
**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): February 13, 2014

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))
-
-

Item 7.01. Regulation FD Disclosure.

On February 13, 2014, the Company issued a press release providing its 2014 guidance. The full text of the press release is attached as Exhibit 99.1 to this report. The information contained in the websites cited in the press release is not part of this report.

In addition, on February 13, 2014, 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 99.2 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	Press release of Molina Healthcare, Inc. issued February 13, 2014.
99.2	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. on February 13, 2014.

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: February 13, 2014

By: /s/ Jeff D. Barlow

Jeff D. Barlow

Sr. Vice President – General Counsel, and Secretary

EXHIBIT INDEX

Exhibit No.	Description
99.1	Press release of Molina Healthcare, Inc. issued February 13, 2014.
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News Release

Contacts:

Juan José Orellana
Investor Relations
(562) 435-3666

MOLINA HEALTHCARE PROVIDES FISCAL YEAR 2014 GUIDANCE

LONG BEACH, California (February 13, 2014) – Molina Healthcare, Inc. (NYSE:MOH) today announced that it is providing its guidance for fiscal year 2014.

The following is the Company's guidance for fiscal year 2014 (*all amounts are approximate*):

Premium Revenue	\$ 9.2 billion
ACA Fee Reimbursement	\$140 million
Premium Tax Revenue	\$275 million
Service Revenue	\$210 million
Investment and Other Revenue	\$ 20 million
Total Revenue	\$ 9.9 billion
Total Medical Care Costs	\$ 8.2 billion
<i>Medical Care Ratio (1)</i>	89%
Total Service Costs	\$170 million
General & Administrative Expenses	\$770 million
<i>G&A Ratio (2)</i>	8%
Premium Taxes	\$275 million
ACA Insurer Fee	\$ 85 million
Depreciation & Amortization	\$100 million
Interest Expense	\$ 55 million
Income Before Taxes	\$210 million
EBITDA	\$385 million
<i>Effective Tax Rate</i>	55% - 59%
Adjusted EPS (3)	\$4.00 - \$4.50

* All amounts are estimates and subject to change.

(1) Medical Care Ratio represents Medical Care Costs as a percentage of Premium Revenue.

(2) G&A Ratio computed as a percentage of Premium Revenue plus Service Revenue.

(3) Assumes 47.7 million average diluted shares outstanding. **Low and high guidance ranges assume full reimbursement of the ACA Fee and related tax effects.**

The following table reconciles adjusted net income per diluted share, continuing operations to net income per diluted share, continuing operations, which the Company believes to be the most comparable GAAP measure:

	<u>Low End</u>	<u>High End</u>
Adjusted net income per diluted share, continuing operations	<u>\$ 4.00</u>	<u>\$ 4.50</u>
Less non-cash adjustments, net of tax:		
Depreciation, and amortization of capitalized software	1.29	1.29
Stock based compensation	0.48	0.48
Amortization of convertible senior notes and lease financing obligations	0.31	0.31
Amortization of intangible assets	0.27	0.27
Net income per diluted share, continuing operations	<u>\$ 1.65</u>	<u>\$ 2.15</u>

* All amounts are estimates and subject to change. Assumes 47.7 million average weighted diluted shares outstanding. Adjusted net income per diluted share, continuing operations, is a non-GAAP measure. GAAP stands for Generally Accepted Accounting Principles.

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The Company will host an Investor Day meeting at the Le Parker Meridien Hotel in New York City on Thursday, February 13, 2014, from 12:30 p.m. to 4:30 p.m. Eastern Time. The Company will webcast the presentations offered by its management team, which will be followed by question-and-answer sessions. A 30-day online replay of the Investor Day meeting will be available approximately one hour following the conclusion of the live webcast. A link to this webcast can be found on the Company's website at www.molinahealthcare.com.

About Molina Healthcare

Molina Healthcare, Inc., a FORTUNE 500 company, provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. The Company's licensed health plans in California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, and Wisconsin currently serve approximately 2.1 million members, and its subsidiary, Molina Medicaid Solutions, provides business processing and information technology administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida. More information about Molina Healthcare is available at www.molinahealthcare.com.

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: *This press release contains "forward-looking statements" regarding the Company's plans, expectations, and anticipated future events. Actual results could differ materially due to numerous known and unknown risks and uncertainties. Those risks and uncertainties include, but are not limited to, the following:*

- *uncertainties associated with the implementation of the Affordable Care Act, including the full grossed up reimbursement by states of the non-deductible health insurance industry federal excise tax, the expansion of Medicaid eligibility in the states that participate to previously uninsured populations unfamiliar with managed care, the implementation of state insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures, including the dual eligibles demonstration programs in California, Illinois, Michigan, Ohio, and South Carolina;*
- *newly FDA-approved drugs such as sovaldi, olysio, and other drugs for hepatitis C or other medical conditions that are exorbitantly priced but not factored into the calculation of our capitated rates for 2014;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and our ability to reduce over time the high medical costs commonly associated with new patient populations;*
- *the accurate estimation of incurred but not paid medical costs across our health plans;*
- *retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates or retroactive premium rate increases;*
- *efforts by states to recoup previously paid amounts, including claims by the Washington Health Care Authority (HCA) that it overpaid our Washington health plan for certain claims related to psychotropic drugs and the Washington Community Options Program Entry System (COPES);*
- *the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to increase our revenues consistent with our expectations;*
- *the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;*
- *government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;*
- *changes with respect to our provider contracts and the loss of providers;*
- *the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;*

-MORE-

- *the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable or unfavorable resolution of litigation, arbitration, or administrative proceedings;*
- *the relatively small number of states in which we operate health plans;*
- *our management of a portion of College Health Enterprises' hospital in Long Beach, California;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *a state's failure to renew its federal Medicaid waiver;*
- *an inadvertent unauthorized disclosure of protected health information;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments;*
- *changes in general economic conditions, including unemployment rates;*
- *increasing consolidation in the Medicaid industry;*

and numerous other risk factors, including those discussed in the Company's periodic reports and filings with the Securities and Exchange Commission. These reports can be accessed under the investor relations tab of the Company's website or on the SEC's website at www.sec.gov. Given these risks and uncertainties, we can provide no assurances that the Company's forward-looking statements will prove to be accurate, or that any other results or events projected or contemplated by the Company's forward-looking statements will in fact occur, and we caution investors not to place undue reliance on these statements. All forward-looking statements in this release represent the Company's judgment as of February 13, 2014, and we disclaim any obligation to update any forward-looking statements to conform the statement to actual results or changes in the Company's expectations.

-END-



Investor Day 2014A

February 13, 2014
New York, New York

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Cautionary Statement

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Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This slide presentation and our accompanying oral remarks contain numerous “forward-looking statements” regarding, without limitation: our 2014 financial guidance; our revenue, revenue mix, and membership projections; our business strategy; duals demonstration projects and their expected implementation start dates; the ACA annual fee or excise tax and its reimbursement by states on a grossed-up basis; the 2014 rate environment; the hepatitis C drug Sovaldi; and various 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 annual report on Form 10-K, as well as the risk factors and cautionary statements in our quarterly reports and 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.

Approx. Time	Topic	Speaker
12:30pm-12:35pm	Opening Remarks	Juan José Orellana, SVP Investor Relations
12:35pm-1:10pm	Business Overview	Dr. J. Mario Molina, Chief Executive Officer
1:10pm-1:45pm	Medical Margin: Results & Initiatives	Terry Bayer, Chief Operating Officer
1:45pm-2:00pm	Q&A	
2:00pm-2:15pm	Break	
2:15pm-2:45pm	Changing Medical Cost Profile	Joseph White, Chief Accounting Officer
2:45pm-3:05pm	Q&A	
3:05pm-3:50pm	Guidance	John Molina, Chief Financial Officer
3:50pm-4:30pm	Q&A	
4:30pm	End of Program	



Business Overview

J. Mario Molina, M.D.
President & Chief Executive Officer

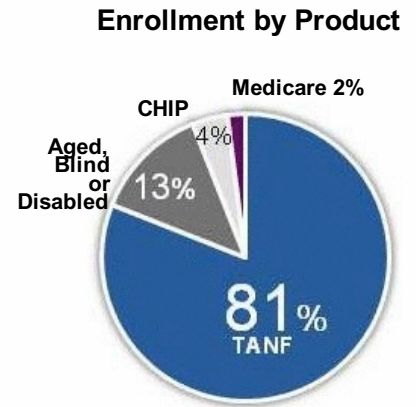
February 13, 2014
New York, New York

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Presence in Key Medicaid Markets

Footprint includes 4 of 5 largest Medicaid Markets

Health Plan Enrollment as of February 2014¹

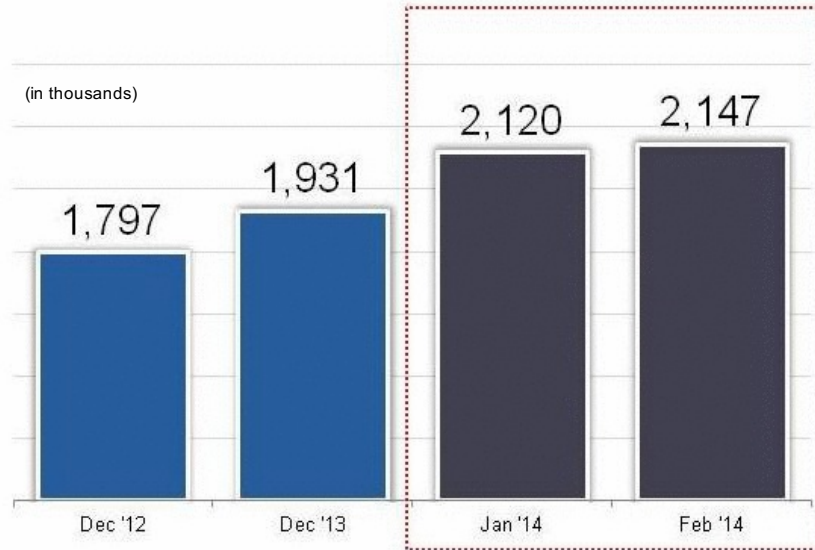


2.1 million members

1. Reflects preliminary enrollment figures.
2. As of September 1, 2013, Illinois health plan began serving ABD members.
3. As of January 1, 2014, South Carolina health plan began serving South Carolina Medicaid members, as a result of the South Carolina Solutions asset acquisition.

Please refer to the Company's cautionary statements.

Molina Healthcare Health Plan Enrollment Growth Dec 2013 - Feb 2014^{(1) (2)}



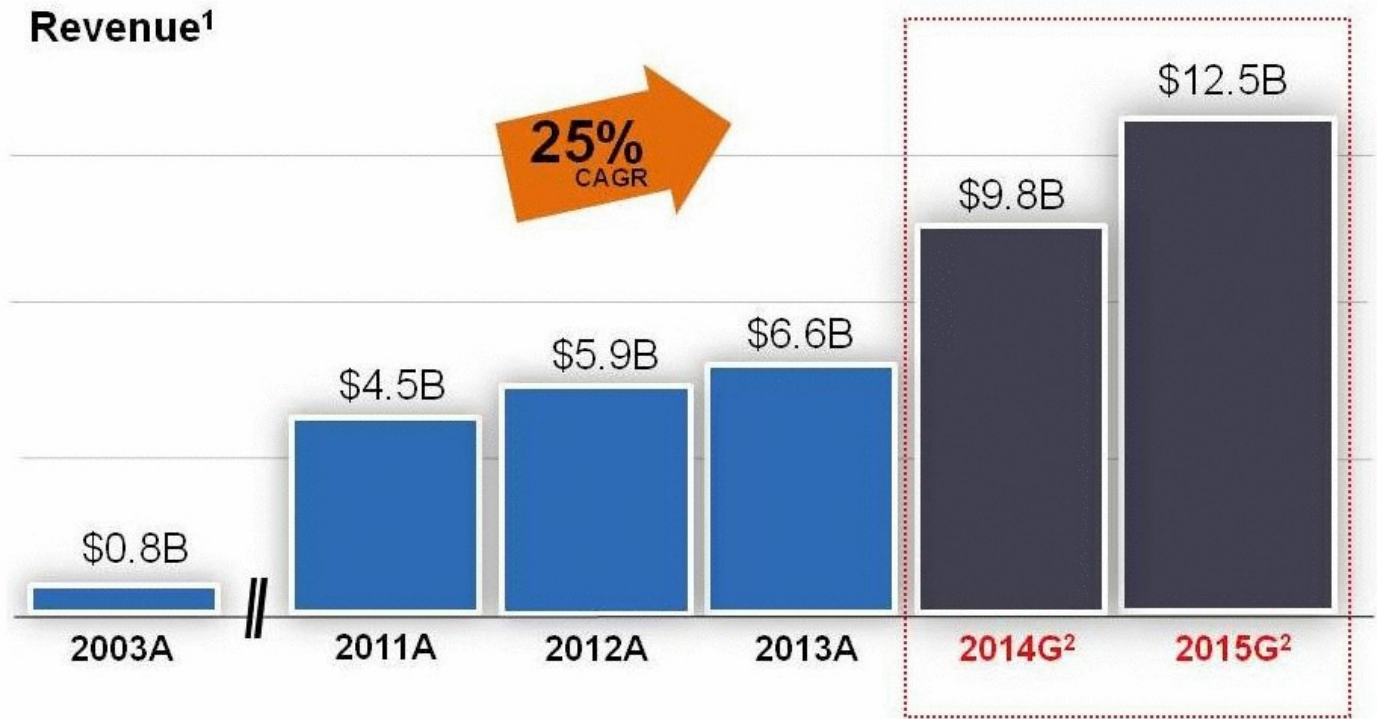
Enrollment grew 11% since December 2013

1. February 2014 enrollment based on preliminary figures.
2. As of January 1, 2014, South Carolina health plan began serving South Carolina Medicaid members, as a result of the South Carolina Solutions asset acquisition.

Long Term Revenue Growth

Estimated potential revenue run-rate by year-end 2015

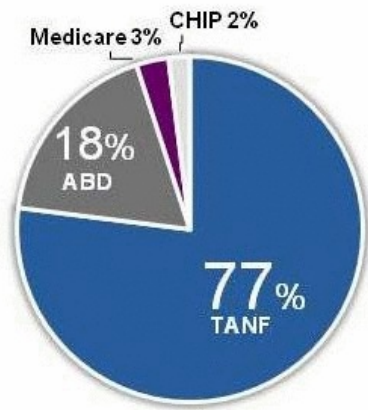
Please refer to the Company's cautionary statements.



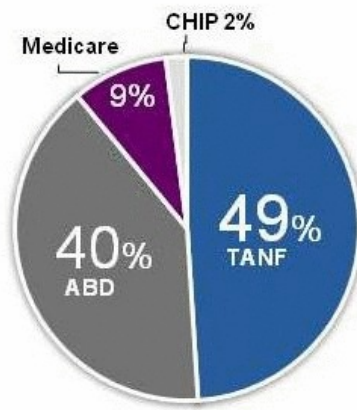
1. Estimated amounts are subject to change.

2. Includes revenue estimates from: New Mexico (Lovelace), and South Carolina (Community Health Solutions assets) acquisitions; dual eligibles in CA, MI, OH, SC, TX, IL; Medicaid expansion in CA, MI, OH, NM, and WA; and Marketplace in CA, FL, MI, NM, TX, UT, WA, OH, and WI. Duals in TX only applies to 2015.

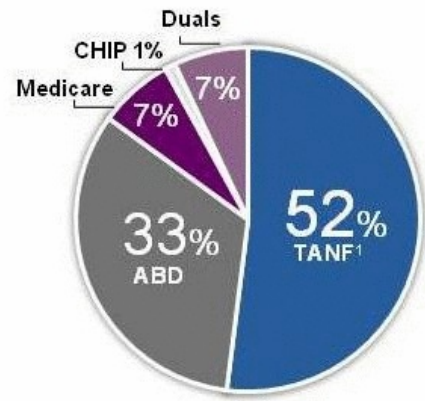




2008A



2013A



2014G

Revenue shift to chronic care is changing our medical cost profile

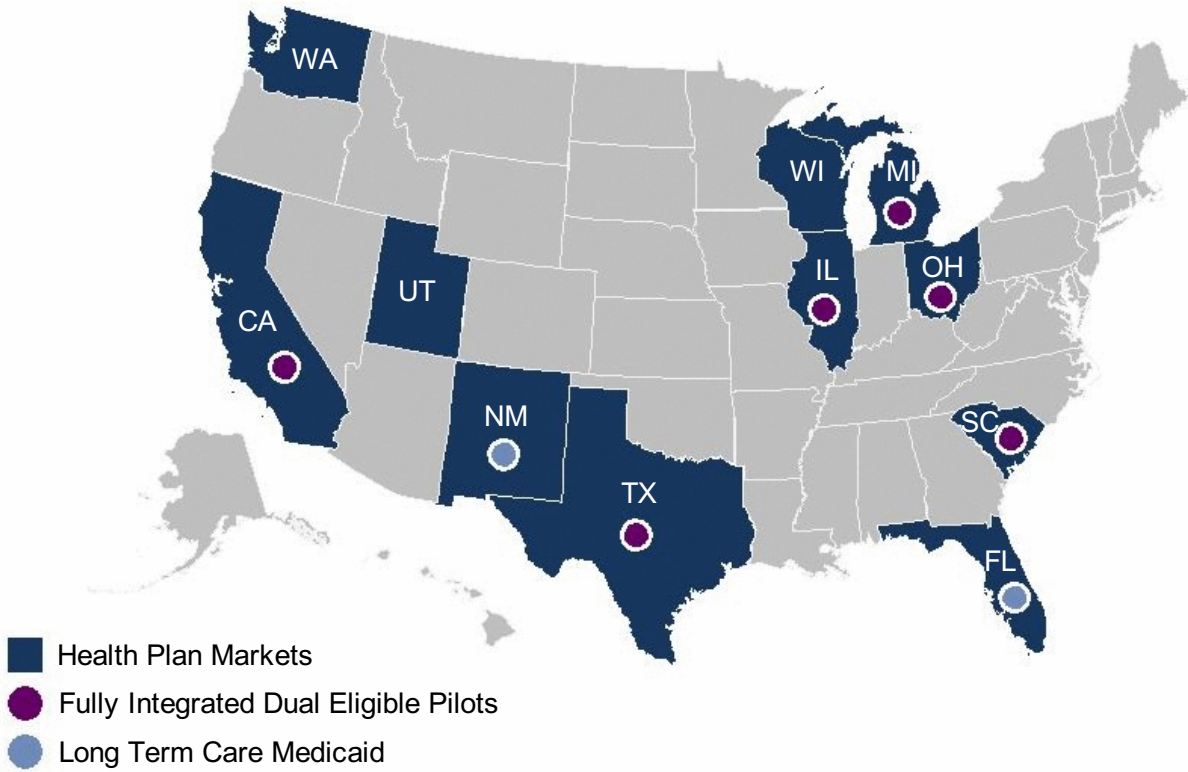
1. For 2014, TANF includes Medicaid expansion and Marketplace lives.



Business requirements are changing as we take on more complex patients

- Member retention
- Emphasis on quality and ratings
- Reduction of unnecessary utilization
- Risk adjustment

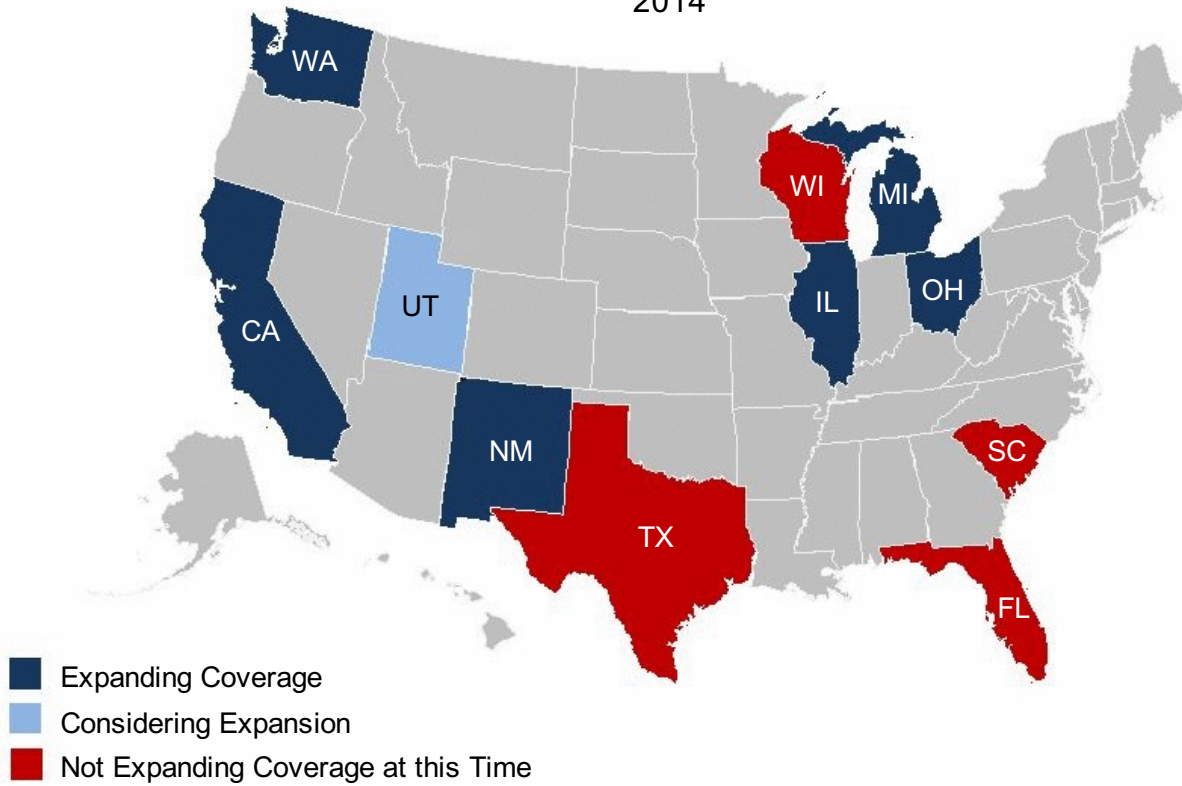
Please refer to the Company's cautionary statements.



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Where **Molina States Stand on Medicaid Expansion** as of February 7, 2014¹



1. The Advisory Board Company. Beyond the pledges: Where the states stand on Medicaid.



Surge in Medicaid applications reported

- Plagued by processing delays & backlogs
- Difference between 'deemed' eligible & actually enrolled
- Transition time from federal exchange to the state programs unknown
- Trust remains an issue



Selected to participate as direct contractor

- Largest duals demo in the country (State caps demo at 200K)
- Leverages existing ABD and Medicare SNP provider network
- Complements other duals service areas in the State: Riverside, San Bernardino, San Diego
- Passive enrollment to begin no sooner than 7/2014
- 20K dual eligible members anticipated¹

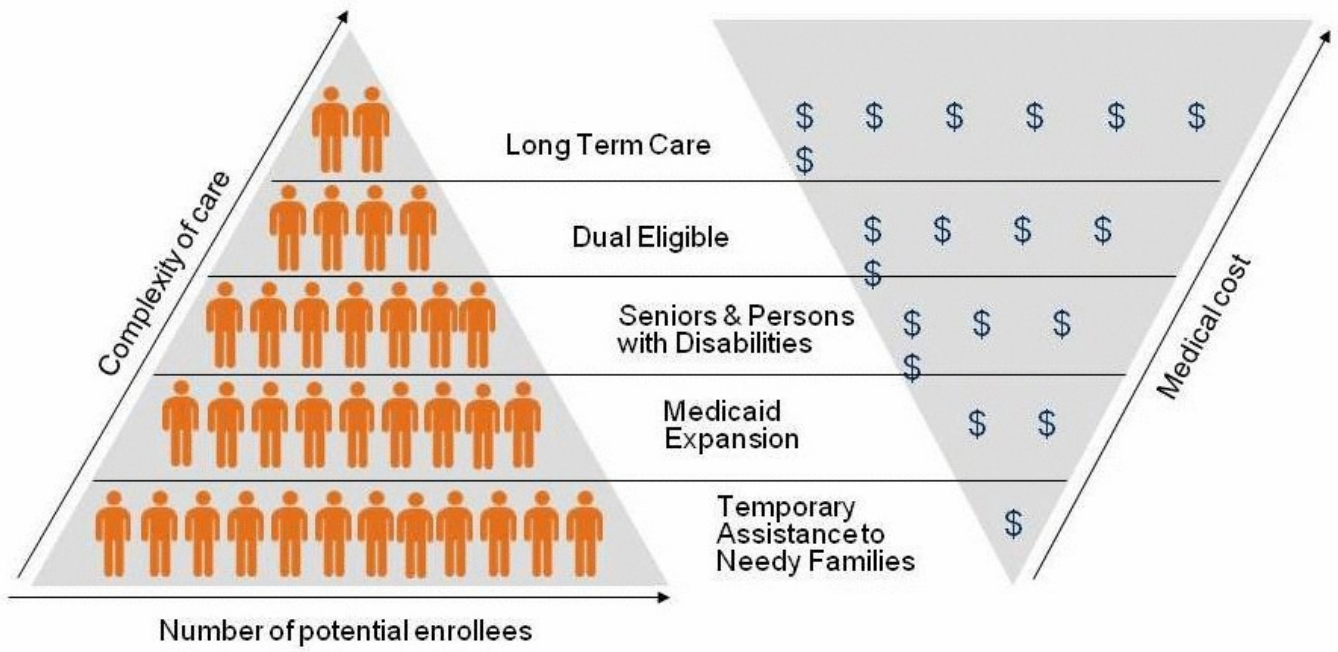
1. Enrollment estimate does not include op-out.

State	Estimated Lives in Molina Markets ¹	Voluntary Enrollment ²	Passive Enrollment ²
California (Riverside, San Bernardino & San Diego counties)	122K	4/1/14	5/1/14
California (Los Angeles county)	200K	TBD	7/1/14
Illinois	18K	3/1/14	6/1/14
Michigan	62K	10/1/14	1/1/15
Ohio	48K	6/1/14	1/1/15 ³
South Carolina	54K	7/1/14	1/1/15
TX	121K	1/1/15	1/1/15

1. Estimated lives are based on state reports.

2. All dates are subject to change.

3. Reflects Medicare MMP passive enrollment. Medicaid MMP Passive enrollment occurs 6/1/2014.



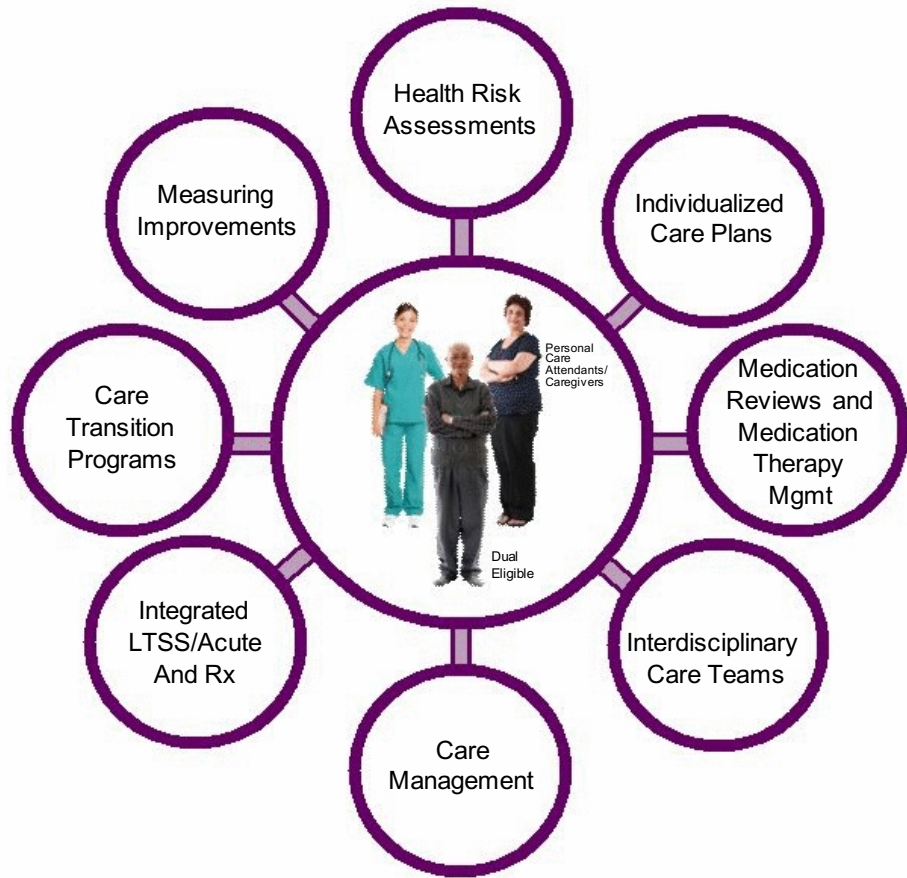
Dual Eligibles Most Common Diagnoses

Inpatient Services:

- Affective psychosis
- Septicemia
- Care involving use of rehab procedures
- Pneumonia
- Chronic bronchitis

Outpatient Services:

- Essential hypertension
- Respiratory and other chest
- Diabetes mellitus
- Fever and fatigue
- Joint disorders





Duals may have chronic conditions and higher costs over time

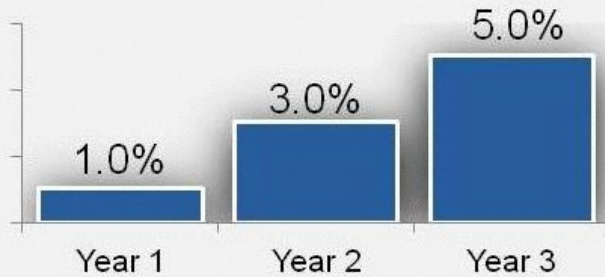
- Risk adjusters
- Rate corridors
- Settlement agreement (CA)
- Savings assumptions

Mitigating our Duals Risk – Savings Assumptions

Savings percentages will be applied equally to the Medicaid and Medicare A/B components. Rate updates will take place on January 1st of each calendar year.

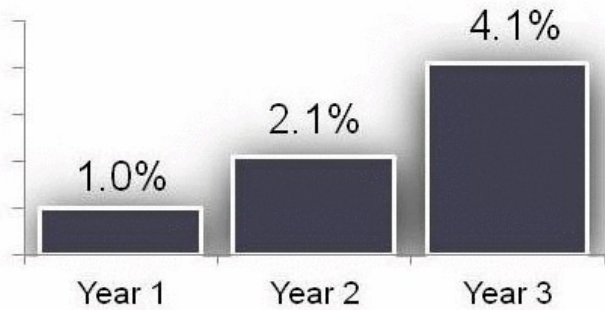
CMS Rate Setting Process Guidance¹

Sample Aggregate Savings Targets Under the Demonstrations



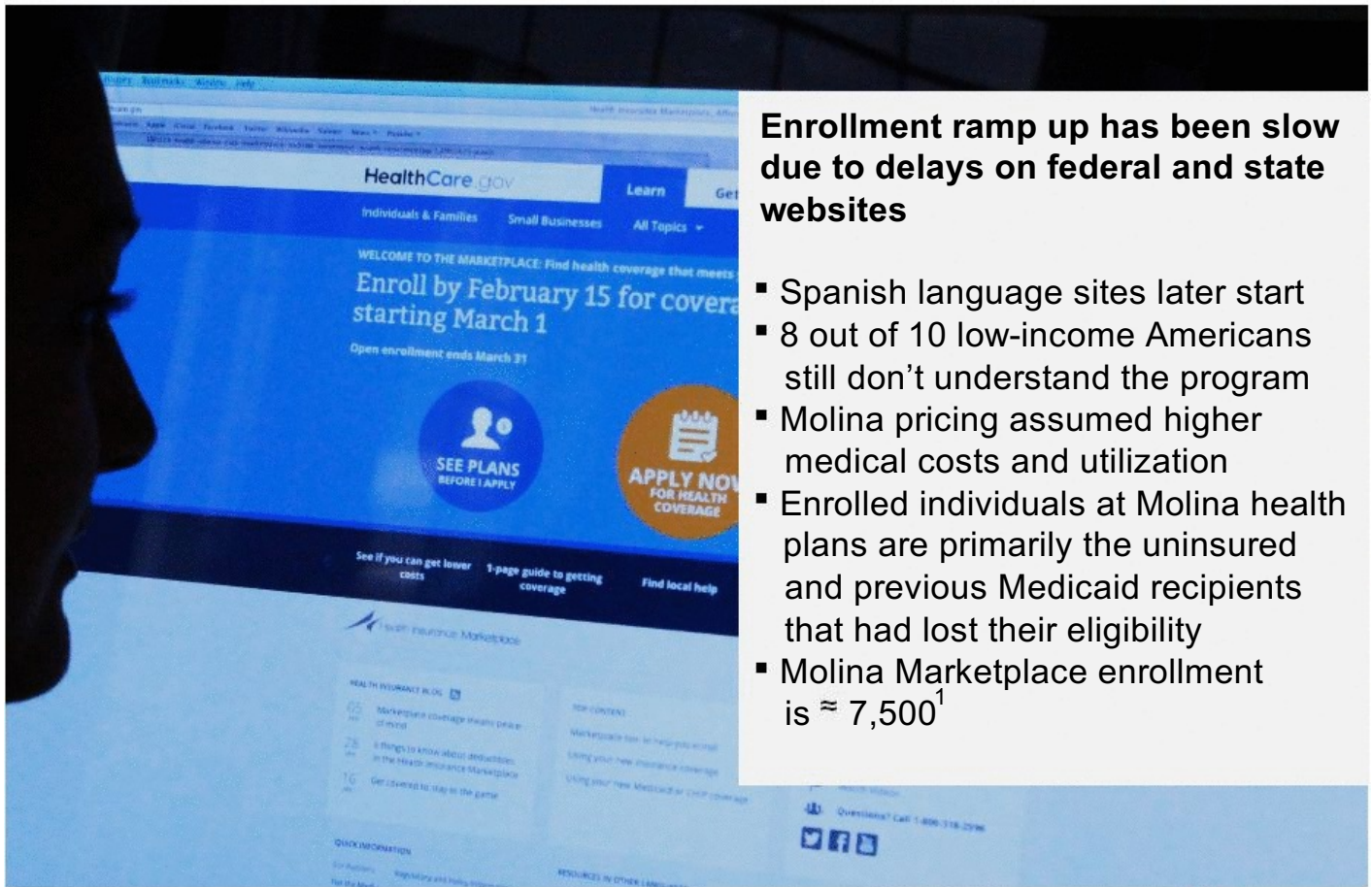
Savings targets may differ among States with low historic Medicare spending, low utilization of institutional long-term care services, or a high penetration of Medicaid managed care.

Molina Duals States² Weighted Average Aggregate Savings Targets³



1. CMS Joint Rate Setting Process Under the Capitated Financial Alignment Initiative.
2. Memorandums of Understanding (MOU) between CMS and the State of California, Illinois, Ohio, and South Carolina.
3. Savings targets weighted by estimated 2014 member months.





Enrollment ramp up has been slow due to delays on federal and state websites

- Spanish language sites later start
- 8 out of 10 low-income Americans still don't understand the program
- Molina pricing assumed higher medical costs and utilization
- Enrolled individuals at Molina health plans are primarily the uninsured and previous Medicaid recipients that had lost their eligibility
- Molina Marketplace enrollment is $\approx 7,500^1$

1. Reflects February 2014 preliminary figures.



Coverage of the cost of new Hepatitis C treatment drug should be carved out until sufficient actuarial claims data is available

- Medicaid managed care rates must factor in claims for the new treatment (actuarial soundness)
- Pricing is extraordinarily cost prohibitive
- Incidence of Hepatitis C in the Medicaid population is uncertain but certainly non-negligible
- Providers have delayed initiating alternative treatment resulting in pent up demand

Mission



Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs.

Priorities

- Manage our growth
 - Organic growth
 - Medicaid expansion
 - Dual eligible population
 - RFPs

- Leverage our business portfolio
 - Health plan business
 - MMS
 - Direct delivery

- Strive for operational excellence
 - Quality care
 - STAR ratings





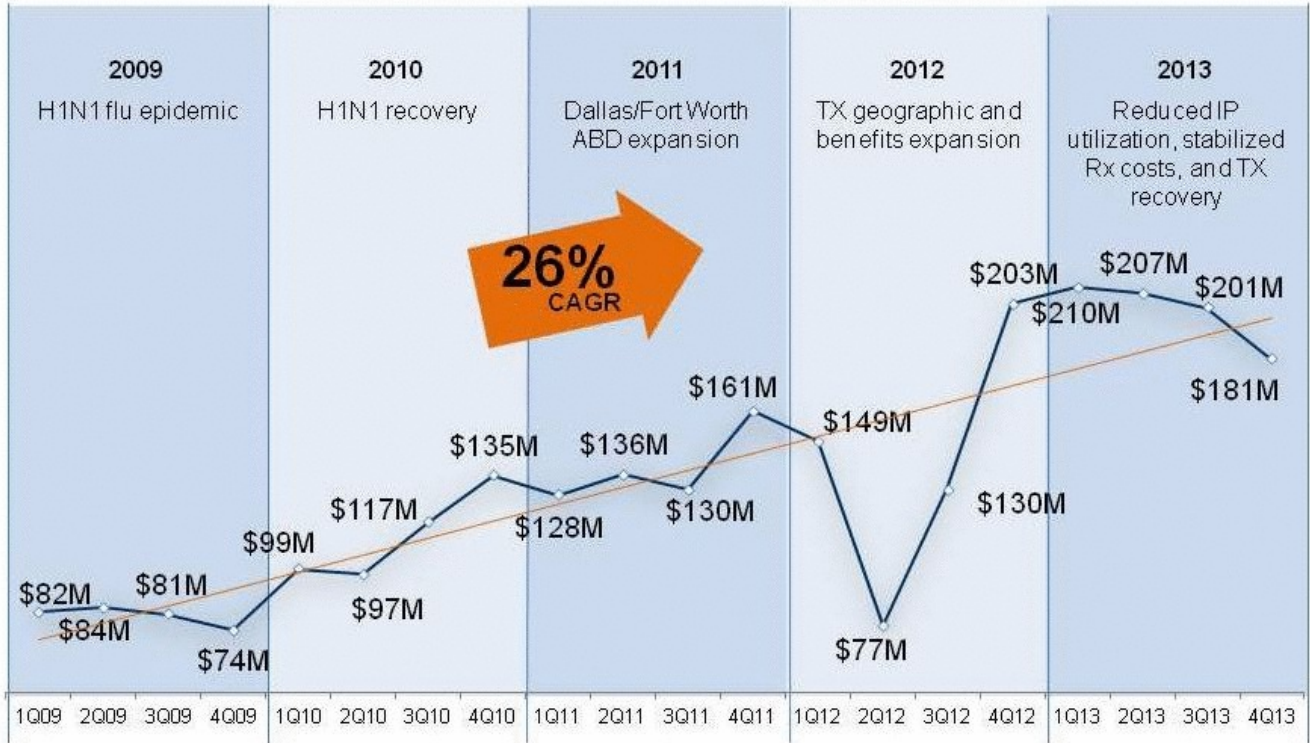
Medical Margin: Results & Initiatives

Terry Bayer
Chief Operating Officer

February 13, 2014
New York, New York

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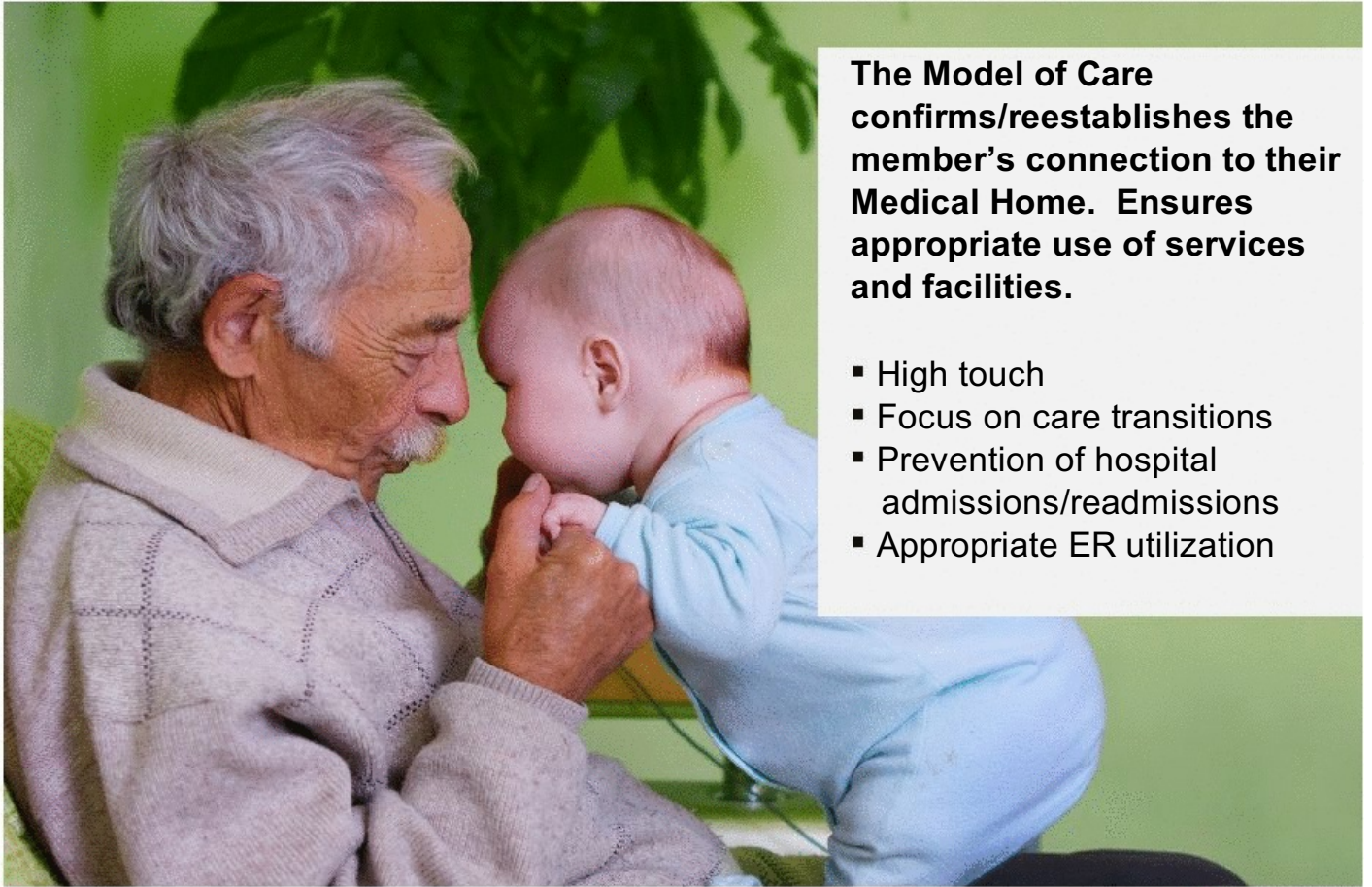
**Molina Medical Margin
Q1 2009-Q4 2013**





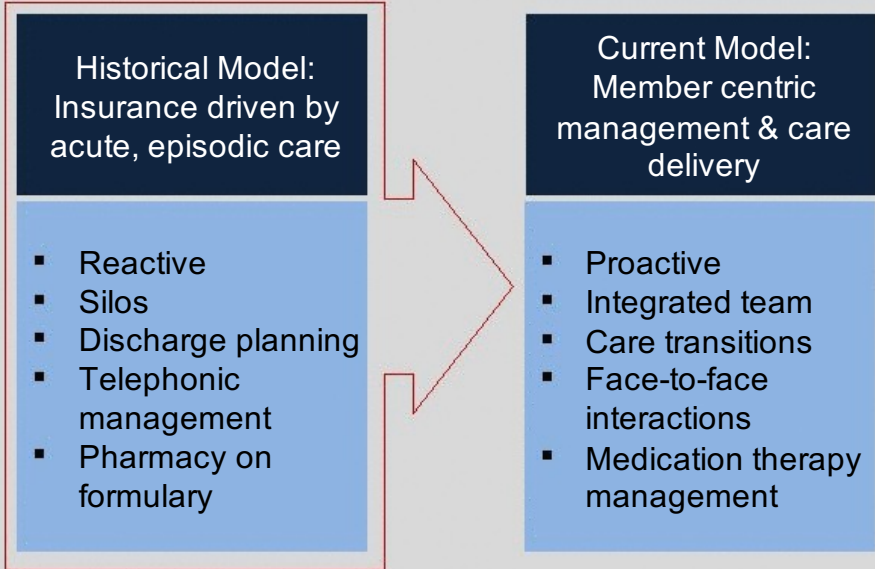
Activities focused on improving Medical Margins

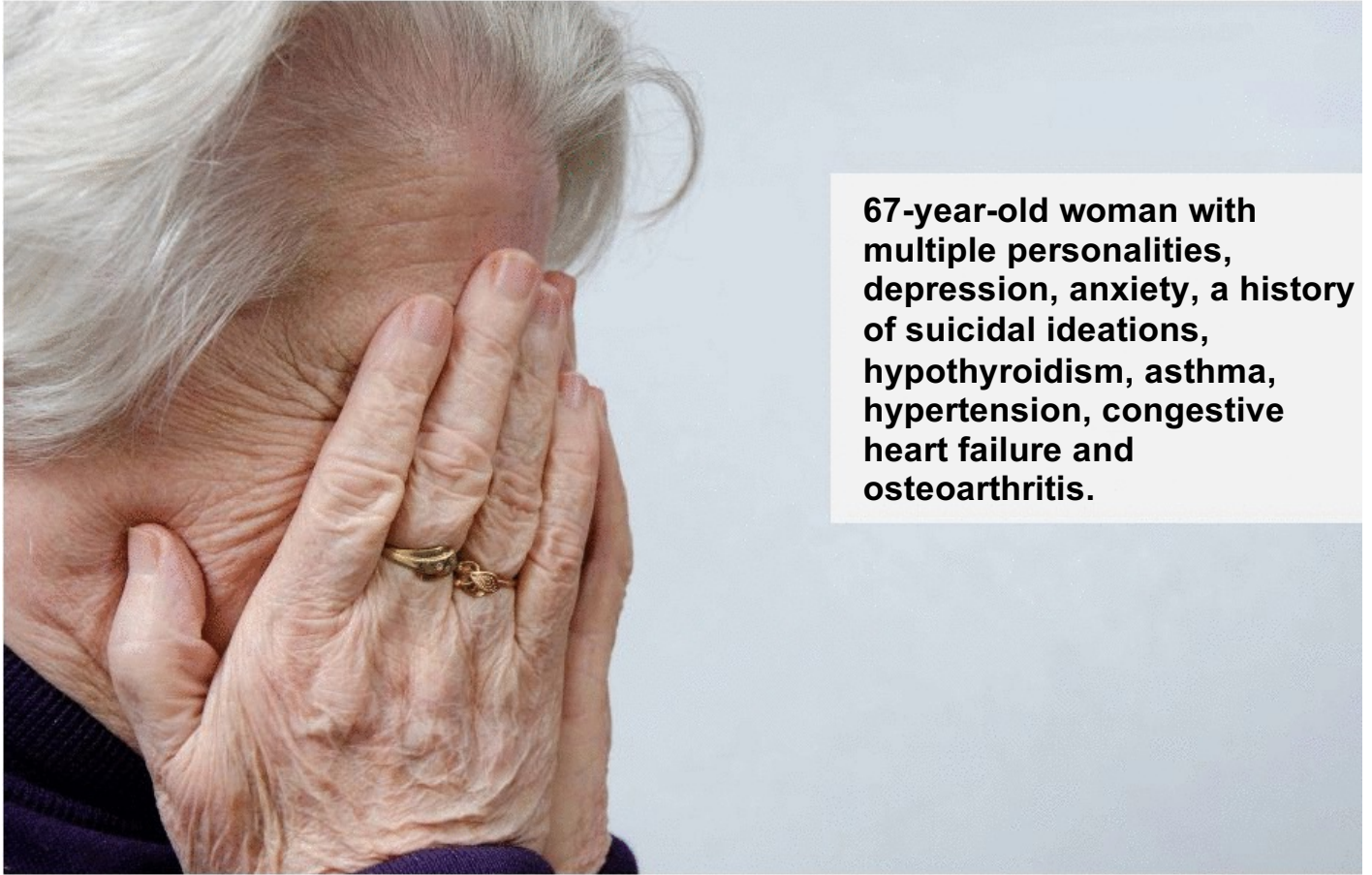
- Health Care Services (Model of Care)
- Focus on Quality
- Member Retention



The Model of Care confirms/reestablishes the member's connection to their Medical Home. Ensures appropriate use of services and facilities.

- High touch
- Focus on care transitions
- Prevention of hospital admissions/readmissions
- Appropriate ER utilization



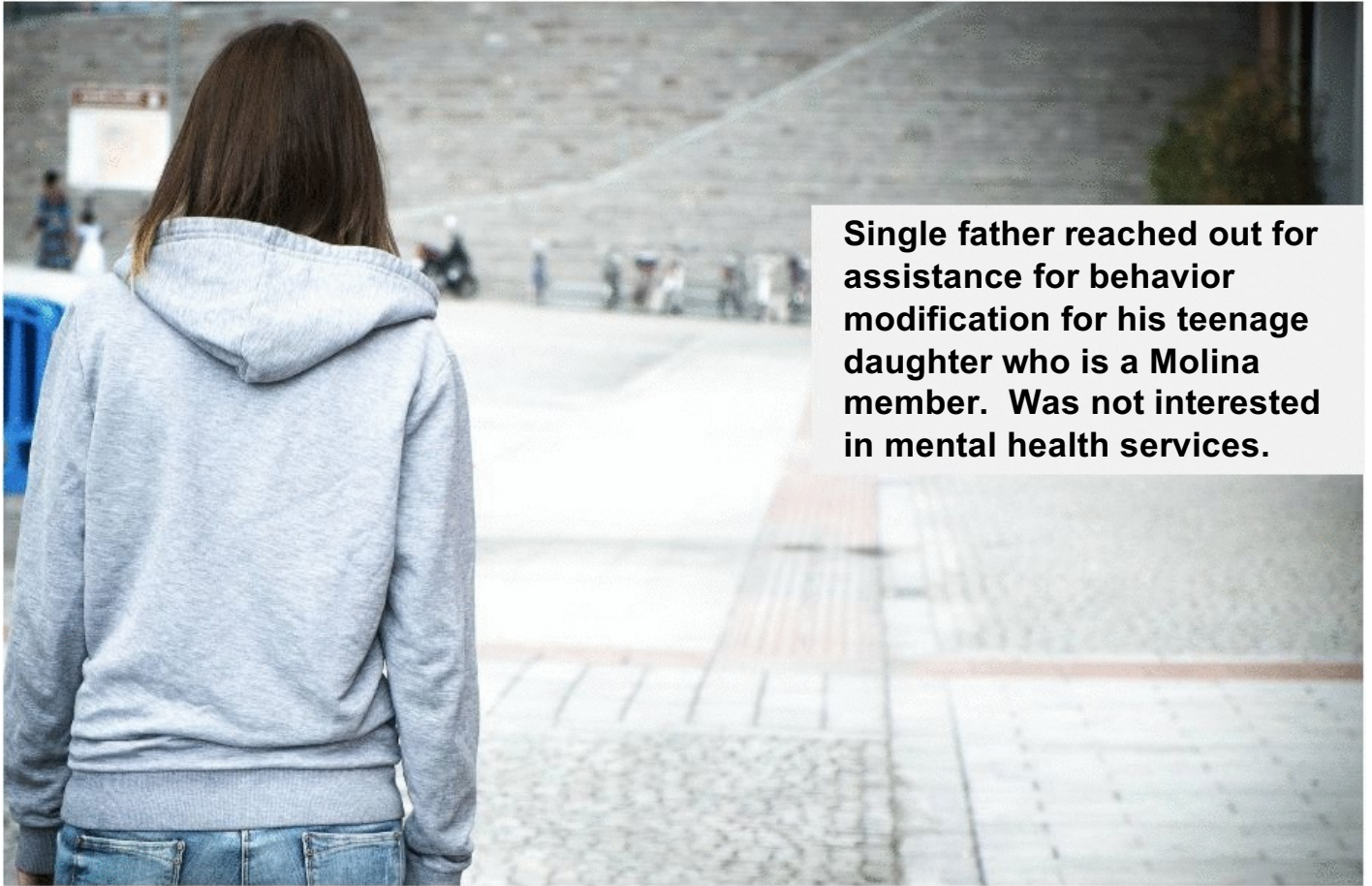


67-year-old woman with multiple personalities, depression, anxiety, a history of suicidal ideations, hypothyroidism, asthma, hypertension, congestive heart failure and osteoarthritis.

Image for illustrative purposes only. Not actual patients.

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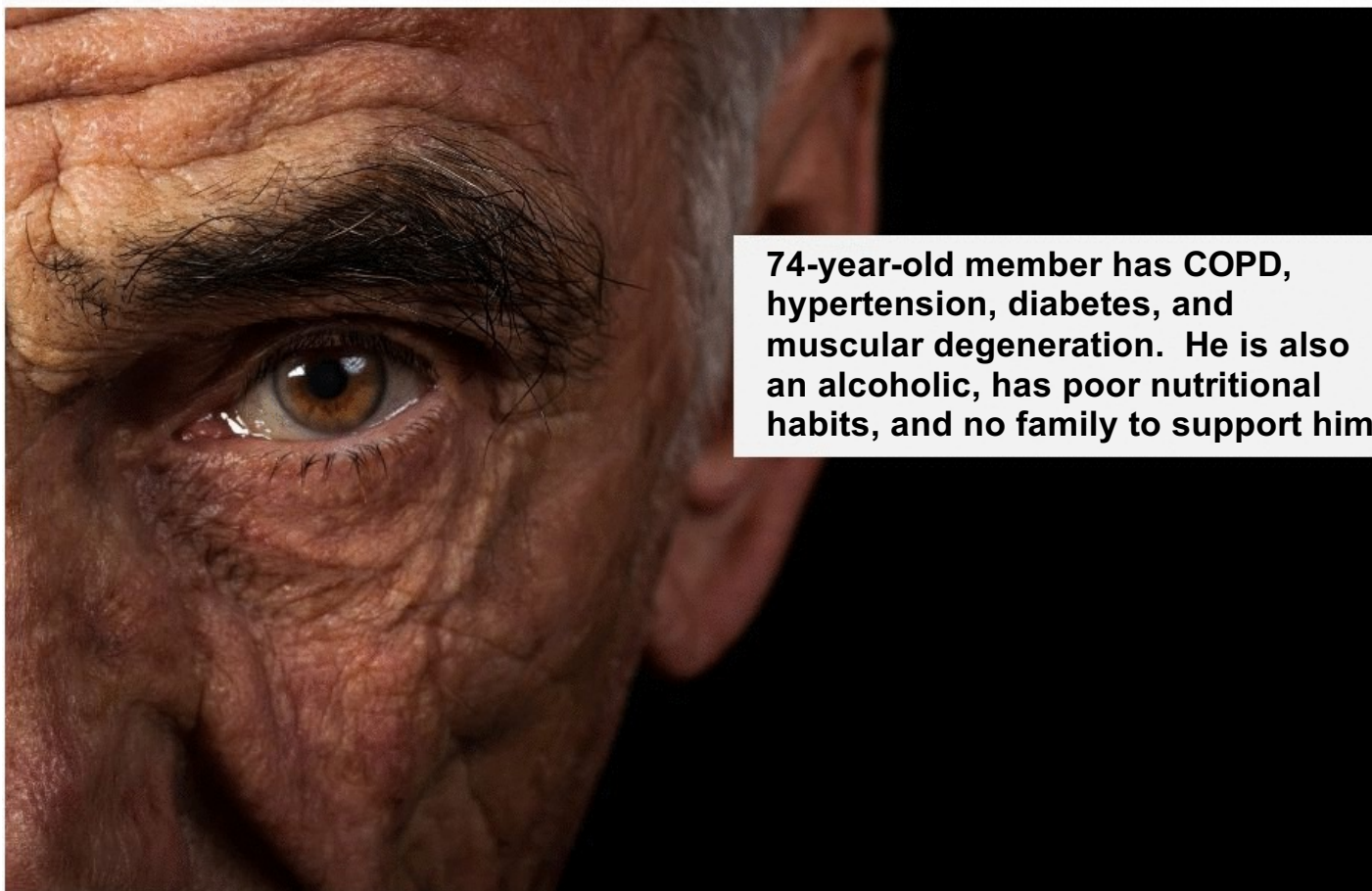


Single father reached out for assistance for behavior modification for his teenage daughter who is a Molina member. Was not interested in mental health services.

Image for illustrative purposes only. Not actual patients.

© 2014 Molina Healthcare, Inc.





74-year-old member has COPD, hypertension, diabetes, and muscular degeneration. He is also an alcoholic, has poor nutritional habits, and no family to support him.

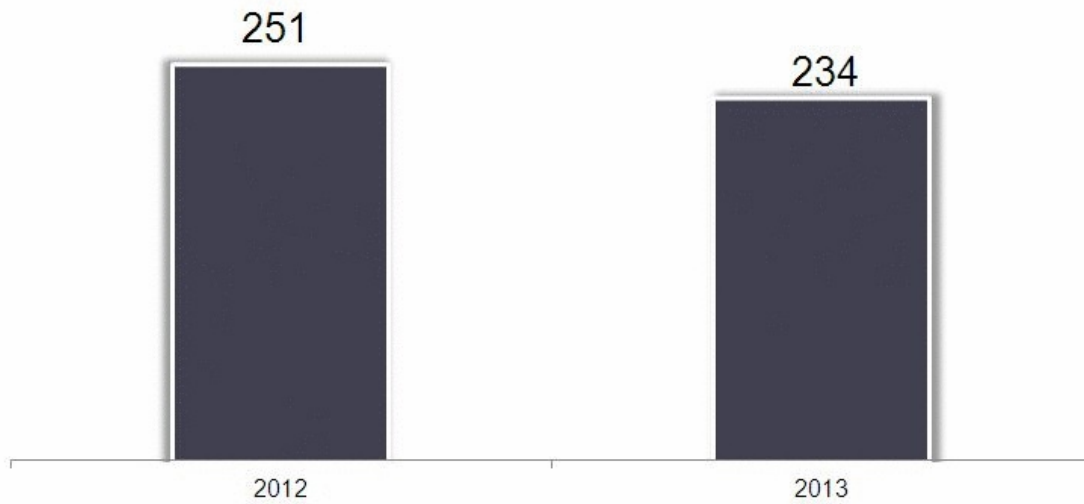
Image for illustrative purposes only. Not actual patients.

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Reduction in manageable inpatient utilization in a previously unmanaged new population

Molina Healthcare of California Admits/K¹



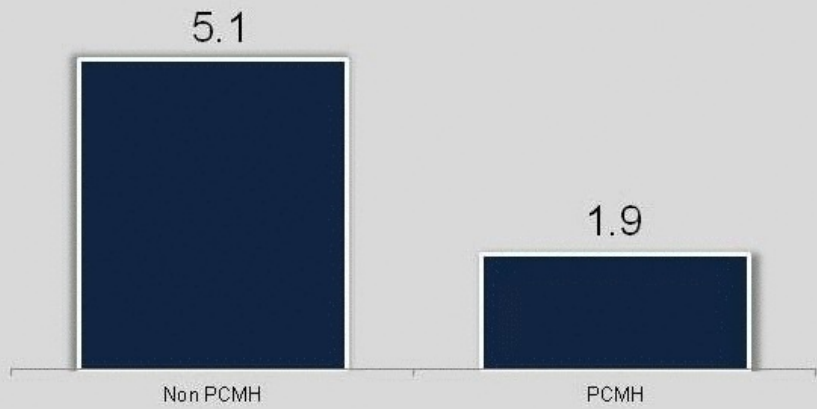
Admits/K reduction of 7%

1. Molina Internal Analytics.



Readmission rates lower among PCMH members vs. Non PCMH members

PCMH vs Non PCMH Readmits/K¹

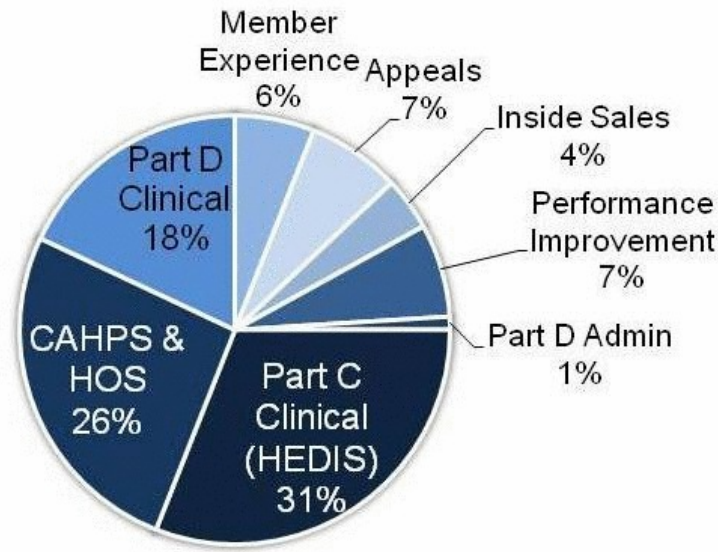


PCMH Readmits/K 63% less than Non PCMH

1. Journal of Community Health. "Community Health Workers and Medicaid Managed Care in New Mexico", June, 2012.

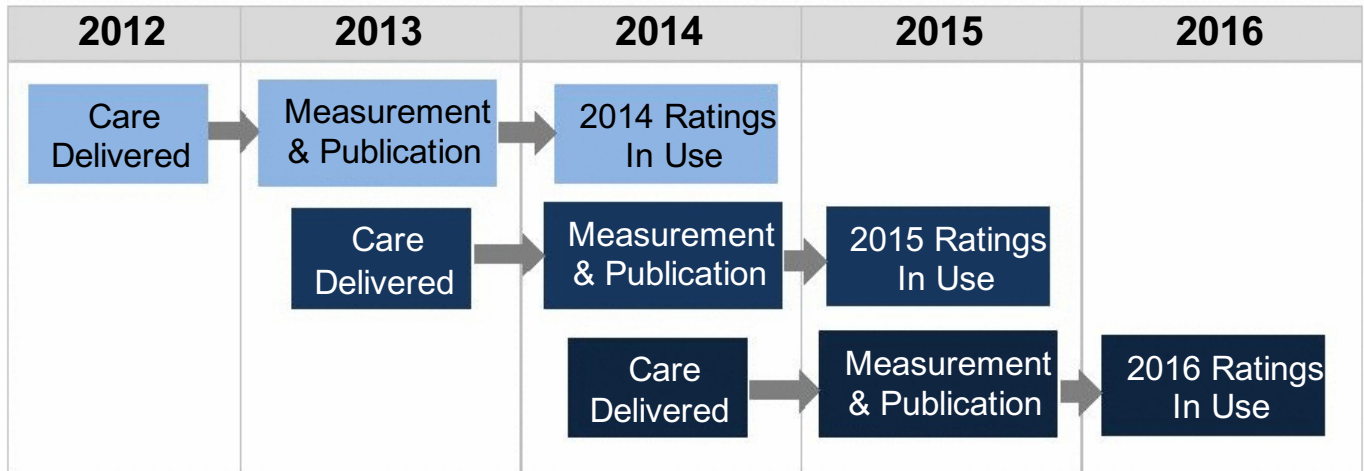
Categories & Measurements Contributing to Medicare STAR Ratings

Data to support STAR ratings come from surveys, claims data, and medical records



CAHPS = Consumer Assessment of Healthcare Providers and Systems
HOS = Health Outcomes Survey
HEDIS = Healthcare Effectiveness Data and Information Set

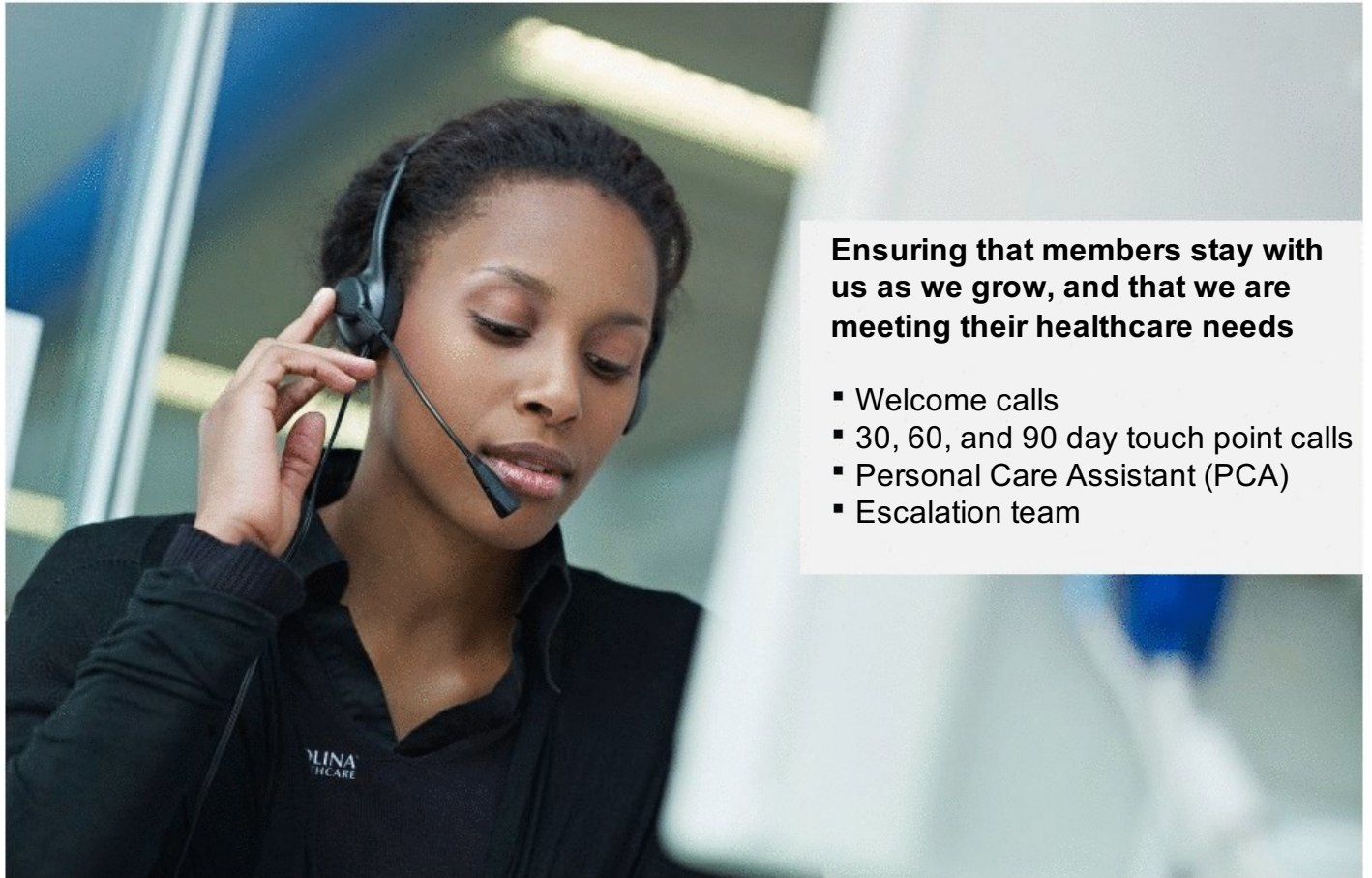
Quality improves margin by increasing pay for performance revenue & removing barriers to care





Align incentives to improve quality results

- Provider incentive programs
- Member HEDIS incentive programs
- Align provider payments to quality metrics



Ensuring that members stay with us as we grow, and that we are meeting their healthcare needs

- Welcome calls
- 30, 60, and 90 day touch point calls
- Personal Care Assistant (PCA)
- Escalation team





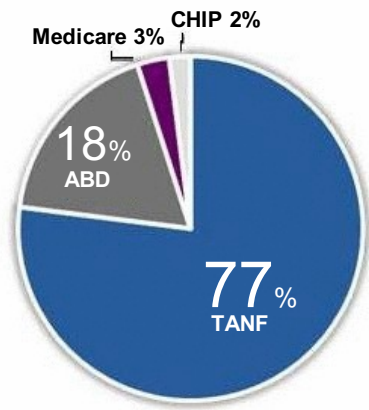
Changing Medical Cost Profile

Joseph White
Chief Accounting Officer

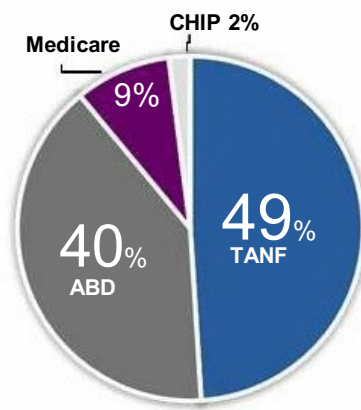
February 13, 2014
New York, New York

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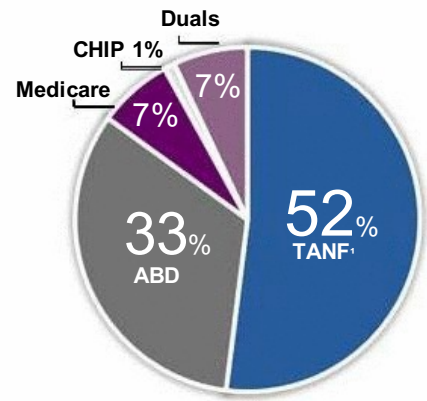
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2013A



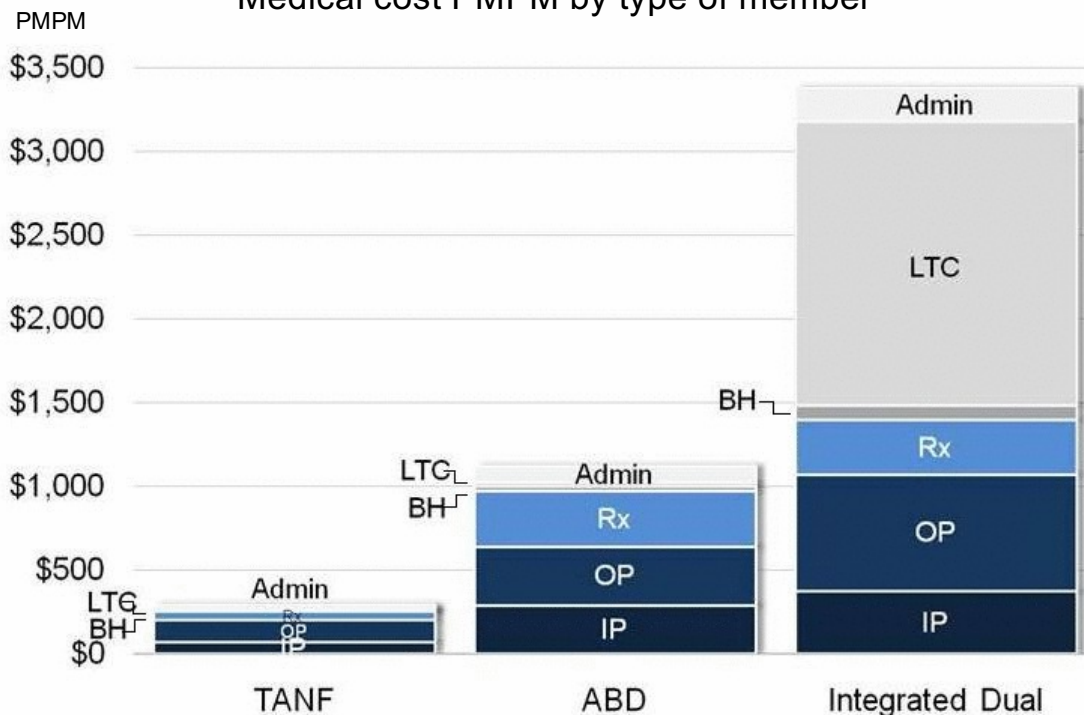
2014G

Revenue shift to chronic care is changing our medical cost profile

1. For 2014, TANF includes Medicaid expansion and Marketplace lives.

Please refer to the Company's cautionary statements.

Molina Healthcare of Ohio
 Medical cost PMPM by type of member



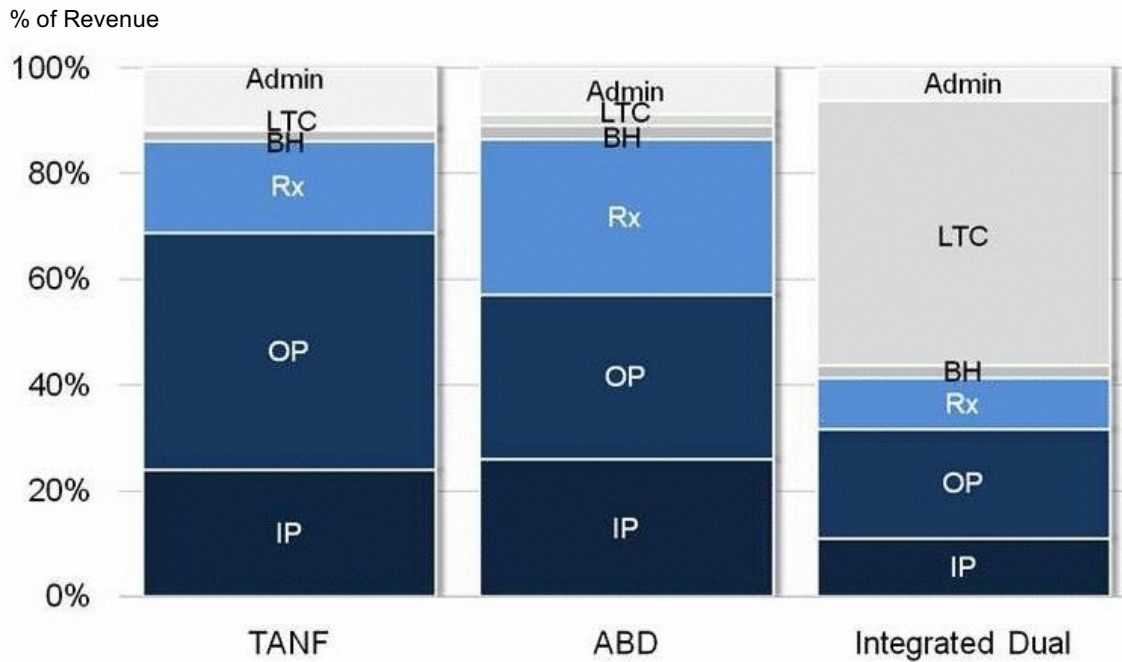
LTC = Long Term Care
 BH = Behavioral Health
 Rx = Pharmacy
 OP = Outpatient
 IP = Inpatient

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Please refer to the Company's cautionary statements.

Molina Healthcare of Ohio
Medical Spend % by Type of Member



LTC = Long Term Care
 BH = Behavioral Health
 Rx = Pharmacy
 OP = Outpatient
 IP = Inpatient

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Chronic care needs of our members are changing our medical cost profile

- Greater significance of risk adjustment
 - Payment linked to health status and demographic characteristics of the member
 - Document medical conditions
 - Process must lead to improved outcomes

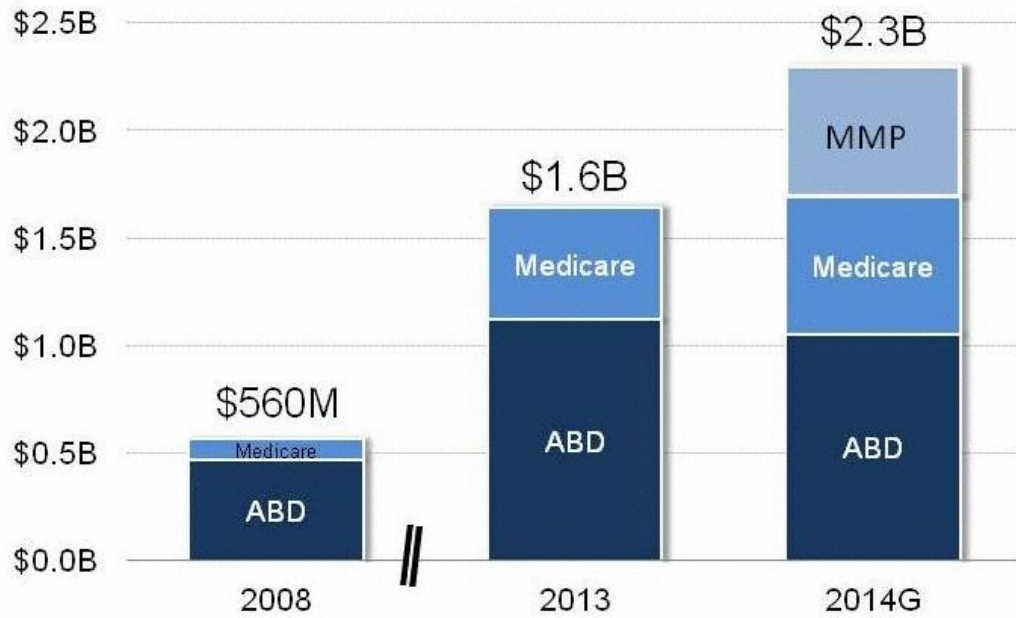
- Greater importance of medically related administrative cost
 - Care coordination
 - Community connectors

- New contracts and new providers
 - Home Health providers
 - In home assessments

- Shorter payment cycles
 - More claims
 - More frequent submission
 - Smaller dollars

Risk Adjusted Revenue is Growing

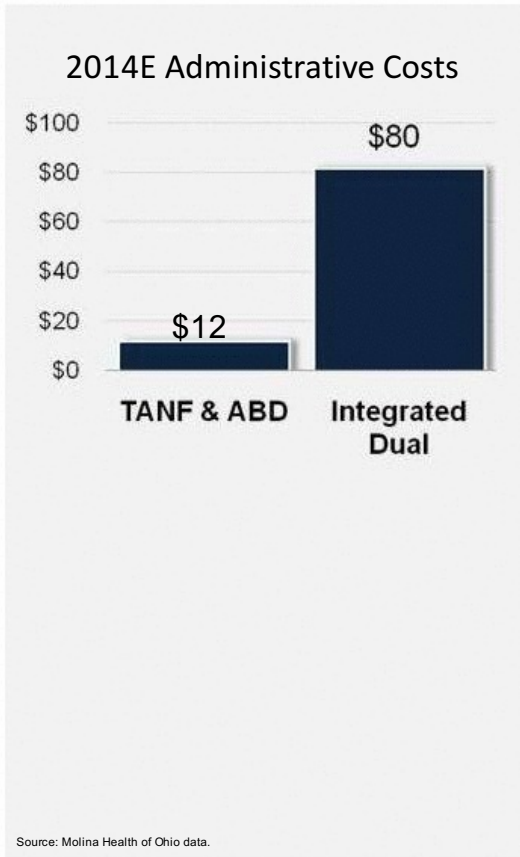
Please refer to the Company's cautionary statements.



1. MMP = Medicare-Medicaid Plan (Duals).



Administrative costs to support Integrated Duals members are nearly seven times higher than a typical TANF or ABD member



Source: Molina Health of Ohio data.

Percentage of population requiring care management

	TANF & ABD	Integrated Dual
% of Population to be care managed	1%	100%





2014 Guidance

John Molina
Chief Financial Officer
February 13, 2014
New York, New York

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Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This 2014 Guidance presentation and our accompanying oral remarks contain numerous “forward-looking statements” regarding: expected financial results; and various 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 annual report on Form 10-K, as well as the risk factors and cautionary statements in our quarterly reports and 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.



<h2 style="text-align: center;">2013 Build</h2>	<h2 style="text-align: center;">2014 Transition</h2>	<h2 style="text-align: center;">2015 Consolidation</h2>
<ul style="list-style-type: none"> ▪ Pursuing new business ▪ Designing & implementing programs and systems ▪ Documenting readiness ▪ Incurring cost before 2014 revenue ▪ Upcoming: <ul style="list-style-type: none"> ○ SC & IL ○ MMP Duals ○ Marketplace ○ Medicaid expansion ○ NM & FL Re-procurement ○ WI Medicare 	<ul style="list-style-type: none"> ▪ Transitioning members into model of care ▪ Mitigating pent-up demand ▪ Right-sizing premiums ▪ Mitigating transition issues ▪ Incurring cost before 2015 revenue 	<ul style="list-style-type: none"> ▪ Refining & enhancing model of care ▪ Refining & enhancing programs and systems ▪ Improving margins

Please refer to the Company's cautionary statements.

2014 Guidance

Revenue	
Premium Revenue	~\$9.2B
ACA Fee Reimbursement	~\$140M
Premium Tax Revenue	~\$275M
Service Revenue	~\$210M
Investment and Other Revenue	~\$20M
Total Revenue	~\$9.9B
Total Medical Care Costs	~\$8.2B
<i>Medical Care Ratio</i> ¹	~89%
Total Service Costs	~\$170M
General & Administrative Expenses	~\$770M
<i>G&A Ratio</i> ²	~8%
Premium Taxes	~\$275M
ACA Insurer Fee	~\$85M
Depreciation & Amortization	~\$100M
Interest Expense	~\$55M
Income Before Taxes	~\$210M
EBITDA	~\$385M
Effective Tax Rate	55% - 59%
Adjusted EPS ³	\$4.00 - \$4.50

Note: Amounts are estimates and subject to change. Actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings.

1. Medical Care Ratio represents medical care costs as a % of premium revenue.

2. G&A ratio computed as a percentage of premium revenue, plus service revenue.

3. Assumes 47.7M average diluted shares outstanding. **Low and high guidance ranges assume full reimbursement of the ACA fee and related tax effects.** See Appendix for a reconciliation of adjusted EPS to GAAP diluted net income per share.

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New Product Membership Included in 2014 Guidance

Please refer to the Company's cautionary statements.








	January 2014					March 2014	
							
State	Various	CA, NM, & WA	NM	SC	WI	OH	IL⁴
Program Type	Marketplace	Medicaid Expansion	LTC	Medicaid	SNP	Medicaid Expansion	MMP Duals⁴
Eligible¹	2M	1.4M	44K	740K	28K	275K	18K
Enrollees²	15K	160K	5K	125K	1K	30K	5K
Revenue PMPM³	\$300	\$550	\$1,600	\$200	\$1,100	\$450	\$1,800
MCR³	88%	88%	93%	90%	82%	86%	95%
Opt Out	N/A	N/A	N/A	N/A	N/A	N/A	40% ⁴

Note:
 Constitutes forward-looking guidance. Amounts are estimates and subject to change. Actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings.
 1. Denotes total number of eligible members in Molina markets.
 2. Denotes membership assumed in guidance at year-end 2014. MMP Dual denotes enrollment after opt-out.
 3. Revenue PMPM and MCR are net of premium tax and ACA fee. Denotes full premium for MMP Duals.
 4. IL assumes opt out however only waiver (HCBS) members can be enrolled in MOH Medicaid. Non-waiver (HCBS) members that opt out return to Medicaid FFS. IL MMP Passive enrollment not until 6/1/2014 and 9/1/2014 for Nursing Home & LTSS.



New Product Membership Included in 2014 Guidance

Please refer to the Company's cautionary statements.

	April 2014	May 2014	June 2014	July 2014			October 2014
							
State	MI	CA⁴	OH⁵	FL	SC	IL	MI⁶
Program Type	Medicaid Expansion	MMP Dual⁴	MMP Duals (Medicare Voluntary)⁵	Medicaid (Re-procurement)	MMP Duals	Medicaid Expansion	MMP Duals⁶
Eligible ¹	500K	322K	48K	1.2M	54K	300K	62K
Enrollees ²	45K	30K	25K	140K	1K	25K	1K
Revenue PMPM ³	\$450	\$2,000	\$3,700	\$280	\$2,000	\$550	\$2,500
MCR ³	87%	94%	97%	88%	94%	88%	92%
Opt Out	N/A	50% ⁴	90% ⁵	N/A	50%	N/A	50% ⁶

Note:
 Constitutes forward-looking guidance. Amounts are estimates and subject to change. Actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings.
 1. Denotes total number of eligible members in Molina markets.
 2. Denotes membership assumed in projection at year-end 2014. MMP Dual denotes enrollment before opt for CA, OH and SC and after opt-out for MI.
 3. Revenue PMPM and MCR are net of premium tax and ACA fee; Denotes full premium for MMP Duals.
 4. Riverside, San Bernardino & San Diego assume 50% opt out. RS, SB, SD opt -outs participates in MOH Medicaid LTSS. MOH awarded 20K members in Los Angeles, assumes 50% opt-out. InLA, HNT provides Medicaid LTSS to opt-outs.
 5. OH passive enrollment for MMP Medicare is delayed until 1/1/2015. Only members that volunteer and select will participate in both Medicaid and Medicare MMP.
 6. MI assumes 50% opt out and members that opt out are no longer enrolled in MMP program.



Status of Reimbursement – ACA Fee in Molina States

Please refer to the Company's cautionary statements.

Our guidance assumes the ACA fee and related tax effects will be fully reimbursed in all states.

	Comments	ACA Fee	Gross Up	Reimbursement Revenue	Reimbursement Not Yet Achieved
Ohio	Actuarial rate memorandum (Mercer) calls for reimbursement of fee - silent on tax impact.	\$17M	\$13M	\$30M	\$30M
Washington	Contract specifically calls for reimbursement of fee and tax impact.	\$15M	\$9M	\$24M	\$0M
Texas	Informal Support from State	\$11M	\$6M	\$18M	\$18M
Michigan	Actuarial rate memorandum (Milliman) calls for reimbursement of fee and tax impact.	\$10M	\$6M	\$16M	\$16M
California	CA DHCS All Plan Meeting: "Mercer is working with DHCS...to develop an appropriate reimbursement/addition...that recognizes MCO specific circumstances regarding the Fee" 2.11.14	\$9M	\$5M	\$14M	\$14M
New Mexico	State has indicated in a phone call Feb 4th with company staff they are awaiting CMS guidance before committing	\$7M	\$4M	\$11M	\$11M
Florida	Letter from AHCA to FL Association of Health Plans 1/23/14: Our plan is to provide funds to managed care plans once they have received federal invoices specifying the amount of liability associated with their Florida Medicaid revenue...we also expect that it will be appropriate to consider the income tax impact of the fee	\$3M	\$2M	\$5M	\$5M
Utah	Informal Support from State	\$3M	\$2M	\$5M	\$5M
Wisconsin	Contract specifically calls for reimbursement of fee and tax impact.	\$3M	\$1M	\$4M	\$0M
Illinois	Contract specifically calls for reimbursement of fee and tax impact.	\$0M	\$0M	\$0M	\$0M
Medicare	Included in bid pricing	\$7M	\$5M	\$12M	\$0M
TOTAL		\$85M	\$55M	\$140M	\$100M

Note: Constitutes forward-looking guidance. Amounts are estimates and subject to change. Actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings.
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Base Business Net Rate Changes Included in 2014 Guidance

Please refer to the Company's cautionary statements.

State	FINAL	
	Effective Date	Rate Change
California	Oct-13	+2.5% ¹
Florida	Sep-13	+1.0% ²
Illinois	Jan-14	(-3.0%)¹
Michigan	Oct-13	+1.0% ¹
New Mexico	Jan-14	0.0% ^{1,2}
Ohio	Jan-14	2.0% ^{1,3}
South Carolina	Jan-14	New Rates
Texas	Apr-14	0.0% ²
Utah	Jan-14	+0.5%
Washington	Jan-14	0.0% ^{1, 2, 3}
Wisconsin	Jan-14	+1.0% ¹

Note:

- 1. All rate changes exclude new product and benefit expansions effective after Dec 31, 2013.
- 2. Net of fee schedule adjustments.
- 3. All rate changes exclude risk adjustment.



California settlement protects margin for California year 1 profitability uncertainties

- Effective January 1, 2014
- Settlement account to serve as a risk corridor for all direct contracts with DHCS
 - Maximum of \$40 million available over a 4 year period
 - Contracts directly with DHCS: Sacramento, San Bernardino / Riverside, & San Diego
 - Dual Eligible Demonstration contracts
 - Does NOT apply to Marketplaces, Medicare SNP & subcontract arrangements

Settlement Calculation

Target Profitability margin is less than 3.25% for any year

50% (75% for 2014 only) of difference between actual and target profitability margins multiplied by the applicable premium revenue is payable to Molina

Target Profitability margin exceeds 3.25% for any year

50% (75% for 2014 only) of difference between actual and target profitability margins multiplied by the applicable premium revenue reduces any amount otherwise due to Molina under the settlement from other years

**In no circumstances will Molina owe any money to the DHCS.
In no circumstances will DHCS owe more than \$40 million to Molina.**

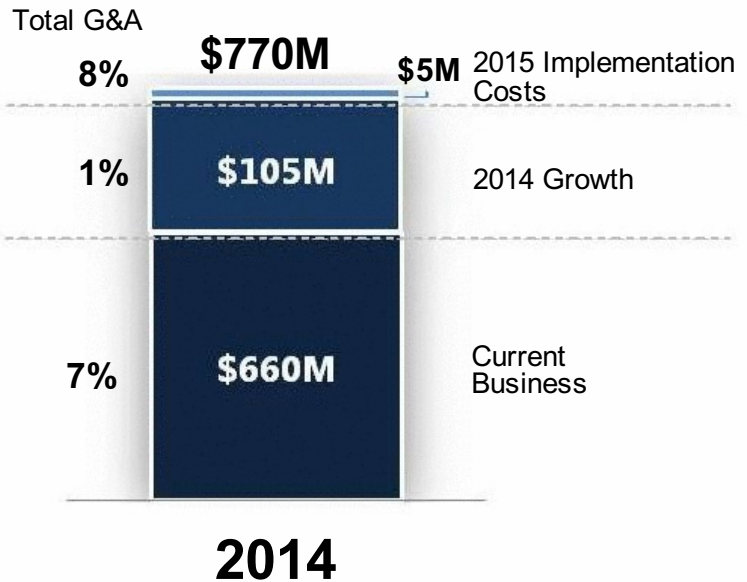
Note - profitability margin is calculated as follows:
Target profitability margin - Profit + Premiums earned
Premiums earned - Gross premiums: (-) Less premium taxes and ACA insurer fee
Profit - Premiums earned: (-) Less medical cost and G&A expenses incurred

Please refer to the Company's cautionary statements.



G&A Expense¹

- Our FY 2014 mid-point guidance assumes G&A expenses of \$770M or 8% of total revenues.²
- Approximately \$110M or 1% of our total revenues is required to support growth.



2014 Guidance G&A Ratio by Quarter^{1, 2}

- Q114 – 8.9%
- Q214 – 8.6%
- Q314 – 7.9%
- Q414 – 7.5%

Notes:

1. G&A ratio computed as a percentage of premium revenue, net of premium taxes & ACA fee reimbursement, plus service revenue.

2. Constitutes forward-looking guidance. Amounts are estimates and subject to change. Actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings.

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Headwinds into 1Q2014¹

Substantial uncertainty around Q1 results

Please refer to the Company's cautionary statements.

- **Continued administrative spend ahead of revenue**
 - G&A expenses incurred in anticipation of related revenues will reduce first quarter GAAP & Adjusted EPS by (~\$0.38)
- **Possible delay in revenue recognition**
 - Delayed recognition of ACA fee reimbursement **may reduce** first quarter GAAP & Adjusted EPS by (~\$0.33)²
 - Delays in recognition of at risk revenue **may reduce** first quarter GAAP & Adjusted EPS by (~\$0.21)
- **Programmatic delays**

Note(s):

1. Constitutes forward-looking guidance. Amounts are estimates and subject to change. Actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings.
2. Delayed recognition of ACA fee and related tax effects. Assumes no 1Q-14 recognition of ACA revenue in CA, FL, MI, NM, OH, TX and UT.

Reconciling Adjusted EPS Ranges¹

Please refer to the Company's cautionary statements.

	Low End	High End
Adjusted net income per diluted share, continuing operations ²	\$4.00	\$4.50
<u>Less non-cash adjustments, net of tax:</u>		
Depreciation, and amortization of capitalized software	\$1.29	\$1.29
Stock based compensation	\$0.48	\$0.48
Amortization of convertible senior notes and lease financing obligations	\$0.31	\$0.31
Amortization of intangible assets	\$0.27	\$0.27
Net income (loss) per diluted share, continuing operations²	\$1.65	\$2.15

**Assumes 47.7M average weighted diluted shares outstanding*

Note(s):

1. Constitutes forward-looking guidance. Amounts are estimates and subject to change. Actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings.
2. Adjusted net income per diluted share, continuing operations, is a non-GAAP measure. The table above reconciles adjusted net income per diluted share, which the Company believes to be the most comparable GAAP measure to net income (loss) per diluted shares. GAAP stands for Generally Accepted Accounting Principles.