \$1.38
Infrastructure Projects	= \$1.59

Source: Mark Zandi, Chief Economist and Co-founder of Moody's Economy.com: Testimony to the Senate Budget Committee, November 19, 2008.

Stimulus package FMAP proposal

- \$87 Billion for increased FMAP over the next 2 years
- 4.9% FMAP increase to all states
 - Rest apportioned based on unemployment
- FMAP funds can not be used for rainy day funds; must be used for Medicaid
- Must maintain eligibility standards no more restrictive than those in effect July 1, 2008

Baucus Plan



- All poor adults eligible for Medicaid
- SCHIP eligibility to 250% of the FPL
- A national insurance exchange
 - with subsidies up to 400% of FPL
 - public plan option within exchange
- Pay-or-play for medium and large firms
- Preventive services covered (“Right Choices”) and Medicare buy-in for 55-64 year olds until exchange in place
- Individual mandate when affordability assured

Obama Plan



- Medicaid and SCHIP expansions
- National insurance exchange and public plan run together
 - sliding scale subsidies
- Pay-or-play for medium and large-size employers
- Parents must cover kids
- Guaranteed eligibility for insurance and federal reinsurance
- \$50 billion over 10 years for HIT

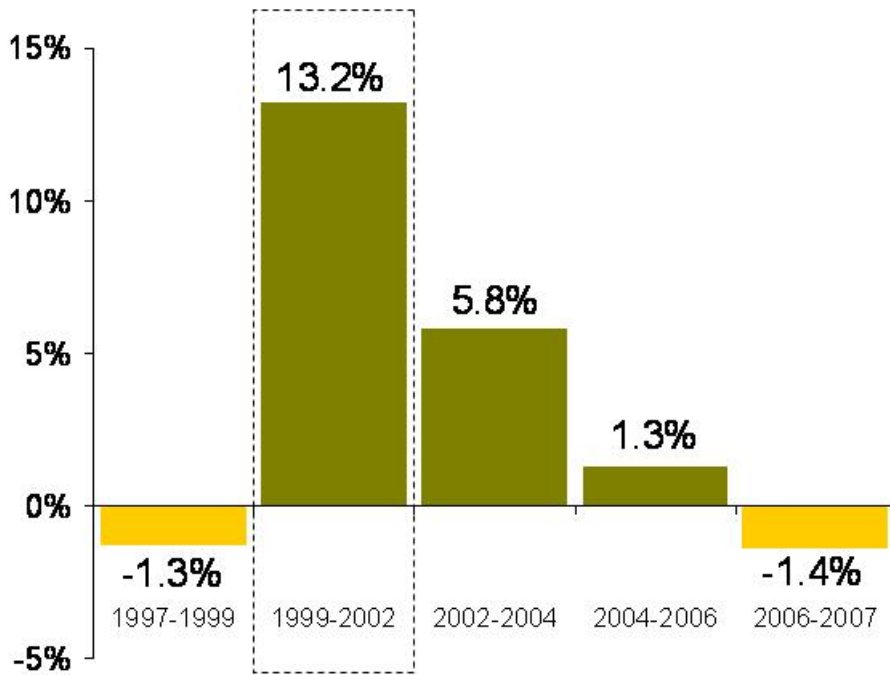
Medicare advantage



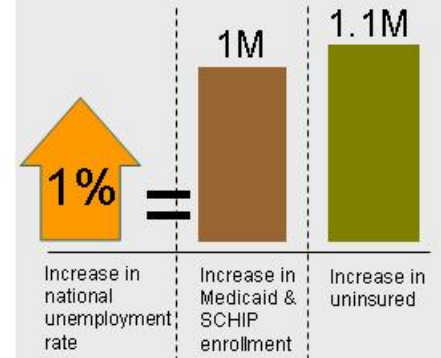
- Medicare Advantage plans will see substantial cuts in payments
- Congress, President Obama want to shrink or eliminate 13% gap between FFS and MA costs
- This would adversely affect primarily ***private fee-for-service plans***

U.S. Medicaid population growth¹

Medicaid population increased quickly during the 2001 recession and its aftermath



Unemployment growth is expected to impact Medicaid, SCHIP, and the uninsured²



MOH enrollment growth in 2008 above Company historical average of ~3.5%

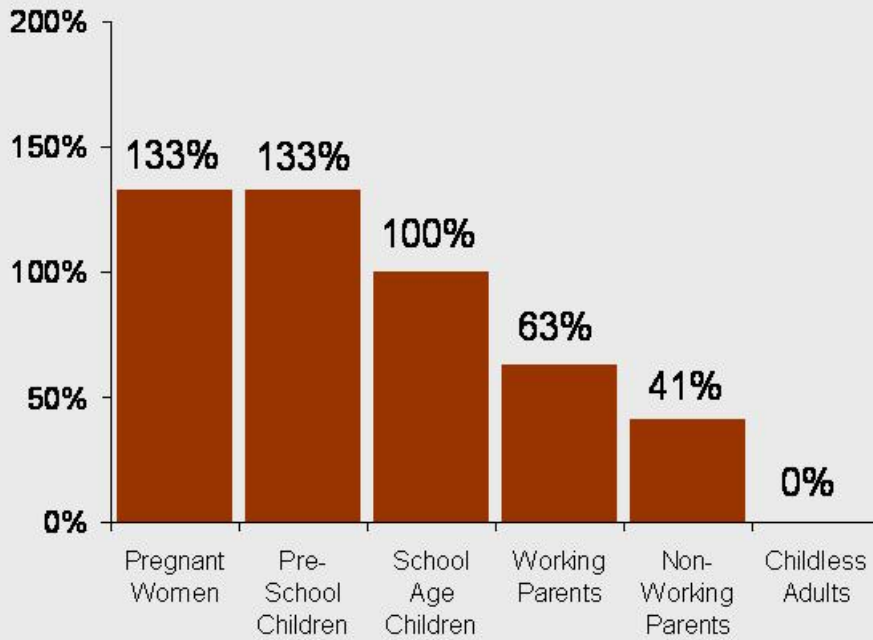


¹ Source: KPMG and Urban Institute estimates based on KPMG Medicaid enrollment data collected by Health Management Associates from 449 sites, normalized to national jobs (2008)
² Source: Stan Don, Bowen Gern, John Holahan, and Alnee Williams, Medicaid, SCHIP and Economic Downturn: Policy Challenges & Policy Responses, prepared for the Kaiser Commission on Medicaid and the Uninsured (2008)

Public coverage during a recession

Low and moderate income workers are especially vulnerable to becoming uninsured

Income eligibility as a % of the poverty level ¹



Low income unemployed families are unable to afford COBRA²

	Average Monthly unemployment income	Average Monthly COBRA premium	Premium's share of unemployment income
Family	\$1,278	\$1,069	83.6%
Individual	\$1,278	\$388	30.4%

If President Obama's plan to cover all adults under 100% FPL is approved it will add:

16 million
Adults to the
Medicaid
Program

1. Source: Health Coverage in a Period of Rising Unemployment (Schwartz); Kaiser Commission on Medicaid and the Uninsured, (December 2009)
2. Source: Squeezed! Caught Between Unemployment Benefits and Healthcare Costs, Families USA, (January 2009)

SCHIP reauthorization

Many of our health plans' principal governmental contracts include SCHIP



House & Senate proposals include:

7 + 4

Million
Currently covered
by SCHIP in U.S.

Million
Additional
uninsured children to
be covered by bill

and:



Coverage for children in families above **300 percent** of Federal poverty level will receive **Medicaid** match rate

Management team

*“No managed care CEO has been in place longer than Mario Molina.” **

*“John Molina is among the longest tenured CFOs in the managed care space.” **



J. Mario Molina, MD
Chief Executive Officer



John C. Molina, JD
Chief Financial Officer



Mark Andrews, JD
Chief Legal Officer & Corporate Secretary



Terry Bayer, JD, MPH
Chief Operating Officer



James Howatt, MD, MBA
Chief Medical Officer



Joseph White, CPA, MBA
Chief Accounting Officer

*Source: Westwood G., Credit Suisse Equity Research, "The Molina Chronicles" – Takeaway from Management Meetings, Feb. 29, 2008.

The Medicaid opportunity



*“Success is where
preparation and
opportunity meet.”*

Bobby Unser



Your Extended Family.

2009 Molina Healthcare Investor Day
January 22, 2009
New York, NY

Medical Affairs Update

James W. Howatt, MD, MBA

Chief Medical Officer
Molina Healthcare, Inc.

Leveraging data to maximize value

The value equation



$$\textit{Quality/} \textit{Cost} = \textit{Value}$$

Leveraging data to maximize value



Maternal health



Discharge planning



Accreditation & quality improvement



In-source behavioral health



Managed care 101



Getting it right

- Right care
- Right place
- Right provider
- Right time in course of illness

Our priority



*Managing medical
costs equals
increasing value*

Why do we care about prematurity?



Babies born before 32 weeks have the greatest risk for death and poor health outcomes.¹

Social costs of preterm births:

\$26.2M

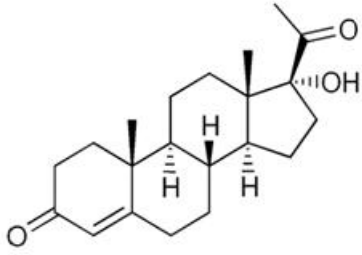
1. Source: Preterm Birth: Causes, Consequences, and Prevention; Institute of Medicine of the National Academies, July 2005

2. Source: National Governors' Association, Issue Brief June 9, 2009

40% of all deliveries in the nation occur in Medicaid²

- Nearly 13% of deliveries in the nation are premature (less than 37 weeks)
- Significant mortality and long-term health complications
- Immediate costs are high (Difference between 28 and 36 weeks around \$175,000)
- Long term costs are high (estimated in excess of \$500,000 lifetime cost for extremely premature)

What is the 17-P Program?



- A program that identifies pregnancies with a history of premature delivery
- Weekly administration of a hormone shot
- Results in an approximately 1/3rd reduction in repeat premature births

Maternal health: reducing prematurity



- 17-P program
- High risk OB recognition & intervention
 - Early identification
 - Intervention
 - Biometrics
- Lengthen gestational period
- Engage pediatrics

17-P Now active across all Molina health plans

Molina 17-P Program Results 2008



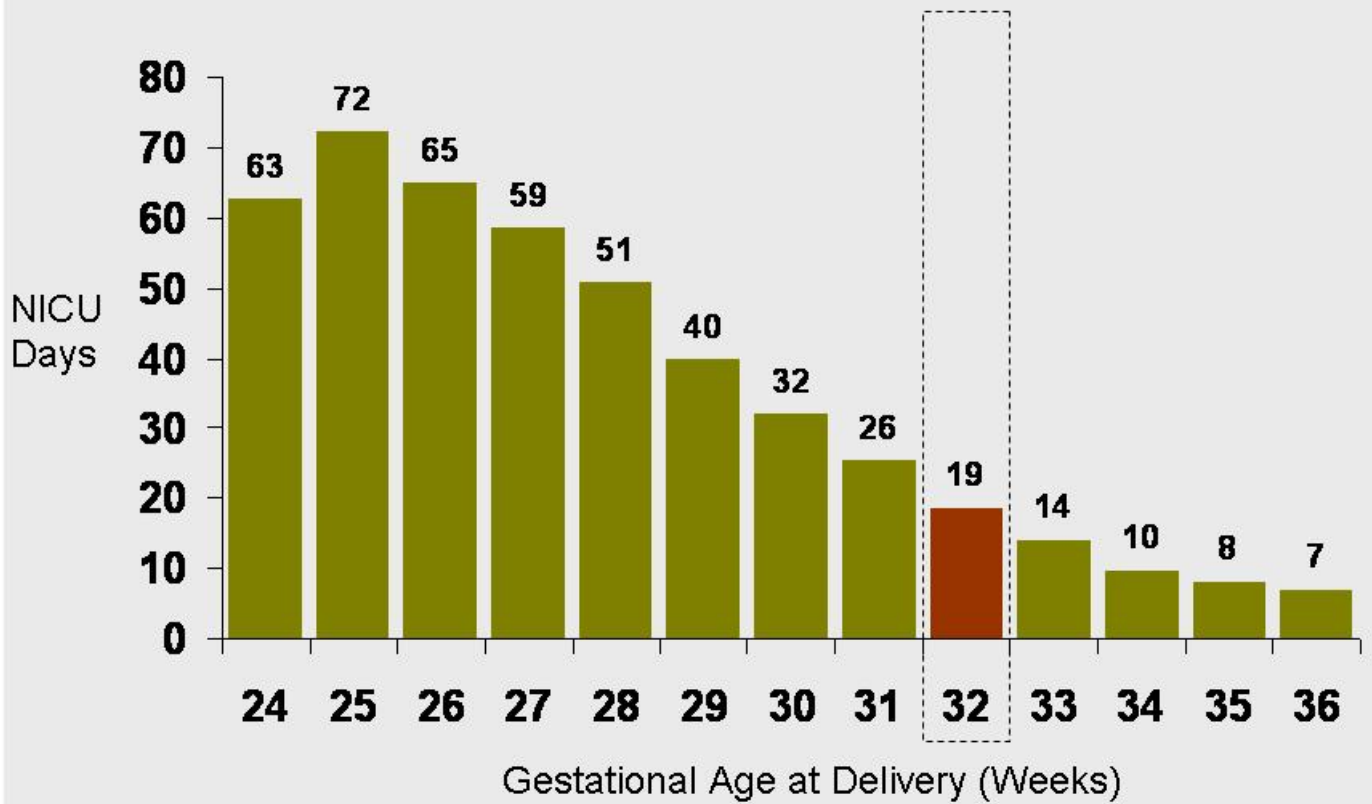
Average Gestation:

30
weeks prior pregnancy

38
weeks treated with 17-P

Why 32 weeks is important.

Average NICU Days by Gestational Age at Delivery



Commitment to quality

Our long-term success will depend on the quality of services we provide



- Enrollment
 - 26 states now rely on some form of accreditation and it can affect enrollment algorithms
- Quality payments
 - Pay for performance
 - Quality bonuses
- Objective evidence
 - Efficiency & effectiveness
- Recognition
 - Molina has more accreditations than any other Medicaid organization (5 currently, and 2 more in the pipeline)

Leveraging data to improve scores



- Identifying missed services
 - Claims
 - Demographics
- Create an 'Every Touch' strategy
 - Engage all elements of Molina
 - Member service – critical
 - Website for providers
- Monitor results
 - Roll out to all Molina plans

Leveraging data: results

Molina has received over 10,000 “hits” with recommendations to obtain care

- Results: within 3 months of advice, an additional 9-15% (over baseline) obtained services.
- Impact: Molina scores estimated to increase significantly year-over-year and compared to peers.



In-sourcing of behavioral health



Terminated behavioral health provider contracts in Ohio in 3Q08 and brought in-house

- Transition complete and generating savings in:
 - in-patient days
 - out-patient services
 - reduction in neuro-psych testing
- Additional savings anticipated from integration of care
- Similar efforts underway in Texas
- Missouri to follow

Discharge Planning



- Reduce Length of Stay
- Facilitate Effective Discharge
- Prevent Readmissions
 - Medications
 - Follow-Up Appointments
 - Transportation
 - Durable Medical Equipment

Emergency room misuse



- Nurse Advice Line
 - Home care advice
 - Urgent care center referral
- Access
 - Commercial clinics
 - Incentives to PCPs to extend hours
 - Partner with facilities
- Surrogate for inadequate care
 - Monitor utilization with select diagnoses
 - Monitor utilization by provider
- Case manager
 - Chronic illness with poor self-management
 - Chronic pain
 - Drug-seeking
 - Behavioral health

The Bottom Line

The top section consists of four vertical panels, each with a photograph at the top and a label in a grey arrow-shaped box at the bottom. From left to right: 1. A photograph of a pregnant woman and a healthcare provider, with the label "Maternal health". 2. A photograph of a healthcare provider pointing at an X-ray, with the label "Discharge planning". 3. A photograph of a newspaper clipping titled "U.S. News America's Best Health Plans" and "The 2007 Rankings", with the label "Accreditation & quality improvement". 4. A photograph of two women, one with a stethoscope, with the label "In-source behavioral health".

A large grey rectangular box contains a summary of financial impact. On the left, a large orange downward-pointing arrow contains the text "1% decrease in our medical care ratio". To the right of this arrow is the word "yields". To the right of "yields" is a large green upward-pointing arrow containing the text "\$0.65 increase to earnings per share".



Your Extended Family.

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Operations Update

Terry Bayer

Chief Operations Officer
Molina Healthcare, Inc.

Operations Update



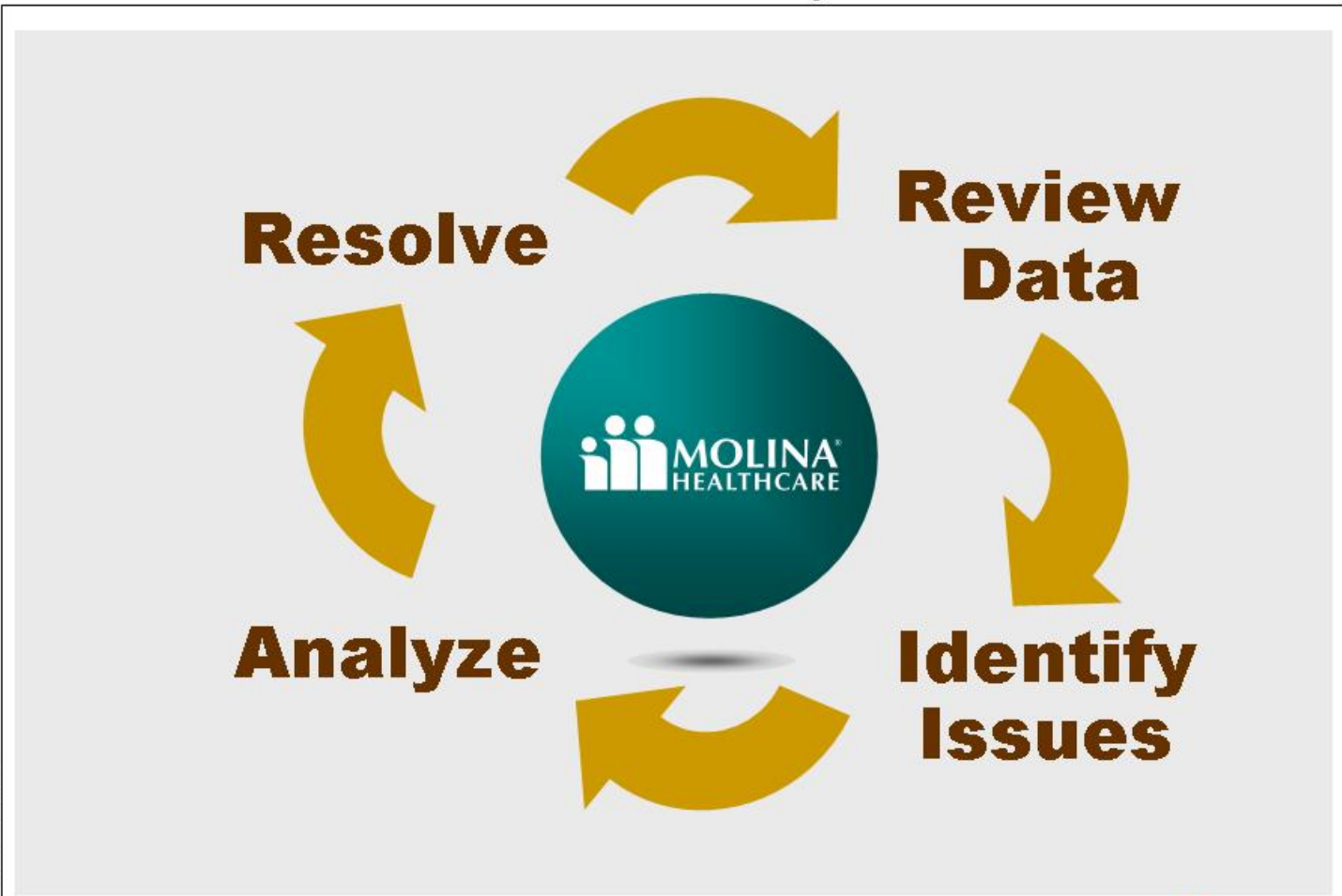
- Leveraging data to meet operational challenges
 - Ohio
 - California
- Acquisition integration update
 - Missouri
 - Florida
- Customer service
 - Claims

Focus on Data

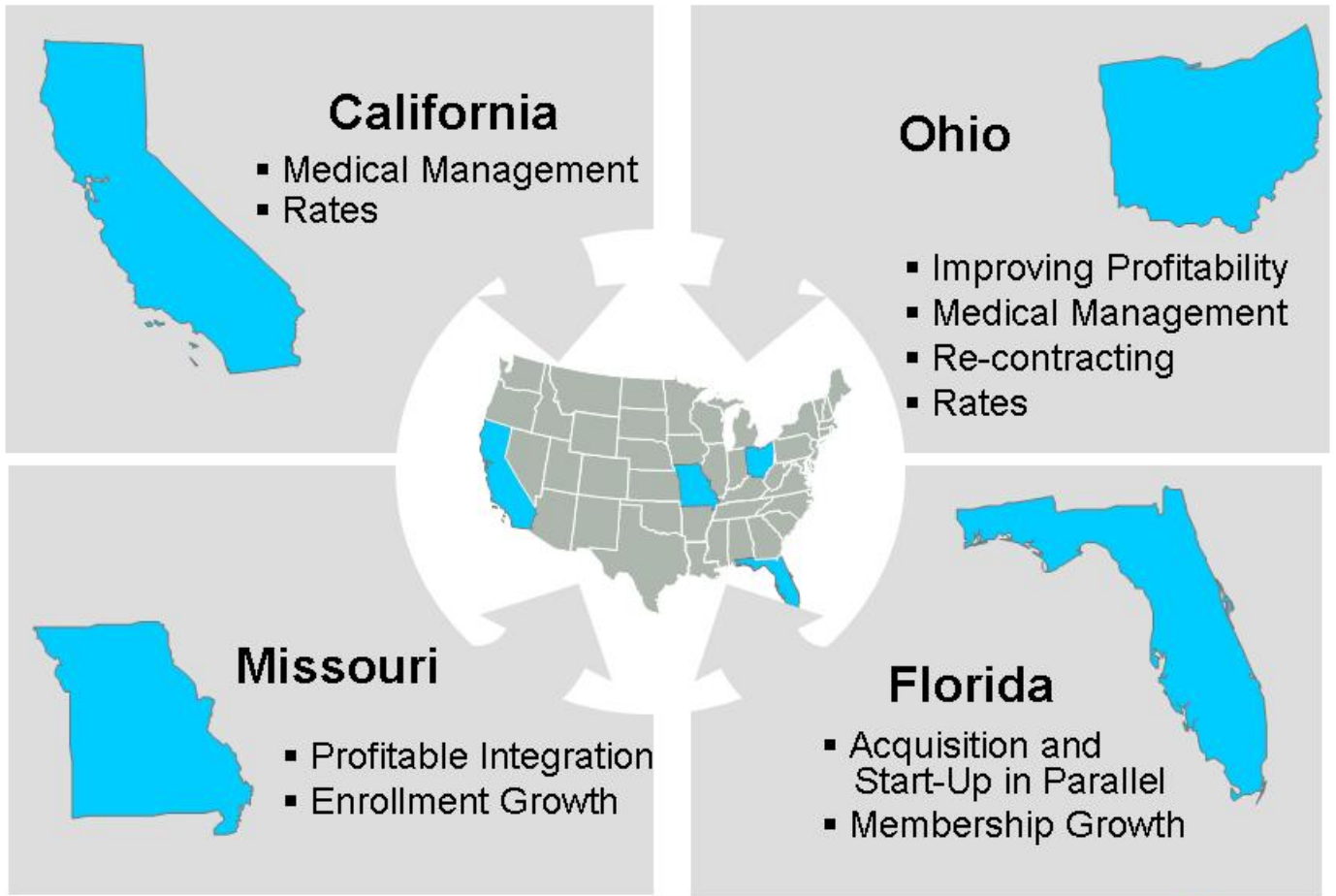


“IN GOD WE TRUST; ALL OTHERS BRING DATA.”

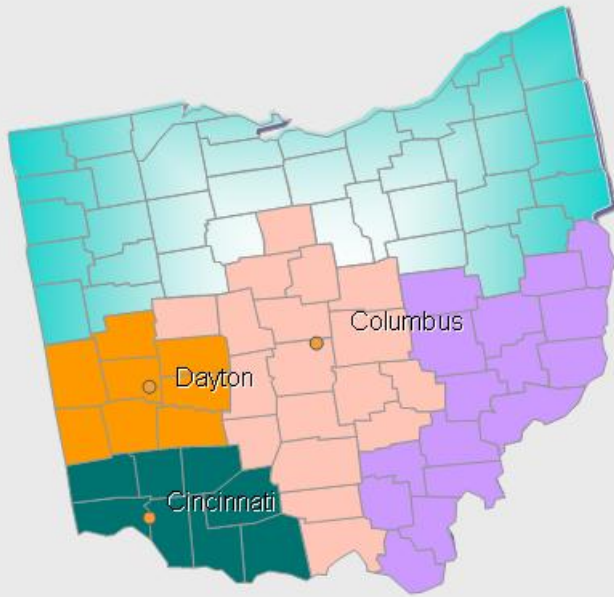
Focus on Data - The Molina Way



Operations Update

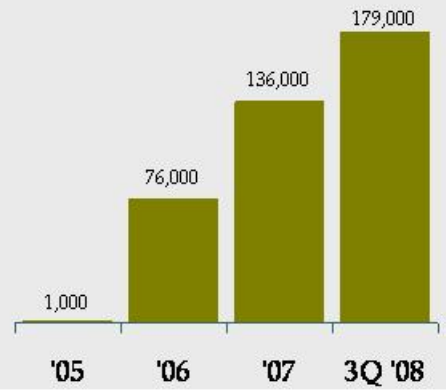


Molina Healthcare of Ohio

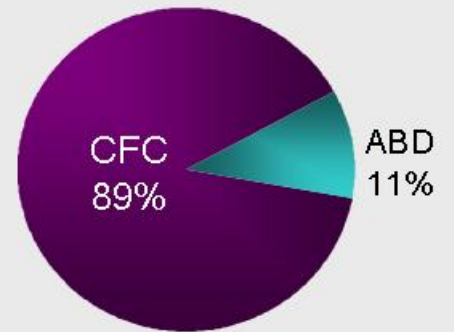


- Serving TANF & ABD populations in 4 regions
- Began operations in December 2005

Membership History



Membership



Molina Healthcare of Ohio – Profitability Improvement

**Medical
Cost
Reductions**



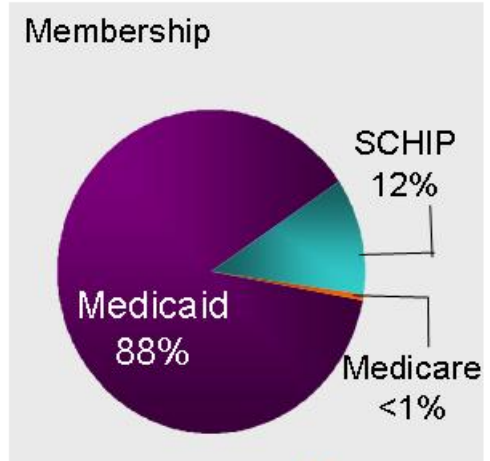
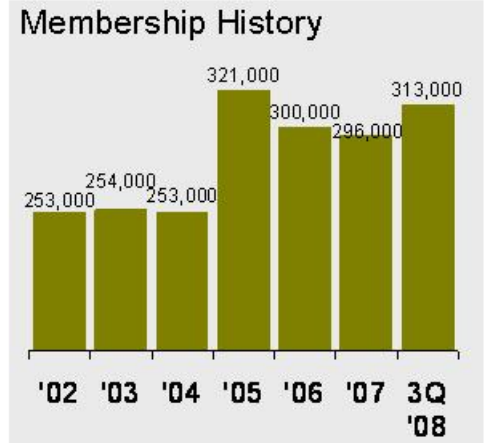
**Rate
Increase**

5%

- Re-Contracting
- Medical Management

- ABD 1/09
- CFC 1/09
- Risk Adjustment Score 9/08

Molina Healthcare of California



The rate challenges

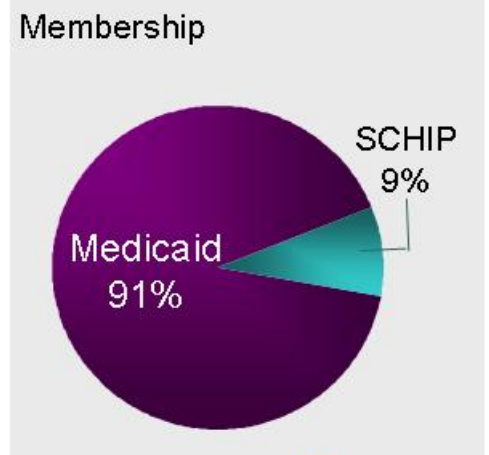
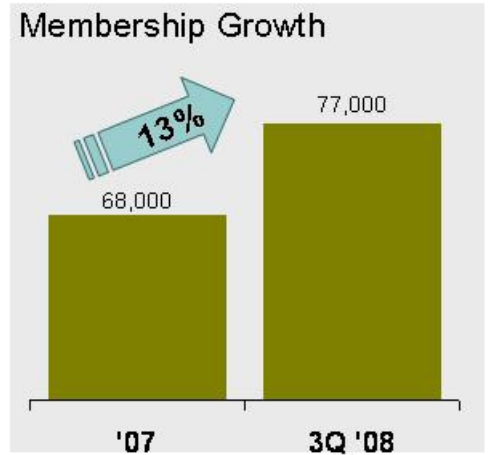
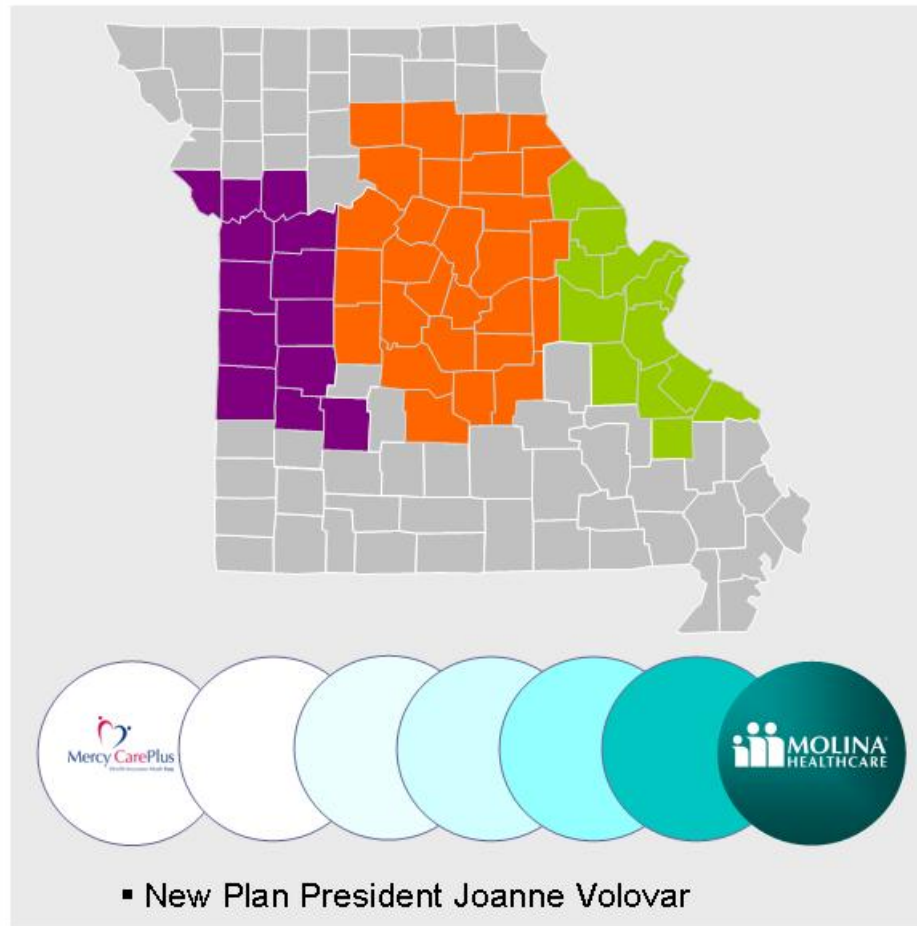


- Term High Cost Hospitals
- Re-contracting
- Medical Management

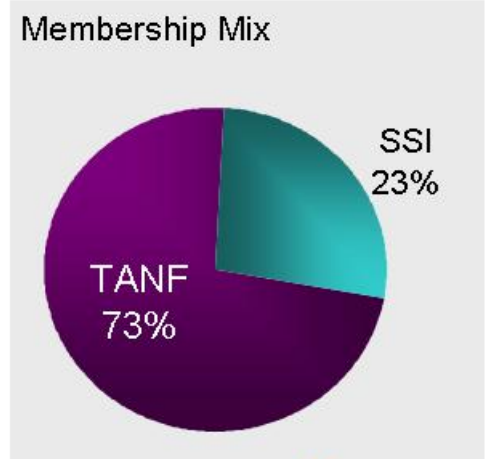
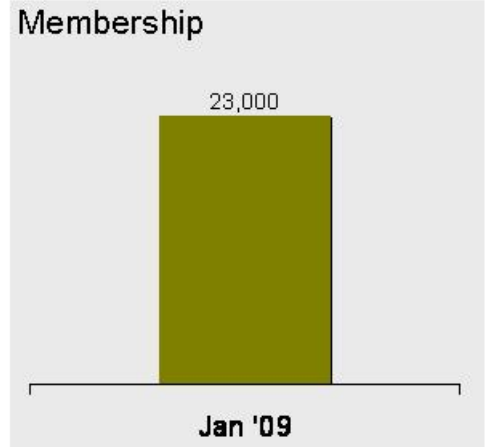
▪ All Regions

- Los Angeles  10/08
- Riverside/ SB  10/08
- San Diego  7/08
- Sacramento Pending

Molina Healthcare of Missouri – successful integration

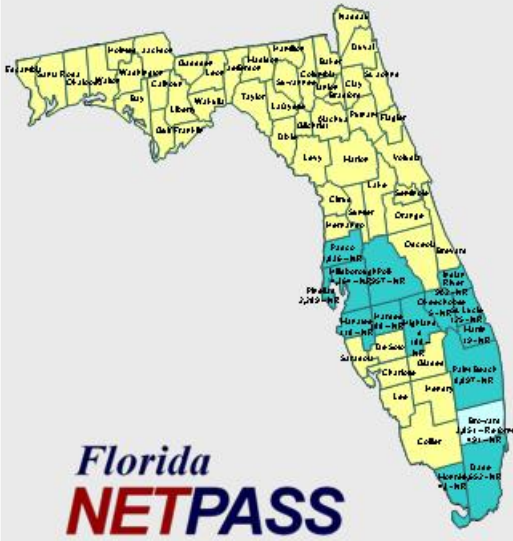


Molina Healthcare of Florida – successful start-up



1. October data publicly available from www.fdhc.state.fl.us

Molina Healthcare of Florida



Our diversification strategy includes both start-ups and acquisitions.

- 8/08 Announced Florida NetPass Acquisition
 - Consideration \$42M (subject to adjustments)
 - 55 thousand members
 - Provider Service Network (PSN)
- 1/08-11/08 Provider Certificates Awarded
 - Broward, Dade, and Palm Beach
- 10/08 Medicaid Contract Awarded (Eff. 12/08)
- 12/08 First Members
- 1/09 Member transition begins

Successful integration of Florida NetPass



- Active enrollment in Dade county
 - January 2009 – 23K members

- Additional counties *

 - Broward
 - Hillsborough
 - Palm Beach
 - Pasco
 - Pinellas
 - Polk

* Pending AHCA approval

Customer service



- Our primary customers are our members
- Our supporting customers include our providers
- Improving provider satisfaction helps organic growth
- Focus groups with providers revealed that faster payment would improve satisfaction

Speed of payment and customer service



“...reducing payment delays and administrative burdens may have more of an impact on access than modest increases in fee levels.”

Cunningham, Peter J. and O'Malley, Ann S. “Do Reimbursement Delays Discourage Medicaid Participation by Physicians?” *Health Affairs*, 28 no.1 (2009): 27.

Customer service

Focus on paying our providers faster

Percentage (%) of Claims Paid within 15 days of Receipt

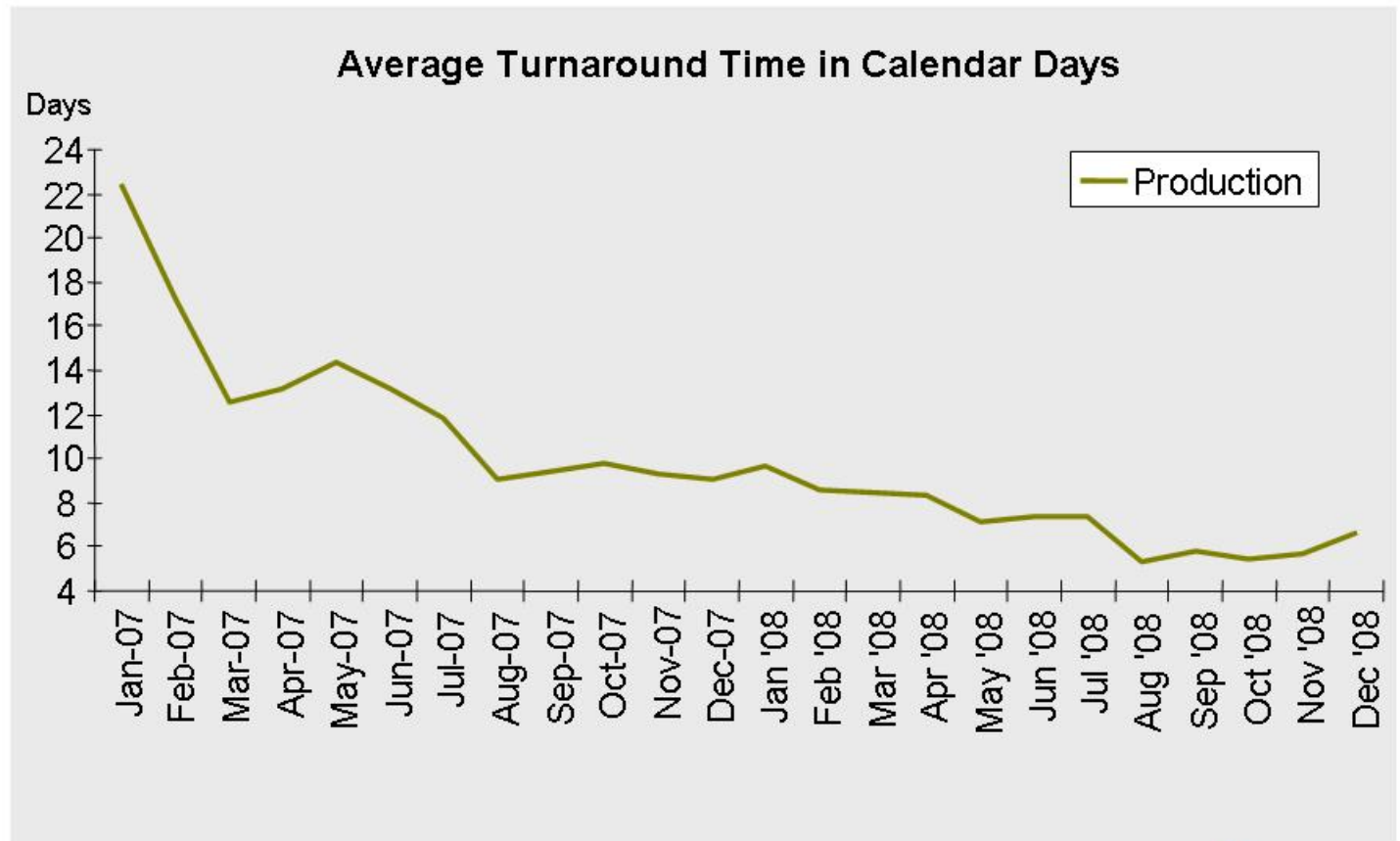


Note: Missouri data not included.



Customer service

Focus on paying our providers faster

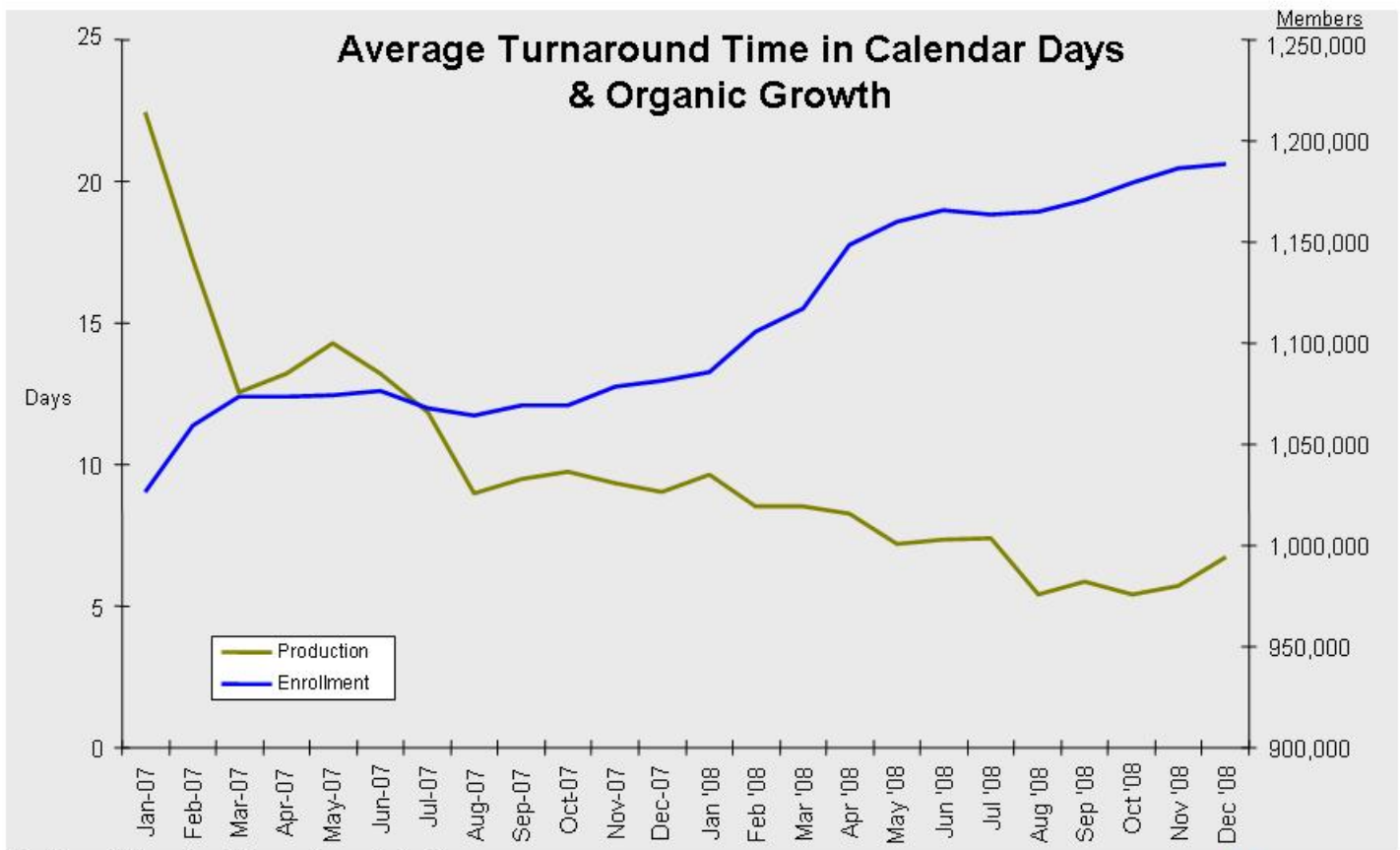


Note: Missouri data not included.



Customer service

Focus on paying our providers faster



Note: Missouri data and acquisition members not included.



Using data and feedback from our customers, we continue to improve our operations.



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2009 Molina Healthcare Investor Day
January 22, 2009
New York, NY

Compliance: A Value Proposition

Mark L. Andrews, Esq.
Chief Legal Officer
Molina Healthcare, Inc.



Why discuss compliance now?



- We are acutely aware of the daily media and regulatory reports of wrongdoing by competitors, providers, and individuals operating within the healthcare sector
- We are acutely aware that Molina is not among those reports and want you to know that we are also intensely focused on keeping it that way

Compliance pays. How?



1. Regulatory Trust



2. Patient Confidence



3. Provider Satisfaction



4. Public Market Clarity





Portrait of Benjamin Franklin, ca. 1794-1802
www.kitfortknox.com

*Wisdom from
Benjamin Franklin*

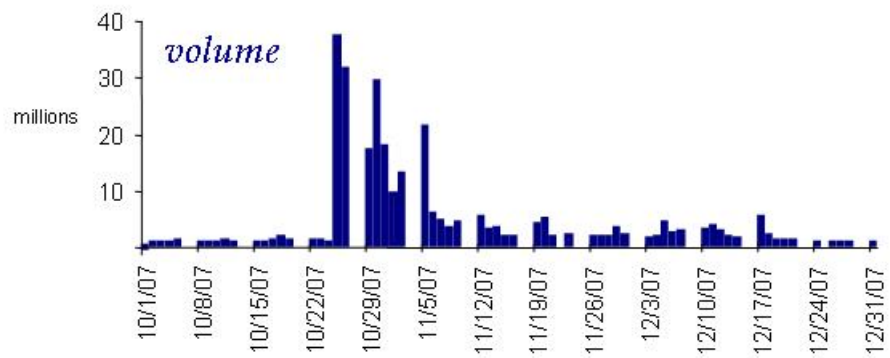
*An ounce of
prevention is worth a
pound of cure.*

Non-compliance undermines earnings



- Increased Costs
 - Fines, penalties, judgments
 - Litigation expenses
 - Insurance premiums
- Lost Revenue
 - Enrollment decline
 - Enrollment freeze
- Resource Drain
 - Personnel time
 - Project distraction
- Lost Expansion Opportunities
- Stock Impact
 - Price
 - Trading volume

The impact is immediate and significant



Compliance delivers quality



- NCQA accreditation matters
- Increasingly required for program entry
- Functions as deemer for meeting program requirements in a streamlined and more efficient manner. That means expense saved
- Recognized as a proper surrogate for quality – increasing regulator, patient, and provider confidence

26 states now rely on some form of accreditation

Compliance contributes to our success

What keep us out of the headlines?

29
years

1. Experience

we have been
doing this
longer



2. Core Value

we choose
to do this



3. Priority

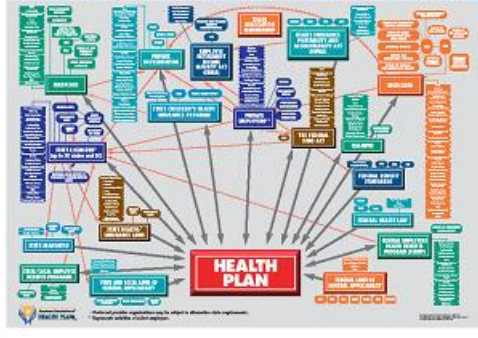
key component
of our strategic
plan

4. Our approach:

- An enterprise wide model
- Spread responsibility more broadly
- Address 'people' component of compliance
- Moved beyond just checklists and memorization

The landscape matters

SUMMARY OF HEALTH PLAN REGULATION



- The environment is too complex for lists and memorization
- Changes too fast to leave in the hands of a few compliance team members
- Team members need to learn and embrace 6 basic concepts



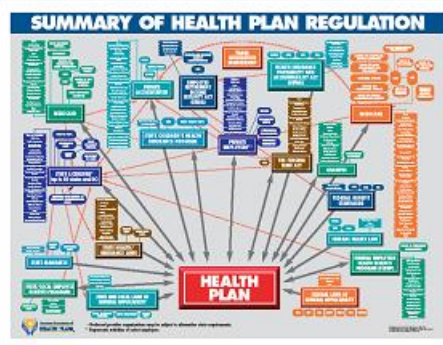
Compliance is driven by people



1. Compliance is part of your role
2. You can't know everything
3. You have permission to raise questions
4. Asking questions does not equal "snitching"
5. You should trust your instincts
6. There are some basic "red flags"

So ask questions

Likely industry compliance hotbeds for 2009



- ID & PHI privacy
- Security
- Data development (UM and cost)
- Claims
- Marketing/Outreach
- Fraud & abuse

Break





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Growth Opportunities

John C. Molina
Chief Financial Officer
Molina Healthcare, Inc.

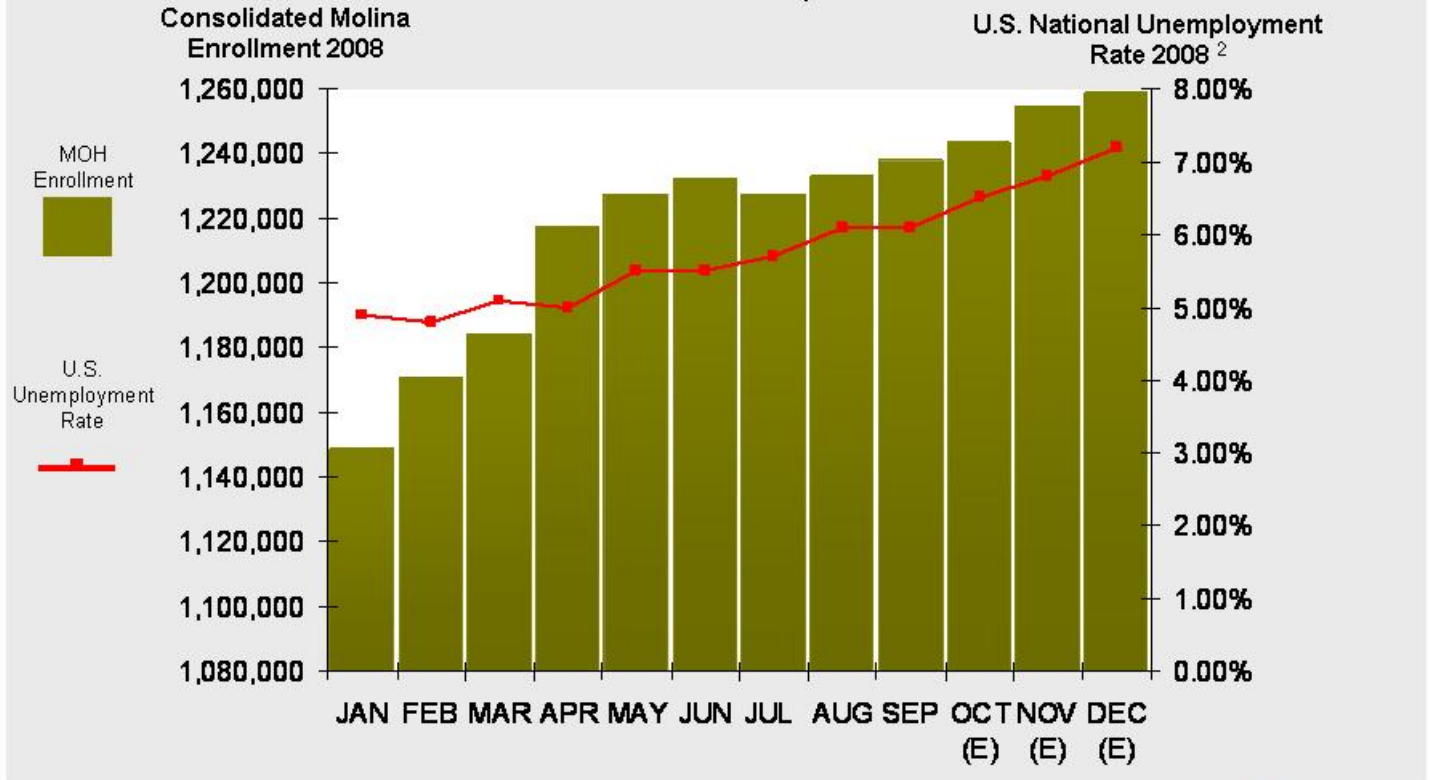
Growth Opportunities - 2009



- Organic growth
- Eligibility expansion
- New populations
- New market opportunities
- Managed care expansion

Organic Growth

Economic deterioration will increase enrollment in existing Molina markets (1% increase in Unemployment results in an additional 1 Million Medicaid Lives¹)



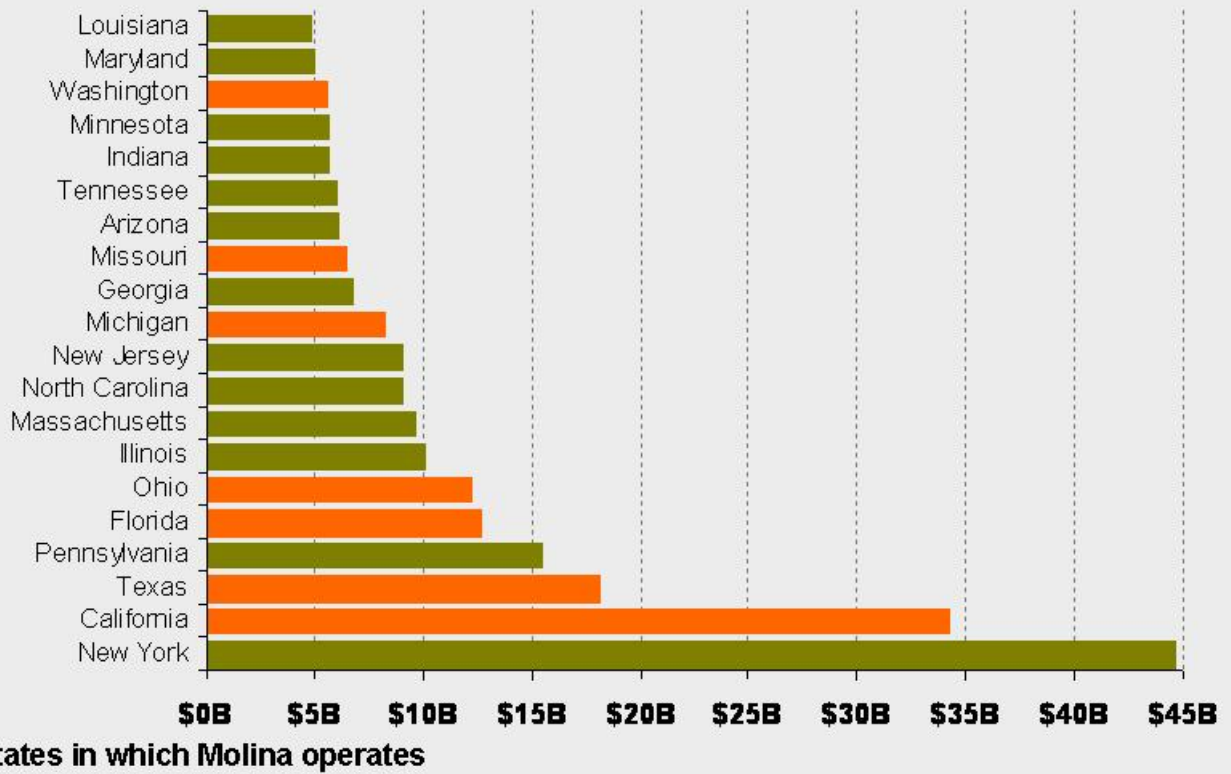
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Source:
 (1) Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses, Kaiser Family Foundation, April 2008
 (2) U.S. Bureau of Labor Statistics, September 2008



Organic growth

7 of Molina's 9 Health Plans are in States that rank among the Top 20 Medicaid spenders.



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Source: Kaiser Commission on Medicaid and the Uninsured
<http://www.statehealthfacts.org>



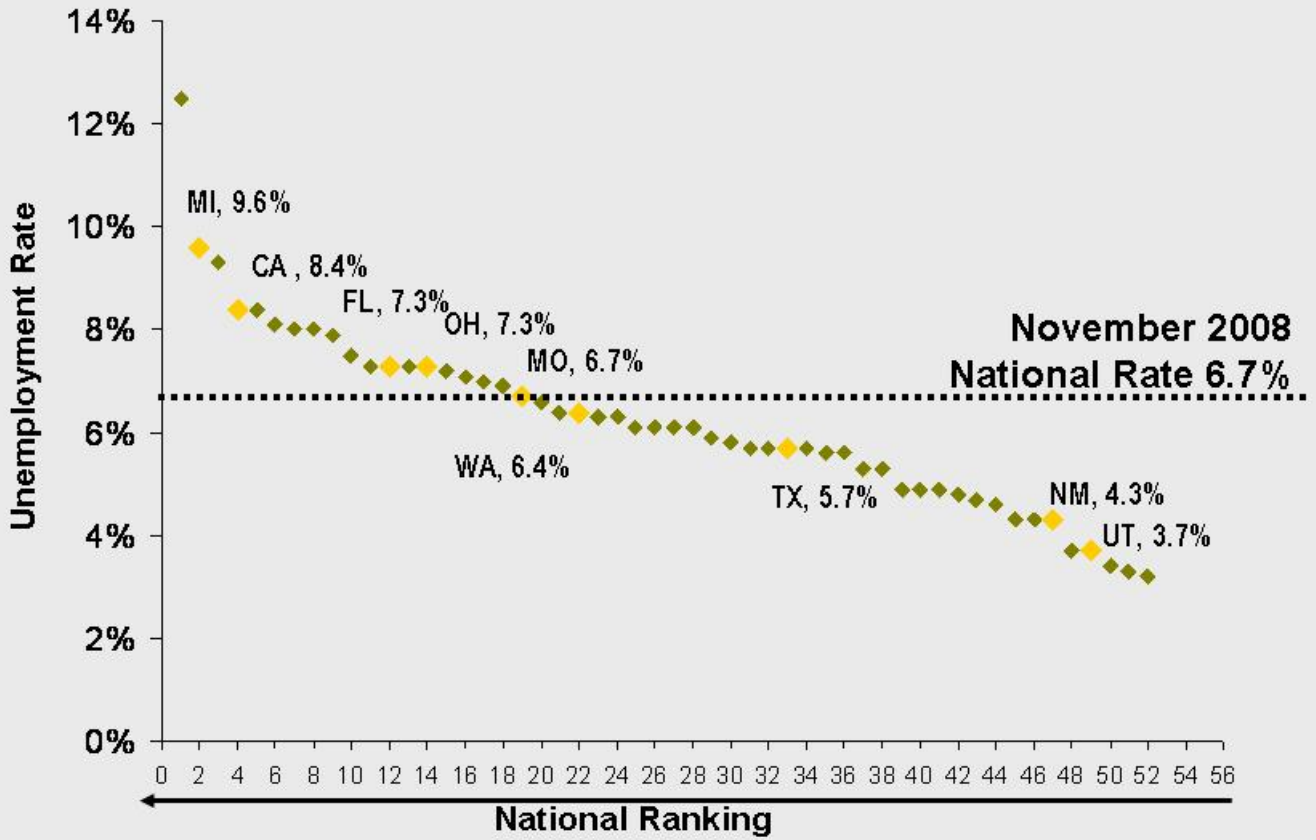
Organic growth: federal stimulus package

Federal stimulus package will increase Federal funding to current Molina markets:

- **Adds \$87B in federal match**
 - 4.9% increased funding to ALL states
 - Federal funds to cover newly unemployed who enter the Medicaid program through 2010
 - Additional relief to states with high unemployment rates

Organic growth: FMAP increase

The **\$87.0B** proposed **FMAP increase** will be distributed based on **States' Unemployment Rates** as well as FMAP percentages.



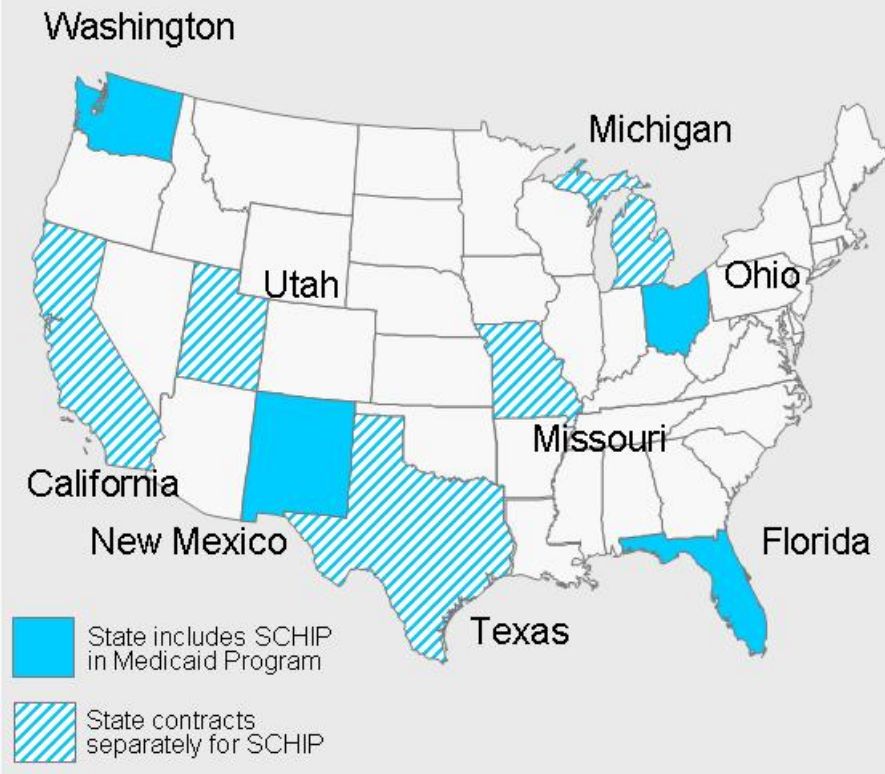
Eligibility expansion: SCHIP reauthorization



- **House bill passed**
- **Senate bill passed out of Committee**
- **Details:**
 - Reauthorized through fiscal year 2013
 - Adds 4.1M children to the 7M already covered
 - Funding for outreach
- **Senate bill also:**
 - Requires GAO to study actuarial soundness of rates
 - Establishes Medicaid / SCHIP Commission (like MedPAC)

Eligibility expansion: SCHIP reauthorization

Many of our health plans' principal governmental contracts include SCHIP



House & Senate proposals include:

7 + 4

Million
Currently covered
by SCHIP in U.S.

Million
Additional
uninsured children to
be covered by Bill

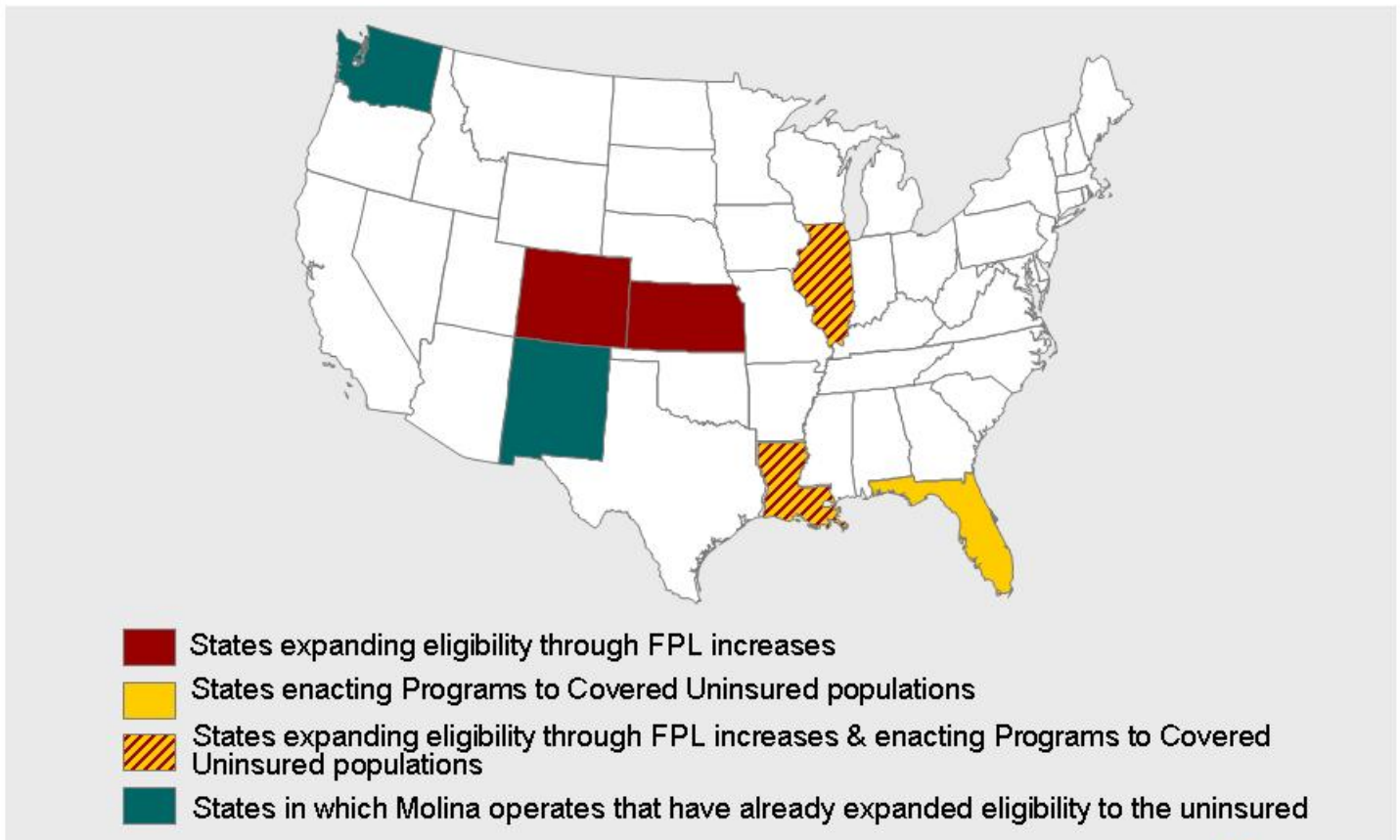
and:



Coverage for children in families above **300 percent** of Federal poverty level will receive **Medicaid** match rate

Eligibility expansion: state level

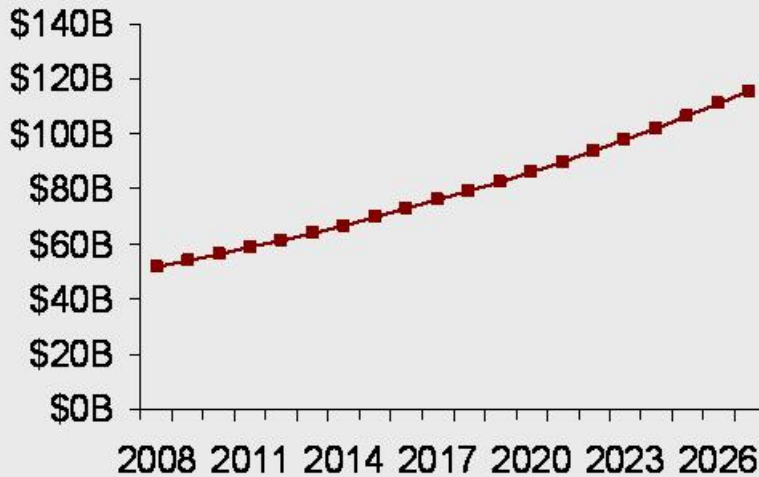
Some states have undertaken their own efforts to expand eligibility




New Populations: Long Term Care (LTC)

- Medicaid LTC expenditures are large and continue to grow.
- Molina has experience operating LTC plans in Texas and Washington

TOTAL STATE MEDICAID LTC EXPENDITURES



 Molina markets in which state governments spent over \$1B in Long Term Care

STATES SPENDING \$1.0B OR MORE ON MEDICAID LTC IN 2008

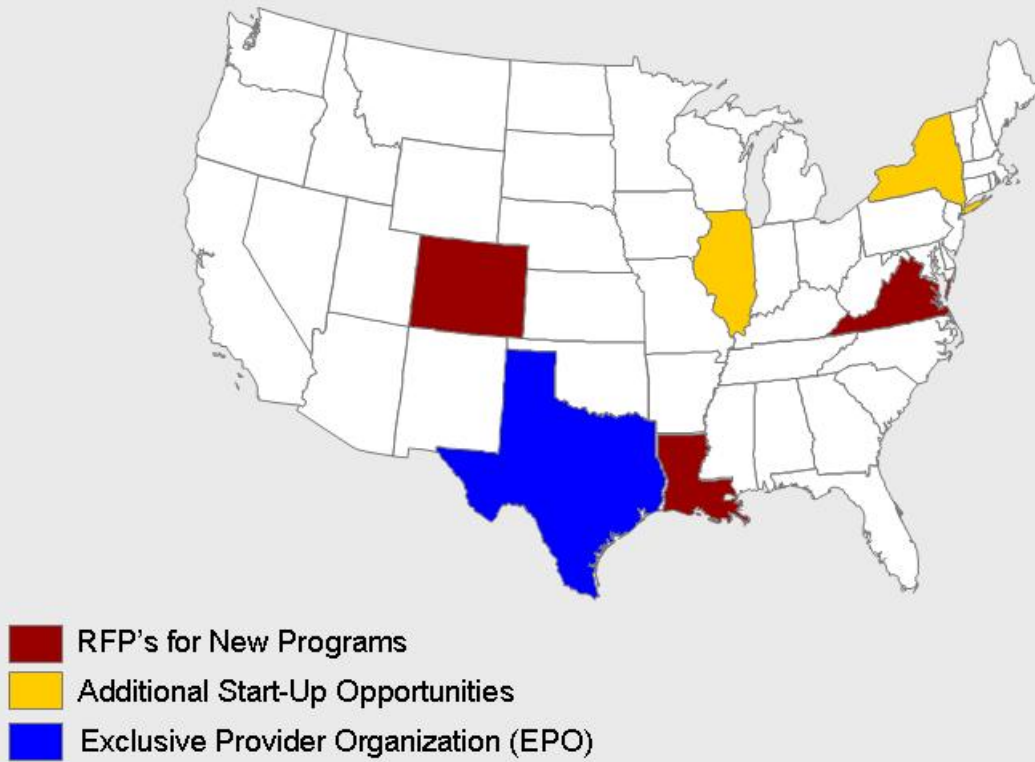
New York	\$10.0B
California	\$5.6B
Pennsylvania	\$3.5B
Ohio	\$2.4B
Texas	\$2.3B
New Jersey	\$2.1B
Florida	\$1.9B
Illinois	\$1.8B
Massachusetts	\$1.6B
Minnesota	\$1.6B
Michigan	\$1.3B
Connecticut	\$1.2B
North Carolina	\$1.2B
Wisconsin	\$1.1B
Washington	\$1.1B

Source: 'State Medicaid Expenditures for Long-Term Care 2008-2027' – AHIP September 2008



New market opportunities

Potential new market opportunities in 2009 and 2010



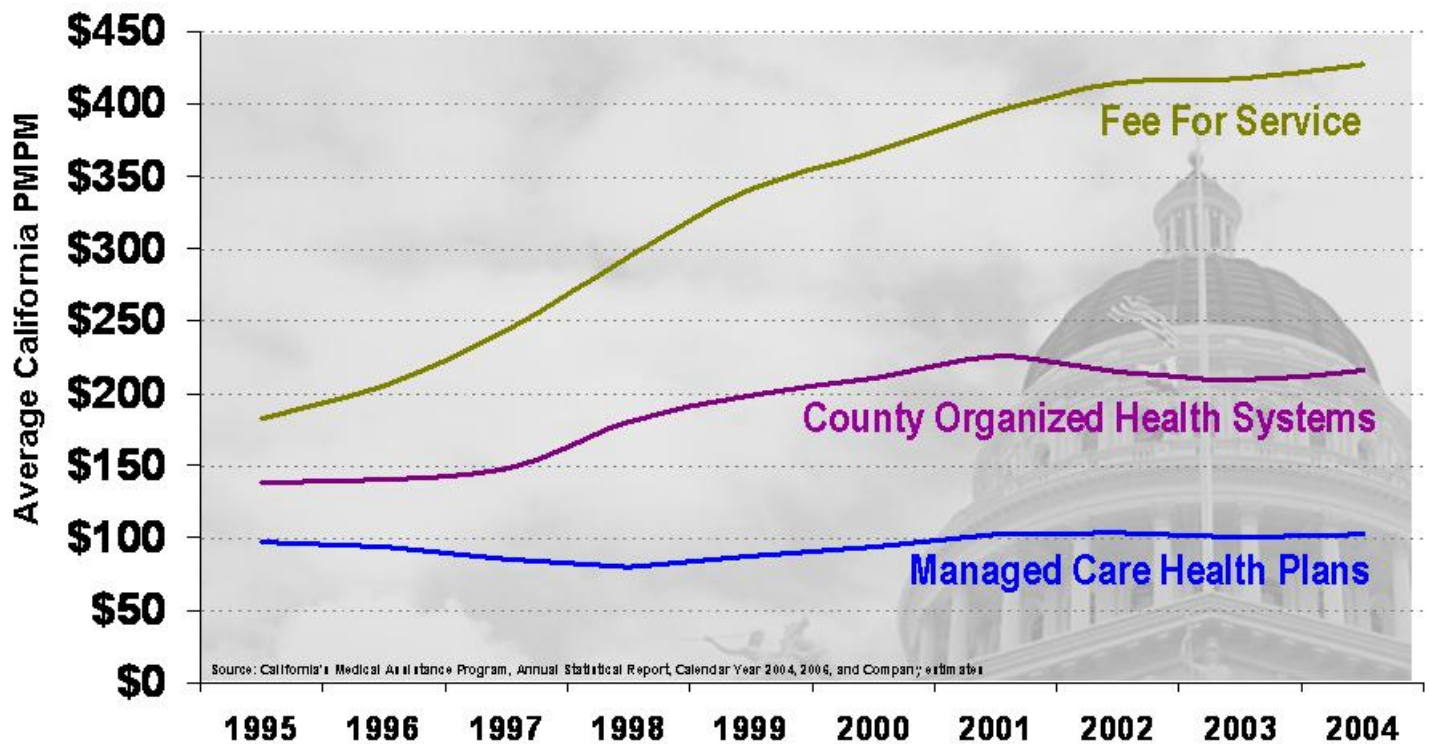
Managed care expansions

States continue to view managed care as a cost-effective response to growing fiscal pressures:

- Medicaid Reform Initiatives in Florida, Louisiana, and Virginia
- Service Area Expansions in Texas
- Transition of ABD population to managed care
- Replacement of FFS and partial risk programs with managed care
- Evidence continues to grow that managed care is a cost-effective solution
- Studies in California and Ohio show managed care saves States money

Will California expand managed care?

California: Managed Care provides a slower growth rate in Medi-Cal expenditures and greater budget certainty.





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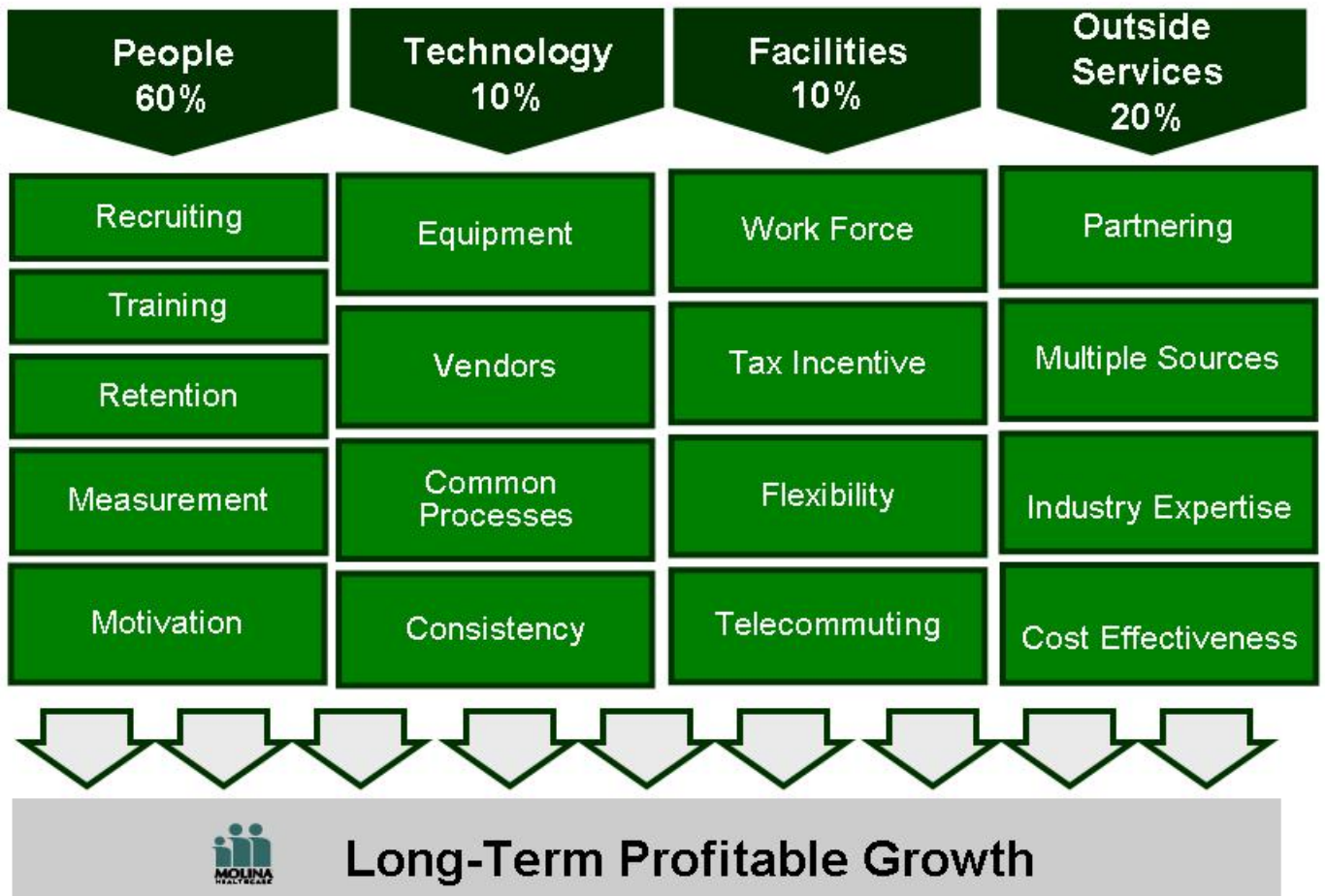
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Leveraging Administrative Investment

Joseph White

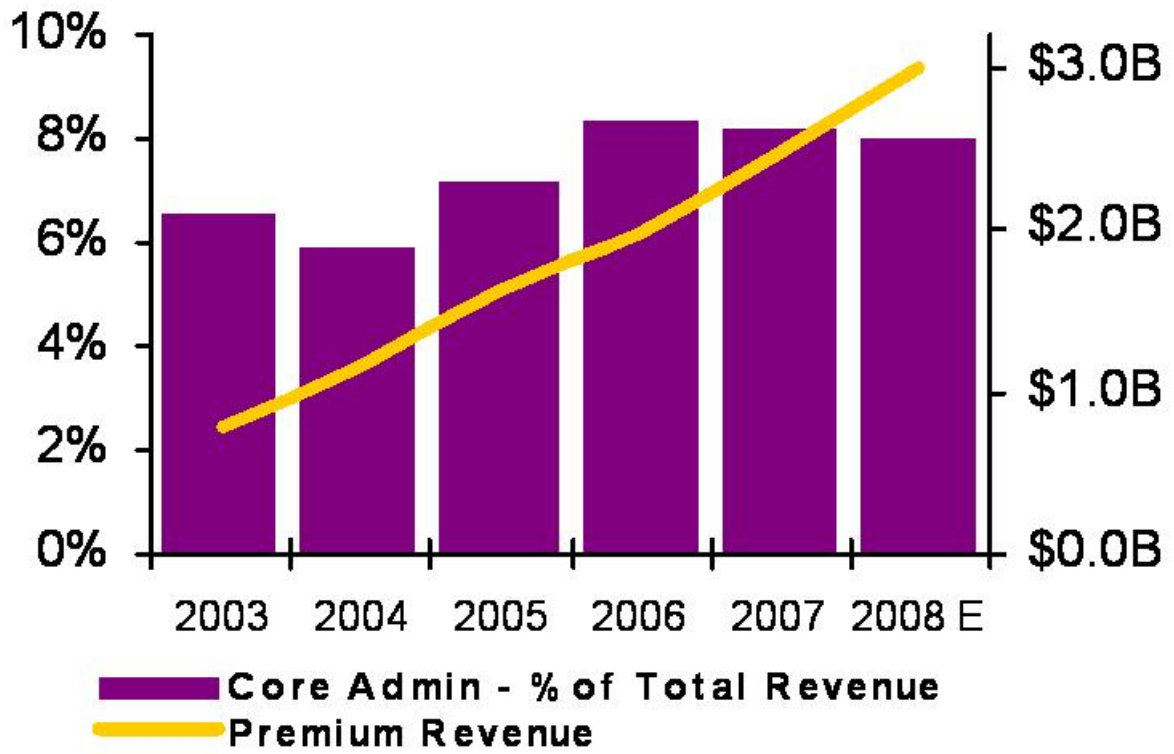
Chief Accounting Officer
Molina Healthcare, Inc.

Administrative expense components



Leveraging administrative expenses

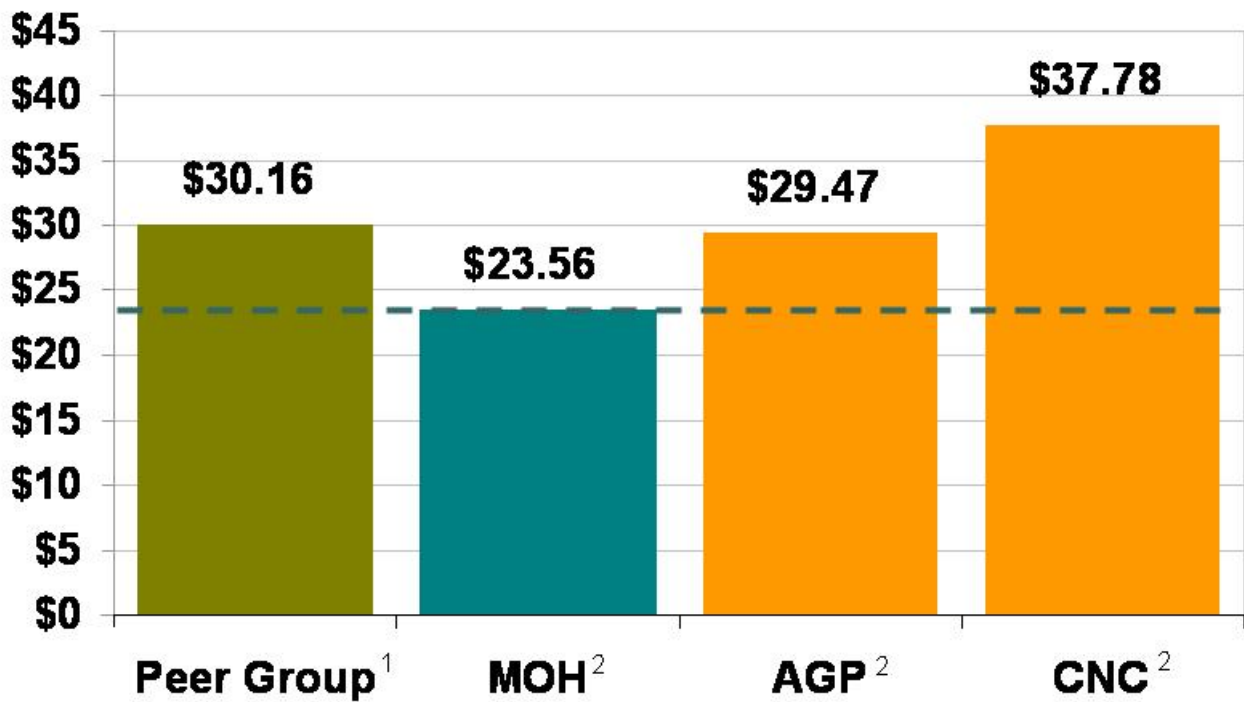
Core Administrative Expense as a percent of revenue is declining



Note: Core Admin percentage excludes premium taxes. 2008E indicates estimate of 2008 financial results.

Administrative leverage as competitive advantage

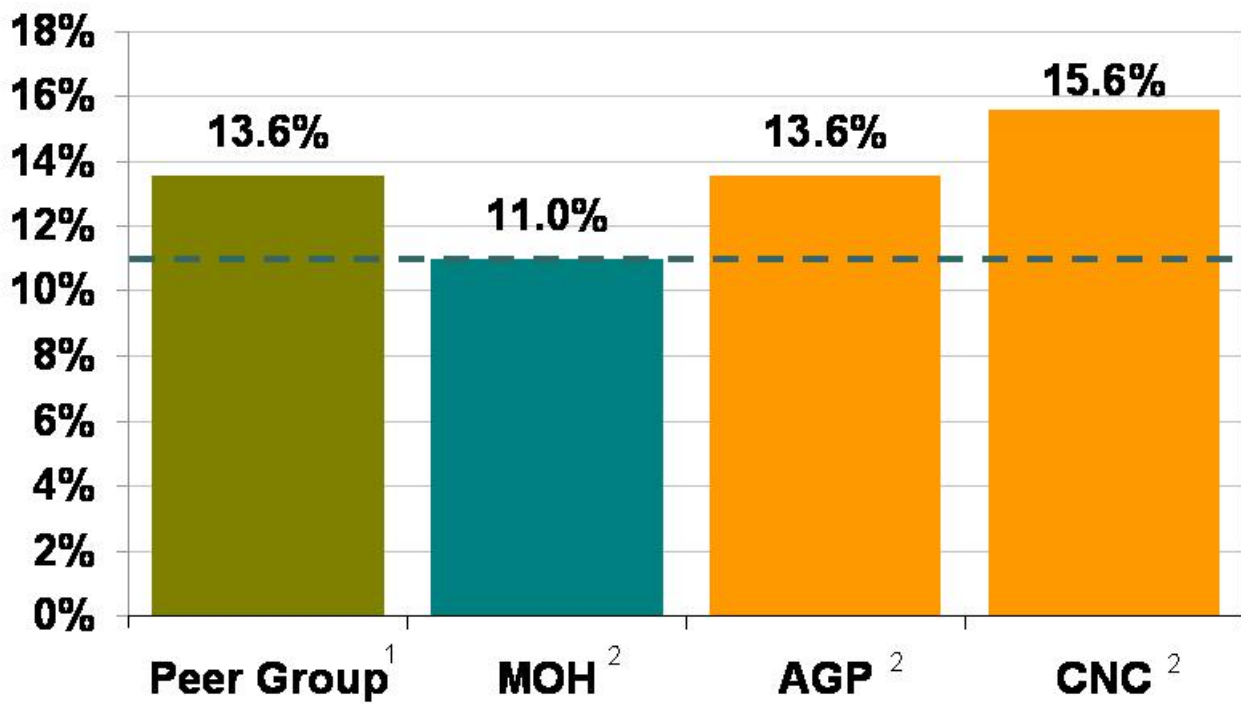
Molina excels in controlling administrative costs



1. Average of nine-month administrative cost PMPM for MOH, AGP, and CNC based on publicly reported information for quarter ended September 30, 2008. Calculation based on total administrative costs divided by average membership for the period.
2. Publicly reported administrative cost PMPM for nine months ended September 30, 2008.

Administrative leverage as competitive advantage

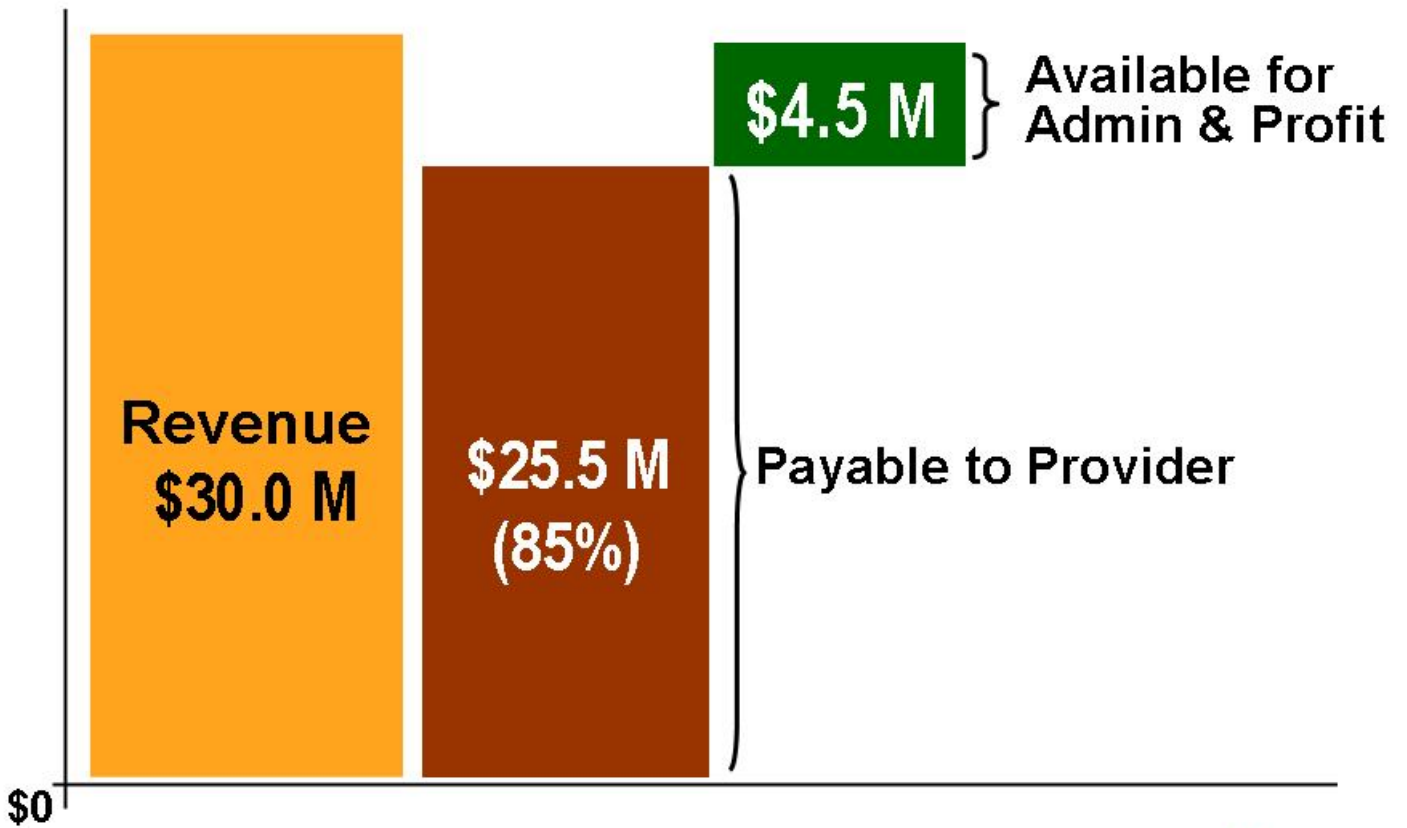
Molina excels at controlling administrative costs



1. Average of nine-month administrative cost ratios for MOH, AGP, and CNC based on publicly reported information for quarter ended September 30, 2008. The ratio represents administrative costs as a percentage of total revenue including interest income.
2. Publicly reported administrative cost ratio for nine months ended September 30, 2008.

Leveraging administrative costs in 2009

A 1% increase in premium revenue potentially yields 10¢ EPS



Note: The amounts shown above do not reflect actual results they are shown for illustrative purposes

Days in claims payable

Claims inventories continue to fall

- Fee for service costs 65% of all medical care costs
- Pharmacy capitation consistent year over year
- Cost recovery
 - Enhanced
 - Now built into lag tables
- Greater clarity from faster payments
 - Faster payment
 - Familiarity with data

Questions?





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January 22, 2009
New York, NY

2009 Guidance

John C. Molina
Chief Financial Officer
Molina Healthcare, Inc.



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

The following 2009 Guidance presentation contains numerous "forward-looking statements" regarding the Company's projected 2009 financial results. Any statement that refers to guidance, projections, expectations, strategies, challenges, and opportunities, or their underlying assumptions, or other characterizations of future events or circumstances, is a forward-looking statement. All of the Company's forward-looking statements are subject to numerous known and unknown risks, uncertainties, and other factors that could cause our actual results to differ materially. Such factors include, without limitation, risks related to: budgetary pressures on the federal and state governments and their resulting inability to fully fund Medicaid, Medicare, or SCHIP or to maintain current membership eligibility thresholds and criteria; the successful management of our medical costs and the achievement of our projected medical care ratios in all our health plans, including the reduction of the medical care ratio of our Ohio health plan; the success of our efforts to leverage our administrative costs to address the needs associated with increased enrollment; risks related to our limited experience operating in Florida and attendant claims estimation difficulties; growth in our Medicaid and Medicare enrollment consistent with our expectations; uncertainties regarding the impact of federal health care reform efforts and the new presidential administration; rate increases and the maintenance of existing rate levels that are consistent with our expectations; our inability to pass on to our contracted providers any rate cuts under our governmental contracts; the budget and liquidity crisis in California and the state's inability to make payment under its contracts with the California health plan; the successful resolution of pending rate litigation in California; the renewal of the provider premium tax beyond October 1, 2009; our ability to accurately estimate incurred but not reported medical costs across all health plans; the successful renewal and continuation of the government contracts of all of our health plans, including the re-selection of our Michigan and Missouri health plans in response to Medicaid RFPs in 2009; in light of the current turmoil and illiquidity in credit markets, the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs; the illiquidity of our auction rate securities; the successful and cost-effective integration of our acquisitions; earnings seasonality; interest rates on invested balances that are lower than expected; high profile qui tam matters and negative publicity regarding Medicaid managed care and Medicare Advantage; changes in funding under our contracts as a result of regulatory and programmatic adjustments and reforms; approval by state regulators of dividends and distributions by our subsidiaries; unexpected changes in member utilization patterns, healthcare practices, or healthcare technologies; high dollar claims related to catastrophic illness; changes in federal or state laws or regulations or in their interpretation; the favorable resolution of litigation or arbitration matters; and other risks and uncertainties as detailed in our reports and filings with the Securities and Exchange Commission and available on its website at www.sec.gov. All forward-looking statements in this release represent our judgment as of January 22, 2009. We disclaim any obligation to update any forward-looking statement to conform the statement to actual results or changes in our expectations.

2009 Earnings Guidance (January 22, 2009)

Premium Revenue	≈ \$3.6B
Investment Income	≈ \$15M
Medical Care Ratio.....	≈ 85.5%
G&A Ratio.....	≈ 10.5%
Core G&A Ratio.....	≈ 7.5%
EBITDA.....	≈ \$158M - \$167M
D&A	≈ \$43M
Interest Expense.....	≈ \$14M
Net Income	≈ \$59M - \$65M
Diluted EPS.....	≈ \$2.20 - \$2.40
Diluted Shares Outstanding	≈ 27M
Effective Tax Rate	≈ 41%



Projected key developments for 2009 guidance

Membership:

- Membership growth of approximately 10% excluding Medicare and Florida.

Revenue PMPM:

- 3% rate increase

Medical Costs:

- 4% increase in medical costs PMPM

Administrative Costs:

- 4.5% decrease in admin cost PMPM

Investment Income:

- \$15M investment income

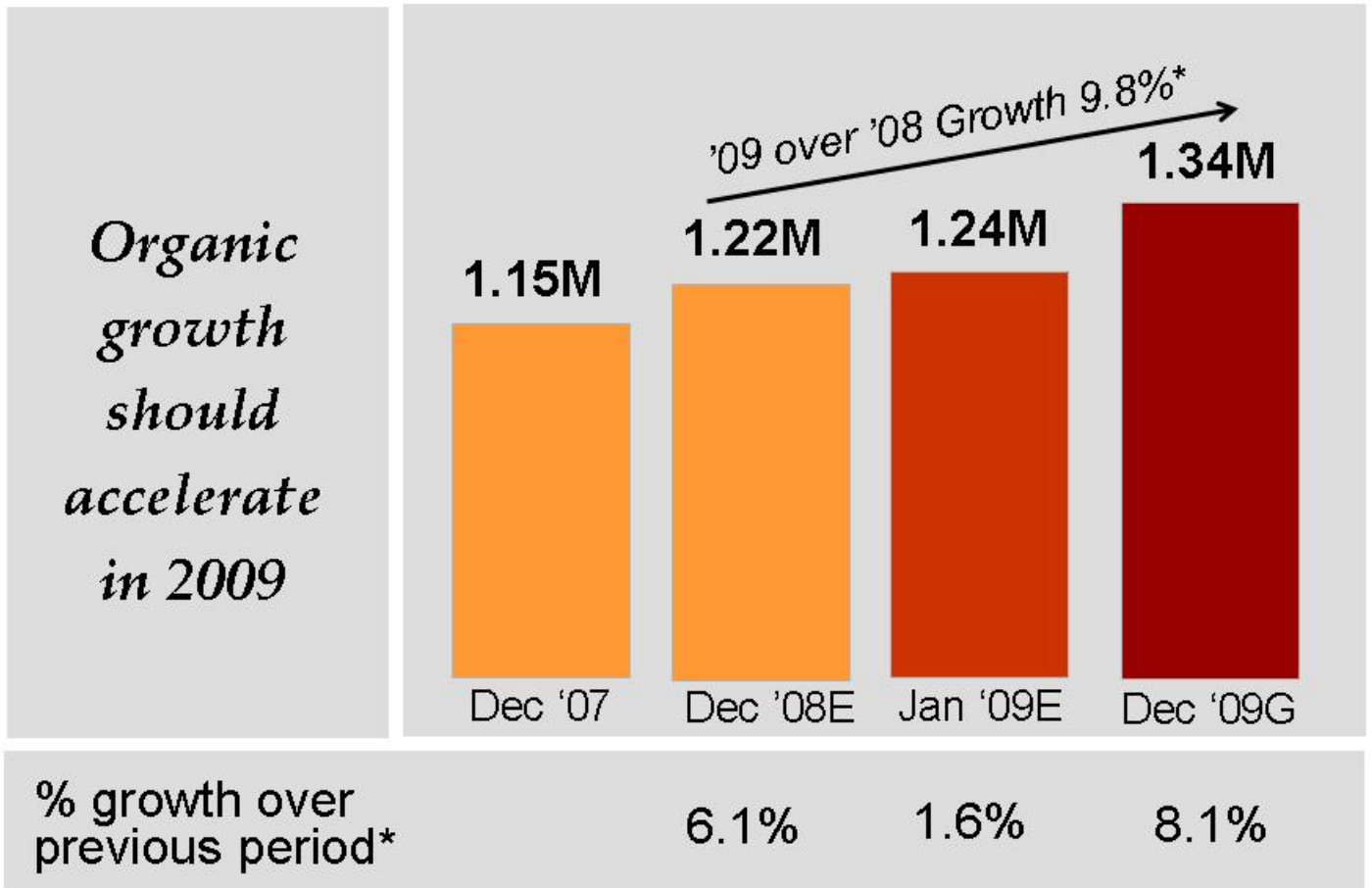
Interest Expense:

- \$5.3M impact from FASB Staff Position APB 14-1 (interest on convertible debt)

Known rate changes impacting 2009 results

	Rate Change	Effective Date
California	3.0%	7/1/2008 and 10/1/2008
Michigan	5.5%	10/1/2008
Missouri	8.5%	7/1/2008
New Mexico	-1.0% / -2.5%	7/1/2008 and 12/1/2008
Ohio	5.0%	1/1/2009
Washington	-1.0% / -3.7%	1/1/2009 and 2/1/2009

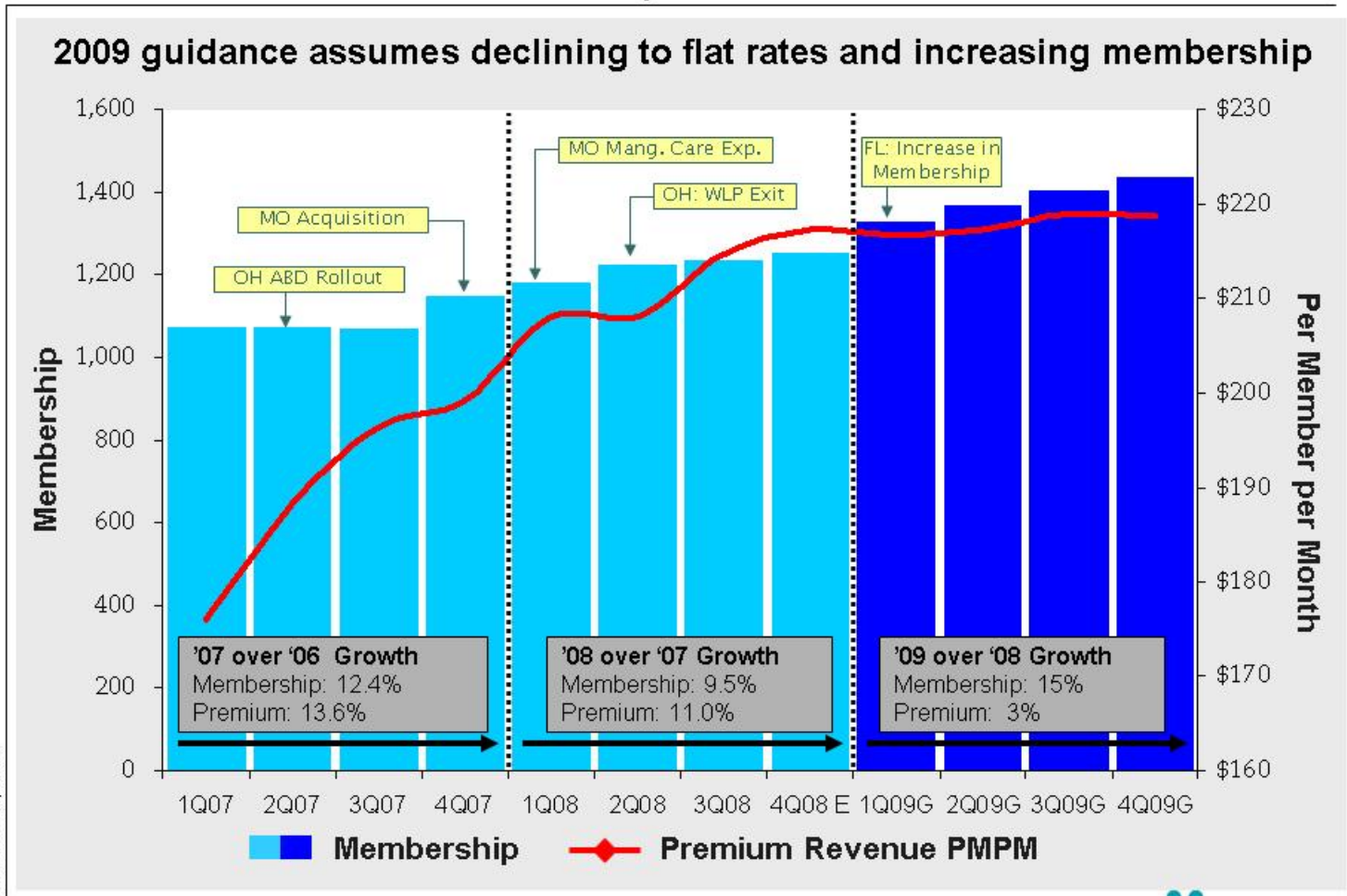
Organic Membership



Note: The percentages and enrollment shown exclude both Florida membership and the membership in Ohio transitioned from other health plans. "E" denotes estimated 2008 results and "G" denote 2009 projected guidance.



Consolidated membership and revenue PMPM



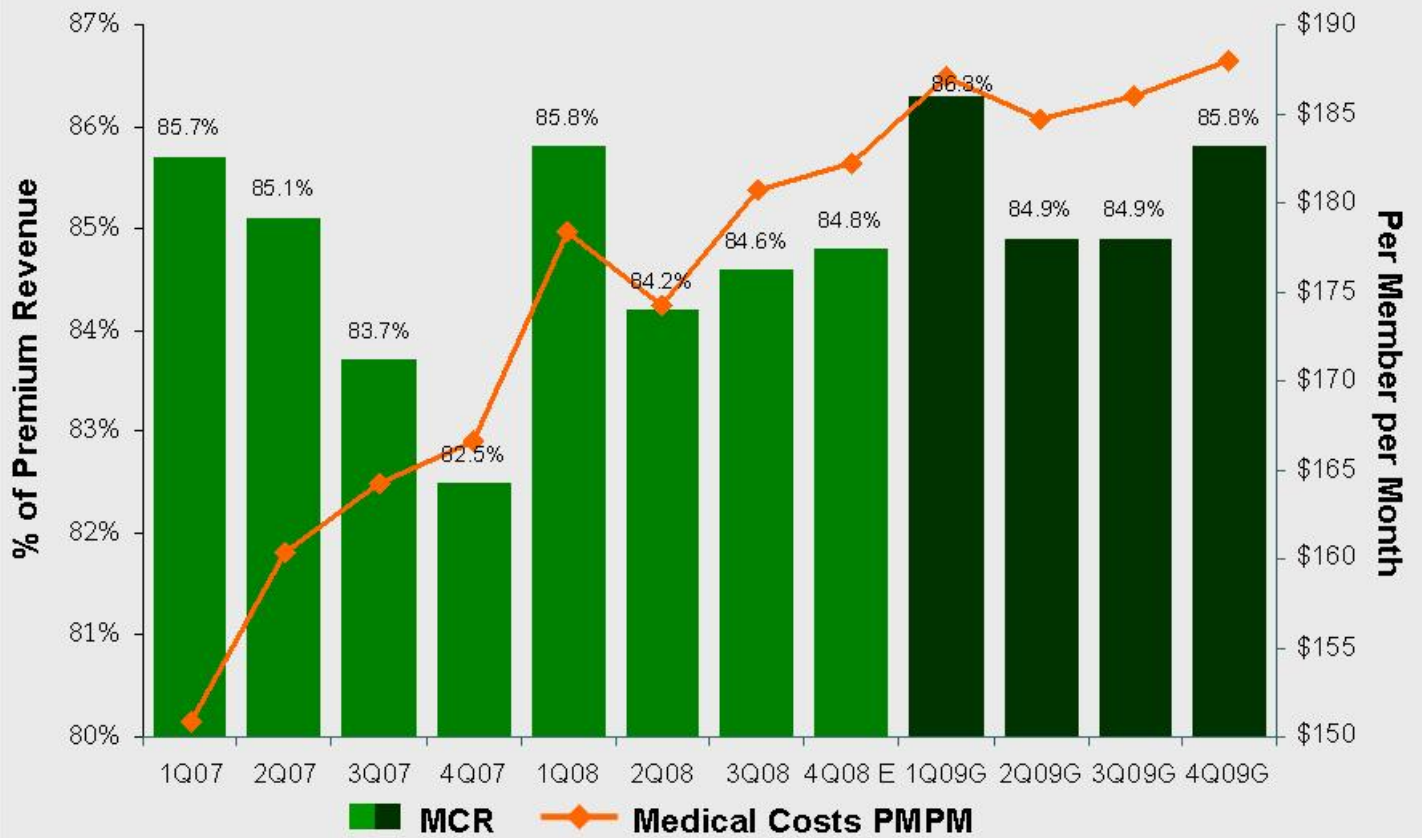
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Note: 'E' denotes estimated and 'G' denotes 2009 Guidance.



Consolidated MCR and Medical Cost PMPM

In 2009 the MCR will increase, but medical costs PMPM will level off.



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Note: 'E' denotes estimated and 'G' denotes 2009 Guidance.



Guidance Summary vs. Preliminary 2008 Results

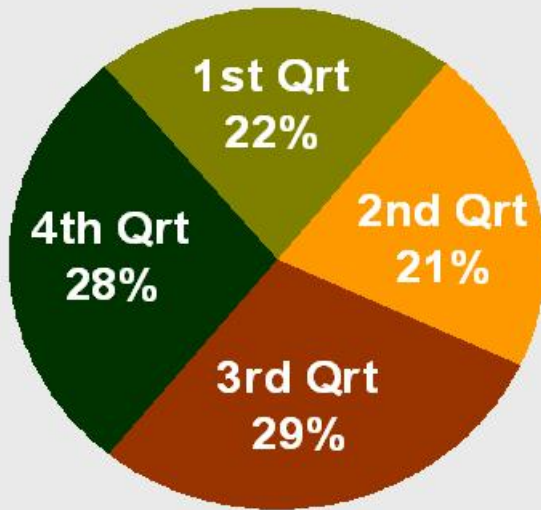
	2009 Guidance	2008E Results	Increase/(Decrease)
Premium Revenue	\$3.6B	\$3.0B	\$0.6B
Medical Care Ratio	85.5%	85.0%	0.5%
Core G&A Ratio	7.5%	8.0%	(0.5%)
EBITDA	\$158M-\$167M	\$145M-\$148M	\$16M *
EBITA Margin	4.4%-4.7%	4.7%-4.8%	(0.2%) *
Net Income	\$59M-\$65M	\$61.7M-\$63.4M	(\$0.6M) *
Diluted EPS	\$2.20-\$2.40	\$2.22-\$2.28	\$0.05 *
Diluted Shares Outstanding	27.0M	27.8M	(0.8M)
Effective Tax Rate	41.0%	40.0%	1.0%
Members	1.44M	1.26M	0.18M

* Represents mid point of range



Historical net income distribution

Average Quarterly Contribution 2001-2008E



Semi-annual contribution not anticipated to change materially in 2009.

Opportunities and Challenges

Opportunities	Discussion
Impact of Economic Conditions on Enrollment	<ul style="list-style-type: none"> ▪ 1% increase in the unemployment rate increases Medicaid and SCHIP membership by approximately 1.0M.¹
Fiscal Stimulus	<ul style="list-style-type: none"> ▪ Impact of fiscal stimulus and SCHIP reauthorization.
Florida	<ul style="list-style-type: none"> ▪ The State of Florida is ranked 5th in the nation in Medicaid spending, constituting 4% of all Medicaid spending.²
M&A Opportunities	<ul style="list-style-type: none"> ▪ Guidance does not include potential acquisitions.
Capital Structure	<ul style="list-style-type: none"> ▪ Guidance does not include any repurchases of our stock or convertible notes.
Admin Leverage	<ul style="list-style-type: none"> ▪ Increasing enrollment will allow leveraging of administrative costs.

1. Source: Kaiser Commission on Medicaid and the Uninsured, April 2008

2. Source: Kaiser Commission on Medicaid and the Uninsured, 2006

Opportunities and Challenges

Challenges	Discussion
State Budgets	<ul style="list-style-type: none"> ▪ Most States face substantial fiscal challenges.
California, New Mexico, and Washington	<ul style="list-style-type: none"> ▪ Rates ▪ Provider Cuts
Ohio MCR	<ul style="list-style-type: none"> ▪ The Guidance assumes an Ohio MCR of 87%. ▪ Rate increase, risk adjustment, re-contracting with providers and in-sourcing of Behavioral Health.
Provider Premium Tax	<ul style="list-style-type: none"> ▪ Guidance assumes no Provider Premium Tax sunset on 10/1/09
Florida	<ul style="list-style-type: none"> ▪ Risks associated with new operations.
Medicare	<ul style="list-style-type: none"> ▪ Guidance assumes 12,000 Medicare members by 2009 year-end.
Investment Income	<ul style="list-style-type: none"> ▪ Interest rates to remain low.

Questions?

