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 26, 2011

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

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Item 7.01. Regulation FD Disclosure.

On January 26, 2011, Molina Healthcare, Inc. (the "Company"), issued a press release announcing its guidance for fiscal years 2011 and 2012. 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 current report.

As part of the Company's presentation at its Investor Day Conference to be held in New York City on January 26, 2011, the Company will present and 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 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 January 26, 2011, reporting guidance for fiscal years 2011 and 2012.
99.2	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. on January 26, 2011.

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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: January 26, 2011

By: */s/ Jeff D. Barlow*
Jeff D. Barlow
General Counsel and Corporate Secretary

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EXHIBIT INDEX

Exhibit No.	Description
99.1	Press release of Molina Healthcare, Inc. issued January 26, 2011, reporting guidance for fiscal years 2011 and 2012.
99.2	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. on January 26, 2011.

Exhibit 99.1

News Release

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

MOLINA HEALTHCARE ISSUES GUIDANCE
FOR ITS 2011 FISCAL YEAR

Long Beach, California (January 26, 2011) — Molina Healthcare, Inc. (NYSE:MOH) today announced its guidance for fiscal year 2011, and limited guidance for its fiscal year 2012.

For the year ended December 31, 2011, the Company currently expects the financial results shown below (all amounts are approximate):

Premium Revenue	$4.5 billion
Service Revenue	$170 million
Investment Income	$7.5 million
Medical Care Costs	$3.8 billion
Medical Care Ratio	84.8%
Service Costs	$145 million
Service Revenue Ratio	84.3%
G&A Expense	$390 million
G&A Ratio	8.4%
Premium Tax Expense	$145 million
Depreciation	$34 million
Amortization	$20 million
Interest Expense	$15 million
Income Before Tax	$110 million
Income Tax	$41.8 million
Net Income	$68.2 million
Diluted EPS	$2.20
Weighted Average Diluted Shares Outstanding	31.0 million
EBITDA	$210 million
Effective Tax Rate	38%

For the year ended December 31, 2012, the Company currently expects the financial results shown below (all amounts are approximate):

Premium Revenue	$5.0 billion to $6.0 billion
Medical Care Ratio	85.0% to 85.5%
G&A Ratio	7.8% to 8.3%
EBITDA	$230 million to $280 million
EBITDA %	4.5%

The Company will host an Investor Day meeting at the Le Parker Meridien Hotel in New York City on Wednesday, January 26, 2011, from 12:30 p.m. to 4:30 p.m. Eastern Time. The Company's conference presentation will include discussions by management of corporate strategy, market factors, and financial metrics, including a discussion of the Company's 2011 guidance and limited 2012 guidance. 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.

Molina Healthcare, Inc. 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. Our licensed health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin currently serve approximately 1.6 million members, and our 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 earnings release contains "forward-looking statements" regarding the Company's expected results for fiscal years 2011 and 2012. All of our forward-looking statements are based on our current expectations and assumptions. Actual results could differ materially due to the unexpected failure of our assumptions or due to adverse developments related to numerous risk factors, including but not limited to the following:*

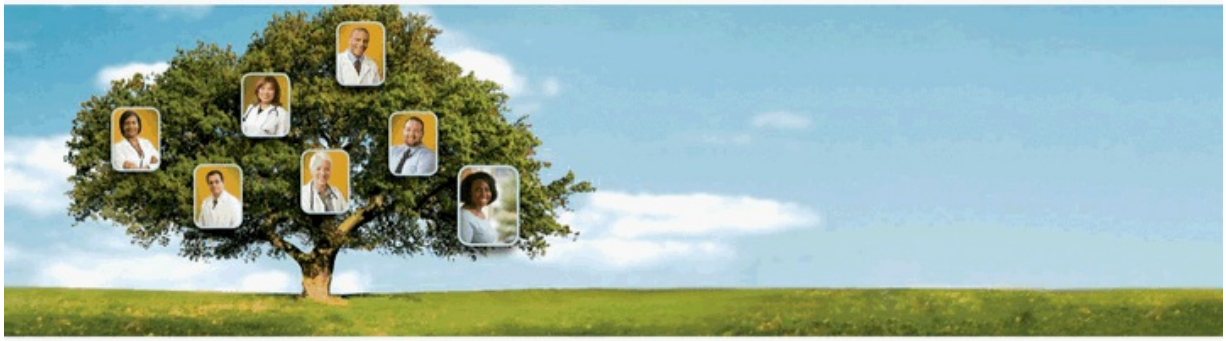
- *significant budgetary pressures on state governments and their potential inability to maintain the currently agreed-upon payment rates to our health plans, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *increases in our Aged, Blind or Disabled membership at our California and Texas health plans consistent with our expectations;*
- *uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate, the effect of various implementing regulations, and uncertainties regarding the likely impact of other federal or state health care and insurance reform measures;*
- *management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations;*
- *the success of our efforts to retain existing government contracts in connection with upcoming state requests for proposals (RFPs) in Washington and Louisiana;*
- *the success of our efforts to obtain new government contracts in connection with upcoming RFPs in both existing states (Texas and Florida) and new states (Arizona, Georgia, and Illinois) and our ability to grow our revenues through 2012 consistent with our expectations;*
- *the accurate estimation of incurred but not reported medical costs across our health plans;*

- *risks associated with the continued growth in new Medicaid and Medicare enrollees;*
- *retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;*
- *the continuation and renewal of the government contracts of our health plans and of Molina Medicaid Solutions and the terms on which such contracts are renewed;*
- *the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions;*
- *additional administrative costs and the potential payment of additional amounts to providers and/or the state as a result of MMIS implementation issues in Idaho;*
- *the certification of the MMIS systems in both Maine and Idaho during 2011;*
- *government audits and reviews, including the audit of our Medicare plans by CMS;*
- *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;*
- *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 resolution of litigation or arbitration matters;*
- *restrictions and covenants in our credit facility;*
- *the relatively small number of states in which we operate health plans;*
- *the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;*
- *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;*

and numerous other risk factors, including those discussed in our periodic reports and filings with the Securities and Exchange Commission. These reports can be accessed under the investor relations tab of our Company website or on the SEC's website at www.sec.gov. Given these risks and uncertainties, we can give no assurances that our forward-looking statements will prove to be accurate, or that any other results or events projected or contemplated by our forward-looking statements will in fact occur, and we caution investors not to place undue reliance on these statements. All forward-looking statements in this release represent our judgment as of January 26, 2011, and we disclaim any obligation to update any forward-looking statements to conform the statement to actual results or changes in our expectations.

-END-

Exhibit 99.2



New York, New York
January 26, 2011

INVESTOR DAY 2011A

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Cautionary statement

"Safe Harbor" Statement under the Private Securities Litigation Reform Act of 1995: This slide presentation, as well as our accompanying oral remarks, contain numerous "forward-looking statements" regarding our operations for 2011 and subsequent fiscal years. 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 2009 Annual Report on Form 10-K filed on March 16, 2010, our first, second and third quarter 2010 Quarterly Reports filed on May 10, 2010, August 4 2010, and November 4, 2010, respectively, and the risk factors and cautionary statements found in our other reports and filings with the Securities and Exchange Commission and available for viewing on its website at www.sec.gov. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results.

MOLINA HEALTHCARE

Agenda

Time	Topic	Speaker
12:30pm-12:35pm	Opening Remarks	Juan José Orellana, VP Investor Relations
12:35pm-1:10pm	Business Overview	J. Mario Molina, MD, Chief Executive Officer
1:10pm-1:30pm	Panel 1 Q&A	
1:30pm-1:40pm	Break	
1:40pm-2:15pm	Health Plan Update	Terry Bayer, Chief Operating Officer
2:15pm-2:40pm	Molina Medicaid Solutions	Norm Nichols, President, MMS
2:40pm-3:00pm	Panel 2 Q&A	
3:00pm-3:30pm	Minimum MCR Requirements	Joseph White, Chief Accounting Officer
3:30pm-3:40pm	Break	
3:40pm-4:00pm	2011 & 2012 Outlook	John Molina, Chief Financial Officer
4:00pm-4:30pm	Panel 3 Q&A	
4:30pm	End of Program	

MOLINA HEALTHCARE

Who we are

We are a multi-state health care organization with flexible care delivery systems focused exclusively on government-sponsored health care programs for low income families and individuals

Health Plans

Risk-based health plan outsourcing for Medicaid and other government programs (includes risk medical management)

Medicaid Health Information Mgmt

Fee-based fiscal agent services, business process outsourcing, and care and utilization management

- Non-risk, fee business with higher margins and no regulatory capital requirement

Healthcare Direct Delivery

Company owned or company operated **primary care community clinics**

- Provide high quality patient care in selected geographies

No other company in the Medicaid space can do all three

MOLINA HEALTHCARE

New York, New York
January 26, 2011

Business Overview

J. Mario Molina, MD
President & Chief Executive Officer

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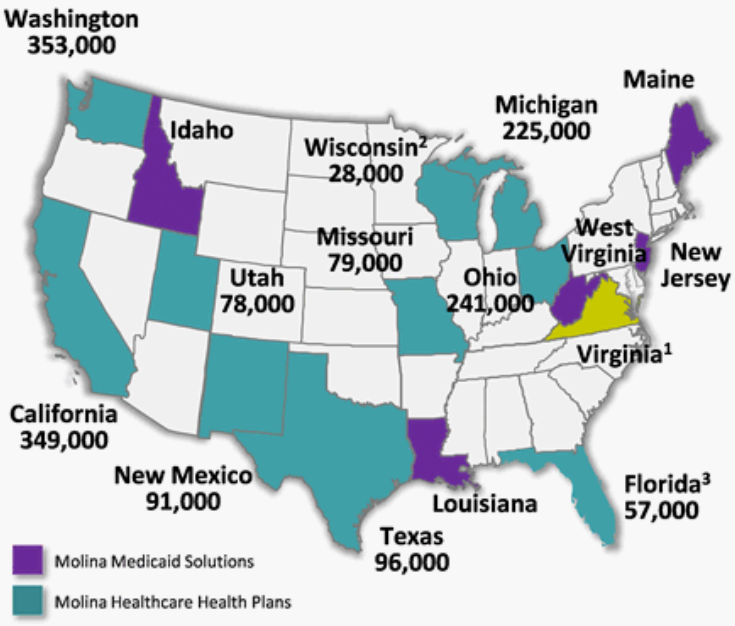
Business snapshot

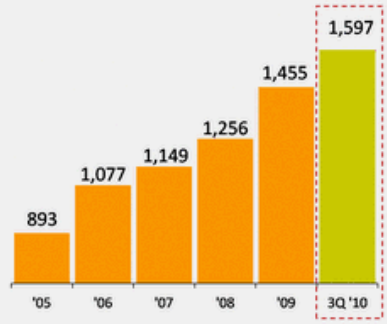
Markets and members served – Q3 2010



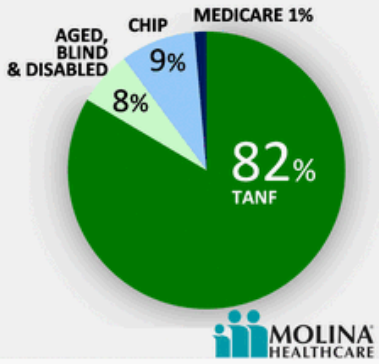
1. Virginia clinics provide Direct Delivery.
2. Molina acquired the Wisconsin health plan on September 1, 2010. As of September 30, 2010, the Wisconsin health plan had approximately 3,000 Medicare Advantage members covered under a reinsurance contract with a third party; these members are not included in the membership count shown above.
3. Florida has a managed care program as well as a Pharmacy Rebate Program.

Health plan enrollment growth

(in thousands)



Health plan membership profile

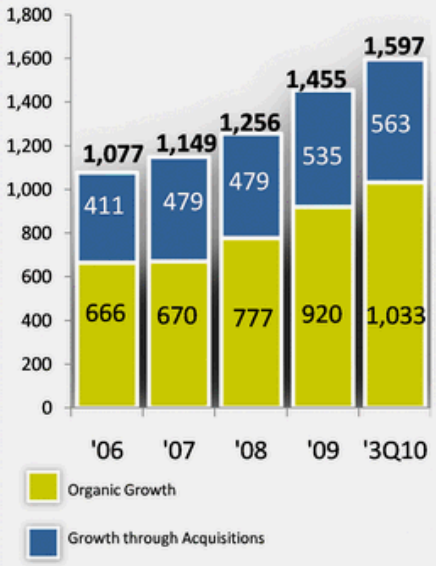


MOLINA HEALTHCARE

Delivering on our strategy

Expanding the business

Health Plan Enrollment Growth
(in thousands)



2010 expansion review:

RFP Awards

- TX Dallas ABD
- TX CHIP RSA
- WI Medicaid Southeast

Strategic Acquisitions

- Fiscal Agent

Tactical Acquisitions

- TX Laredo
- WI Abri

Direct Delivery

- WA Molina Medical @ Compass
- CA Additional capacity to be deployed

MOLINA HEALTHCARE

Accelerating growth in health plan opportunities

In the next three years, it is expected that states will be offering many new Medicaid RFPs or expansions in order to avoid disruption in 2014.

Examples of expected Health Plan RFPs include:

	GA	FL [3]	IL [3]	TX	AZ
TANF Lives	.9M	1.3M	1.8M	1.8M	-
ABD Lives	.4M	.3M	-	.4M	.027M [1]
CHIP Lives	.2M	-	-	.3M	-
Total Lives	**1.5M**	**1.6M**	**1.8M**	**3.2M**	**.027M**
RFP	2/11	n/a	n/a	2/11	1/11
Go Live	7/12	n/a	n/a	3/12	10/11
Total Revenue Opportunity [2]	**$5.0B**	**$4.3B**	**$3.6B**	**$9.9B**	**$1.1B**

1. Re-procurement of ALTCS program (Acute + Long Term Care Services for Medicaid Enrollees)
2. Based on current PMPM rates
3. State evaluating RFP

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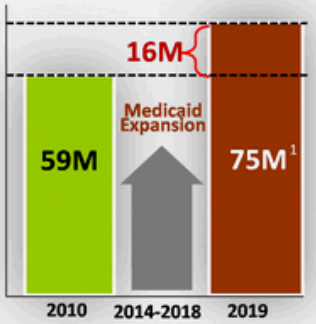
Organizing for health care reform

In preparation for the large scale change associated with health care reform, Molina has organized a dedicated unit to address health care reform strategy, policy and information, reform readiness and implementation.

Estimated Enrollment Growth (2010-2019)



Areas of Uncertainty :

- Exchanges
- Redetermination of eligibility
- Provider payments (Medicaid @ Medicare Rates)
- Federalization of Medicaid
- Uniformity/Regionalization of MMS
- Patient ratios
- Coordination with other government programs

Sources: 1. CMS, Congressional Budget Office; does not include organic population growth. 2010.

Unit designed to focus leadership attention on the key aspects of reform, while allowing leaders to continue to run the business.

- Reviews critical health care reform information and analysis
- Addresses enterprise strategic inquiries regarding reform
- Provides direction and allocates resources to enable reform readiness
- Leverages internal expertise
- Disseminates important information to key employees and constituents

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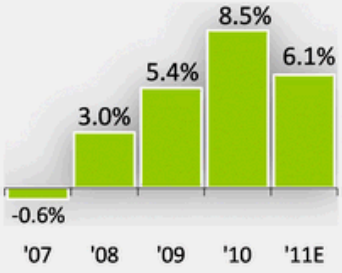
Near and long-term catalysts

Change in Medicaid Enrollment
FY 2007-2011E
Annual Growth Rate



Kaiser Commission on Medicaid and the Uninsured Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends; September 2010

Before Reform Opportunities

- State budgets under pressure leading to MCO RFP activity
- ABD expansion; more states are evaluating transitioning this population to managed care
- Technology requirements (ICD-10) generating Fiscal Agent RFP activity
- State interest in new demonstration programs
  - Primary Care + Behavioral
  - Fiscal Agent + Care Management
- Greater consolidation expected due to benefits of scale

Health Care Reform Opportunities

- 16 million more eligible for Medicaid by 2019
- 30 million more individuals covered by Medicaid-like Exchanges
- Growth in populations that are harder to manage
- Increasing demand for long-term care and behavioral health care services

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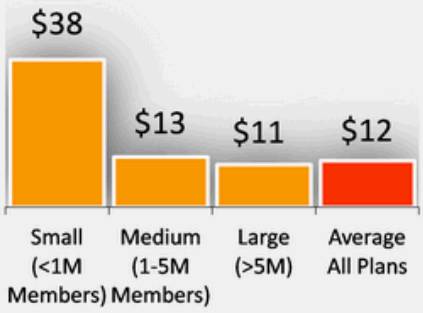
Benefits of scale

Over the next three years, health insurance plans are required to upgrade their systems for diagnosis, procedure coding and claims processing to the International Classification of Diseases – ICD-10.

Per-Member Estimated Cost of ICD-10 Implementation
by size of company



Source: America's Health Insurance Plans, Center for Policy and Research. September 2010

Department of Health and Human Services will require U.S. payers and providers to fully transition to ICD-10 by 10/2013

- ICD-10 implementation will result in incremental information technology spend
- Capital requirements will significantly burden small health plans with limited access to capital
- ICD-10 represents a revenue opportunity for Fiscal Agent business partially mitigating costs on the MCO side
- May result in greater consolidation as smaller plans cannot absorb costs

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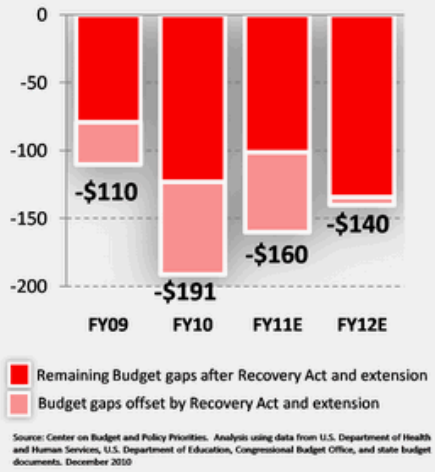
Why managed care is a viable solution

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

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



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

States will look for Medicaid health plans to provide budget certainty, cost savings, and flexible financing mechanisms.

- Utah: Transition from cost plus contract to full risk in late 2009
- Ohio: Switched from pre-payment of its premium, to mid-month payments in which premium is earned
- California: Delayed premium payments or issued State IOUs until budget was finalized (100 days late)

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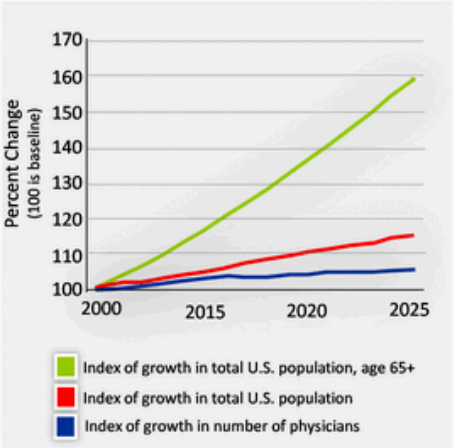
Molina Direct Delivery

The growing and aging U.S. population foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is estimated to worsen the shortfall by 25%. The shortfall will be most acutely felt among already underserved populations.



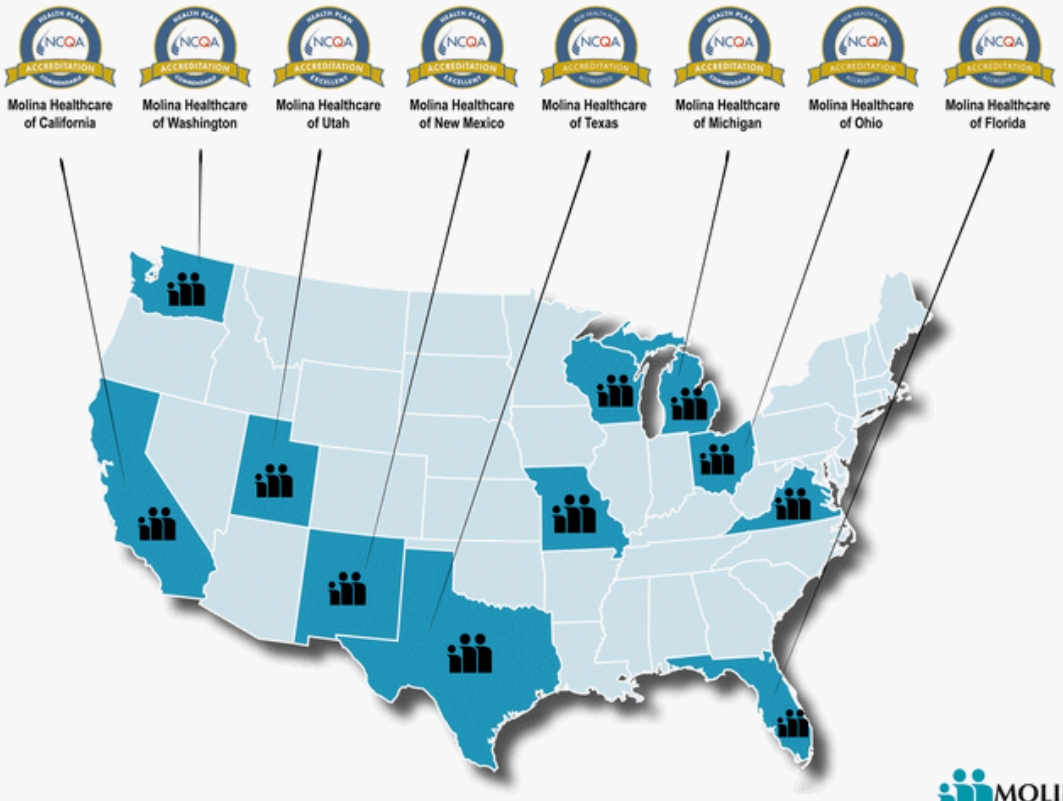
Sources: Associate of American Medical Colleges, "The Physician Shortage and Health Care Reform" https://www.aamc.org/download/70308/data/physicianshortagefs.pdf

- Approximately 20% of California health plan membership now being served by plan's primary care clinics
- Increasing capacity to accommodate ABD growth in California and Washington
- Increased access to primary care through collocation with behavioral health provider
- Expansion in direct delivery provides a vehicle for capturing increases in reimbursement

Our clinics allow us to respond to the physician shortage.

MOLINA HEALTHCARE

Quality and value

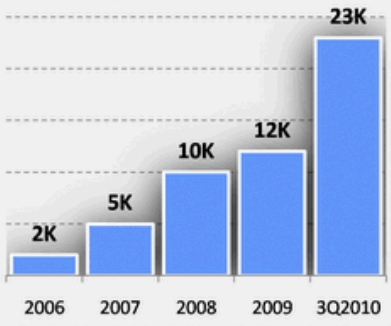


MOLINA HEALTHCARE

Refocusing of Medicare

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

Change in Medicare Enrollment
2006-YTD 3Q2010



Source: Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles" fact sheet, December 2010. http://www.kff.org/medicaid/upload/4091-07.pdf

- Duals account for approximately 15% of Medicaid enrollees but contribute to 39% of all Medicaid spending
- Medicaid/Medicare spending averages $20K per dual per year, 5X greater than other Medicare beneficiaries
- Dual population will highly benefit from managed care

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The future of health plan RFPs

The Request for Proposal (RFP) is a common tool employed by State Medicaid agencies for selecting health plans. Although a robust RFP pipeline is expected ahead of health care reform, States will have to consider other contracting methods.

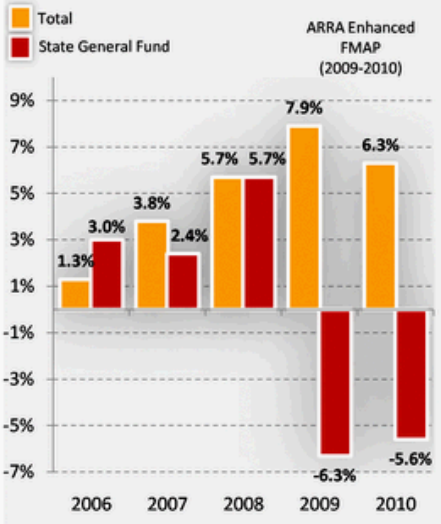
- States determine pricing; not the bidders
- Health plan RFPs are becoming increasingly costly for States to administer
- Separate processes for similar populations and programs across different geographies is not cost-effective
- Separate contracts may lead to selective participation
- Limiting the number of health plans reduces competition

MOLINA HEALTHCARE

Response to changes in FMAP

Enhanced FMAP funding to states was extended for 6 months and is set to expire on June 30, 2011 if Congress does not act to extend it.

Total & State Funds
Medicaid Annual Spending Growth
2006-2010



SOURCE: FY 2011 estimated by HMA. 2009 and 2010 from: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz. Caryn Marks and Molly O'Malley, "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," The Kaiser Commission on Medicaid and the Uninsured, September 2009. http://www.kff.org/medicaid/7985.cfm

An end to ARRA FMAP in July is estimated to increase States' non-federal share of Medicaid expenditures by over 30%.

- Possible state responses include changes in:
  - Eligibility
  - Provider Rates
  - Benefits
  - Utilization Controls
  - Cost Sharing
  - Use of managed care (expansion)

MOLINA HEALTHCARE

Investment highlights

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

MOLINA HEALTHCARE

Panel 1 Q&A

MOLINA HEALTHCARE

New York, New York
January 26, 2011

Health Plan Update

Terry P. Bayer
Chief Operating Officer

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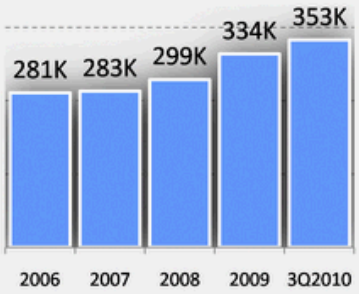
Washington health plan

Molina Healthcare of Washington
Historical and YTD Enrollment
2006-YTD 3Q2010



Molina Healthcare of Washington
Historical and YTD Enrollment
2006-YTD 3Q2010

Note: MCR for Q3 2010 is YTD.

- Utilization management efforts
- Second clinic launched
- Request for proposal postponed

MOLINA HEALTHCARE

Michigan health plan

Molina Healthcare of Michigan
Historical and YTD Medical Care Ratio
2006- YTD 3Q2010

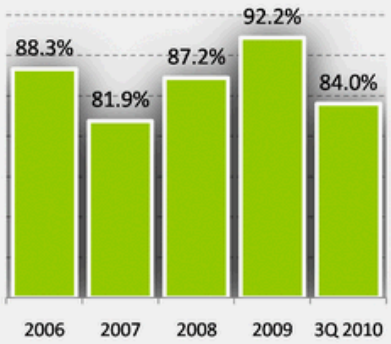
Note: MCR for Q3 2010 is YTD.

- Utilization management efforts in Medicaid and Medicare lines of business
- Solid performance despite challenging State revenues

MOLINA HEALTHCARE

California health plan

Molina Healthcare of California
Historical and YTD Medical Care Ratio
2006-YTD 3Q 2010



Note: MCR for Q3 2010 is YTD.

- 2010 significant performance improvement
- State of California preliminary Budget for FY 2011/2012 includes:
  - 3.9% increase in the base Medi-Cal managed care budget
  - 10% Medi-Cal provider rate cut
  - Cost sharing ($5 office visit/$50 ER)
- 1115 Waiver requires ABD (called SPD in California) mandatory enrollment in managed care effective 6/1/11

MOLINA HEALTHCARE

California 1115 Waiver expands ABD program

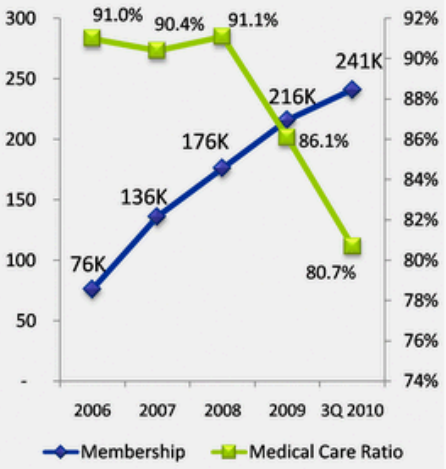
$10 billion Medicaid expansion plan to help California improve its health insurance program was approved.

- Improved Care for vulnerable populations: **enrollment of Seniors and Persons with Disability (SPD) in Medicaid managed care**
- 380K new eligibles in California
  - 260K new eligibles in Molina markets
  - 12K additional enrolled with Molina by year end 2011

MOLINA HEALTHCARE

Ohio health plan

Molina Healthcare of Ohio
Historical and YTD Medical Care Ratio and Enrollment
2006-YTD3Q 2010



Note: MCR for Q3 2010 is YTD.

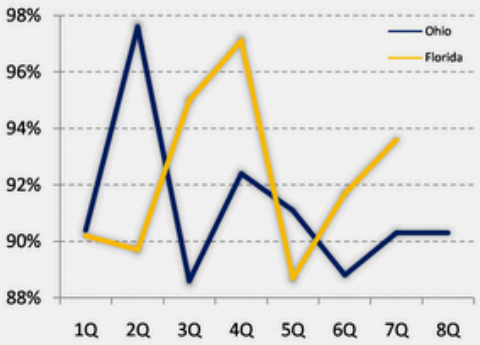
- Enrollment growing and medical costs managed
- 1/1/11 Rate Increase - of 4.5% ABD and CFC
- State managed care population expansions not anticipated before 2012
- New Governor/Administration

MOLINA HEALTHCARE

Florida health plan

Molina Healthcare of Florida began its initial enrollment of Medicaid members in January of 2009 as part of a contract award by the Florida Agency for Health Care Administration (AHCA).

Ohio and Florida Medical Care Ratios by Quarter
During First Two Years of Operations



During the first several quarters after initial market entry, medical care ratios generally exhibit a high degree of fluctuation and remain elevated due to smaller populations and lack of provider familiarity with the heath plan.

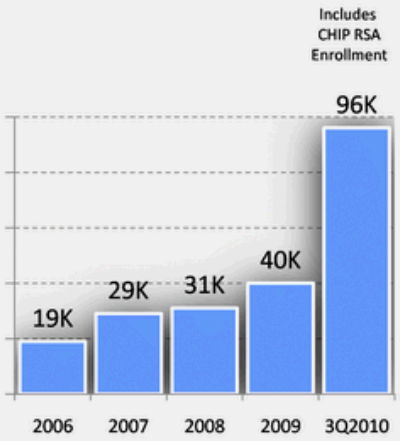
- Low enrollment (57K)
- Applying initiatives similar to California and Ohio
- Medical cost management initiatives
  - Pharmacy
  - Provider network re-contracting
  - Behavioral health

MOLINA HEALTHCARE

Texas health plan

The additional scale offered by the expansion of our CHIP and STAR+PLUS programs in the state will contribute to greater administrative efficiency and enhanced provider contracting.

Molina Healthcare of Texas
Historical and YTD Enrollment
2006-YTD 3Q2010



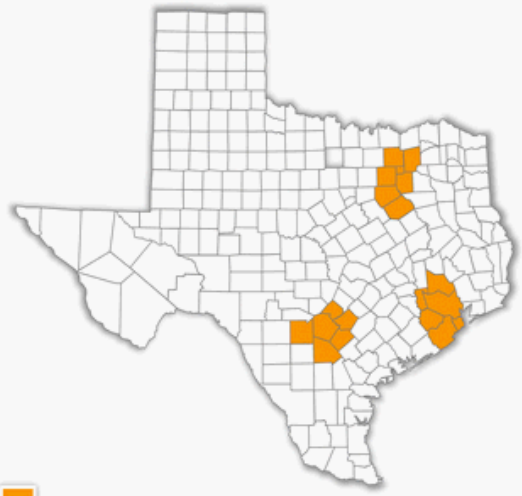
- CHIP Rural Service Area contract began September 1, 2010
- STAR+PLUS contract award in the Dallas Service Area
  - Contract effective February 2011
  - Competitor exit in that service area

MOLINA HEALTHCARE

Texas opportunity review

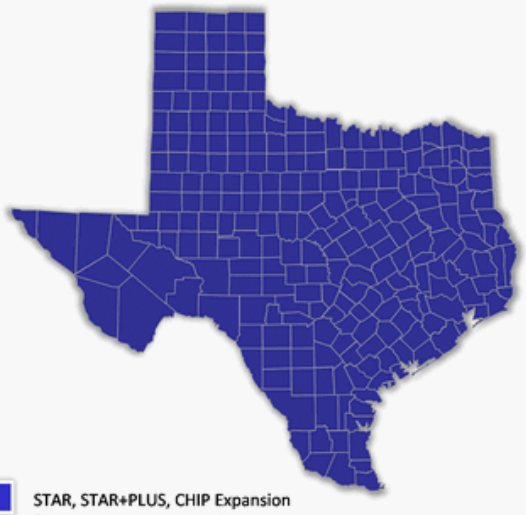
State of Texas will implement a re-procurement and expansion of its STAR (TANF) and STAR+PLUS (ABD) Medicaid programs covering 3.2 million lives.

MOLINA
STAR and STAR+PLUS Footprint



Molina STAR, STAR+PLUS Footprint

STAR, STAR+PLUS & CHIP
Expansion & Re-procurement 2011-2012



STAR, STAR+PLUS, CHIP Expansion & re-procurement counties.

Re-procurement markets: 2.2 million lives + Expansion markets: 1.0 million lives

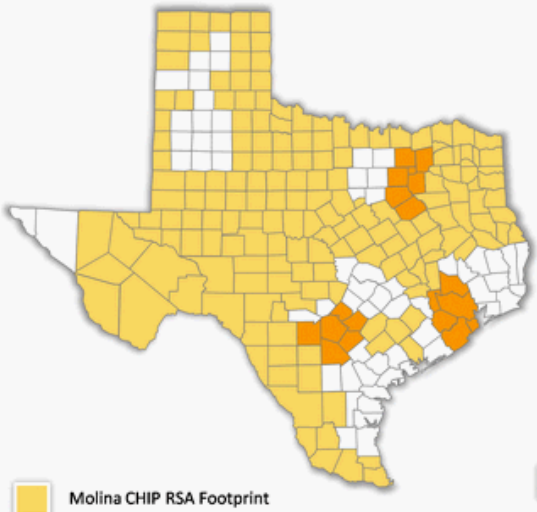
Source: Texas Health and Human Services Commission
http://www.hhsc.state.tx.us/medicaid/MMC-Contiguous-Counties.pdf

MOLINA HEALTHCARE

Texas opportunity overview

Through our current STAR, STAR+PLUS and CHIP RSA contracts, we have a strong network in place to build from to accommodate the STAR and STAR+PLUS expansion.

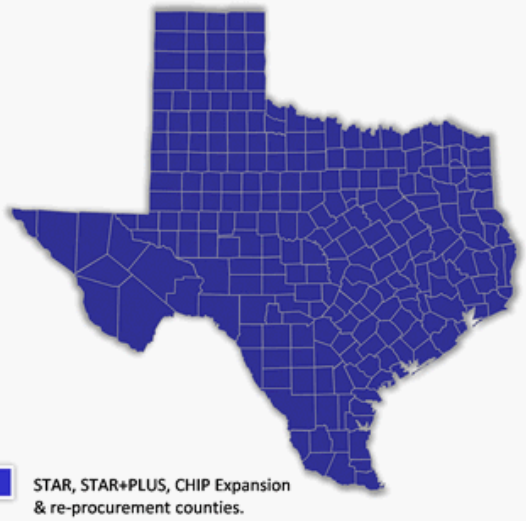
Molina STAR, STAR+PLUS, and CHIP RSA Footprint



Molina CHIP RSA Footprint

Molina STAR, STAR+PLUS Footprint

STAR, STAR+PLUS & CHIP Expansion & Re-procurement 2011-2012



STAR, STAR+PLUS, CHIP Expansion & re-procurement counties.

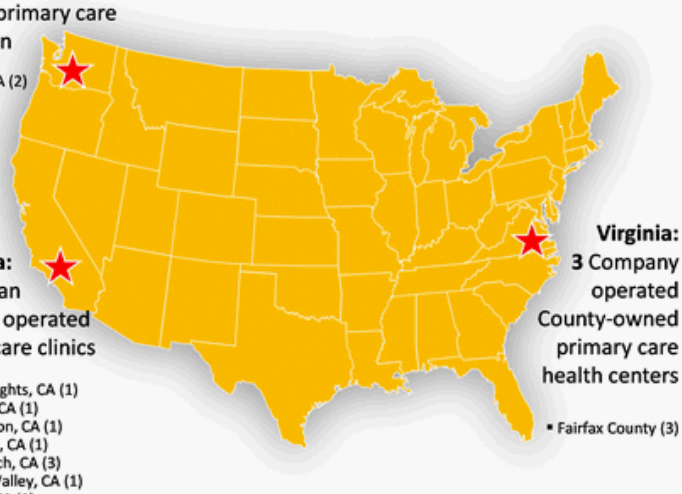
MOLINA HEALTHCARE

Direct Delivery

Our approach to direct delivery is flexible and can accommodate changes in local market requirements and needs. We currently operate 21 clinics.

Washington: mental health & primary care integration

- Everett, WA (2)



California: Health plan owned & operated primary care clinics

- Citrus Heights, CA (1)
- Fontana, CA (1)
- Wilmington, CA (1)
- Lancaster, CA (1)
- Long Beach, CA (3)
- Moreno Valley, CA (1)
- Ontario, CA (1)
- Pomona, CA (2)
- Riverside, CA (1)
- San Bernardino, CA (1)
- Sacramento, CA (3)

Virginia: **3** Company operated County-owned primary care health centers

- Fairfax County (3)

MOLINA HEALTHCARE

New York, New York
January 26, 2011

Molina Medicaid Solutions

Norman Nichols
President, Molina Medicaid Solutions

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Molina Launches Molina Medicaid Solutions

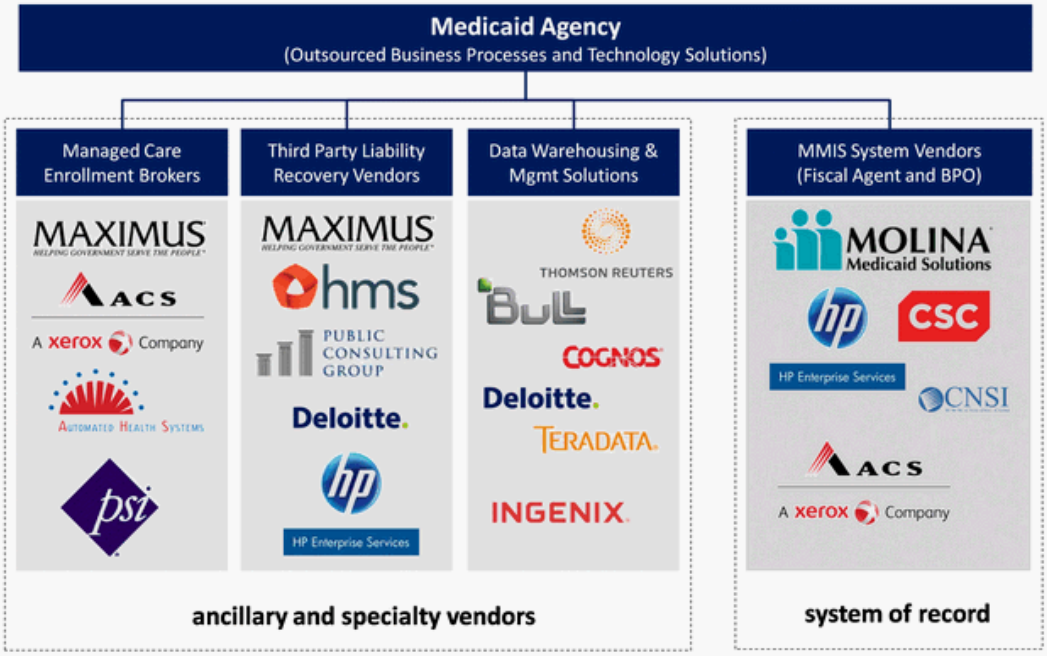
Molina Acquires Unisys Health Information Management Unit (HIM)
2010

- **$131 million purchase price**
- **Transaction closed on May 1, 2010**
- **Molina acquired:**
  - MMIS/Fiscal Agent contracts in ID, LA, ME, NJ, & WV
  - Pharmacy Rebate Management contract in Florida
  - Market leading QNXT-based Health Pas MMIS platform technology
  - ~1,000 HIM employees
- **Strategic acquisition which:**
  - Complements core business model of serving government programs
  - Expands services footprint of care management and managed care model with fiscal agent and IT services model
  - Expands Molina's overall Medicaid program market share

MOLINA HEALTHCARE

Medicaid systems & technology vendors

Medicaid business processes are supported by vendors and systems, which provide Medicaid system, specialty or operational services.



MOLINA HEALTHCARE

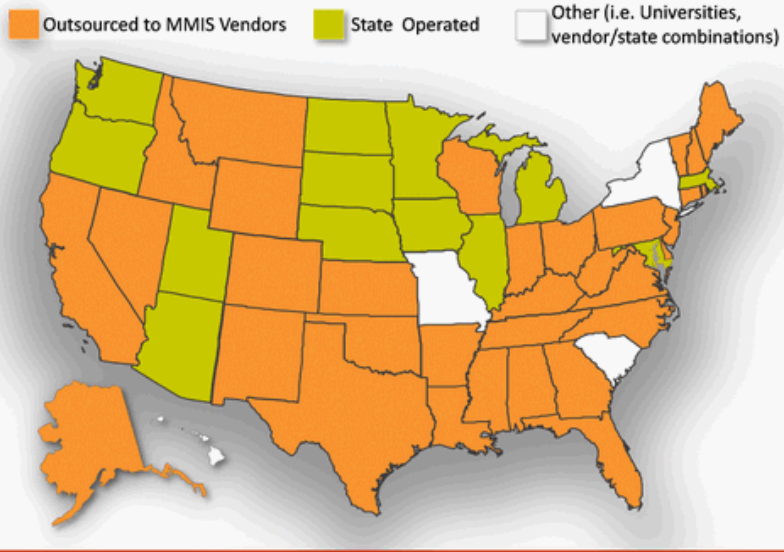
MMS operational – First 6 Months

Enterprise	Idaho	Maine	Louisiana	West Virginia
▪ Deleveraged Molina Healthcare, Inc. through follow-on equity offering ▪ Integrated personnel (~1,000) ▪ Identified new leadership ▪ Re-branded	▪ System went live on 6/2010 ▪ Supplemented with additional resources to support system implementation	▪ System went live on 9/2010	▪ Secured contract addendum to achieve 5010 compliance	▪ Secured three year extension through 3/2014 with 2 option years

MOLINA HEALTHCARE

MMIS market opportunity

MMIS has been around for more than 30 years and is one of the most expensive and complex system for states to maintain, enhance or replace.



$1.5 – 2BN spent annually with future spending focused on upgrading to 5010 and ICD-10 compliance/MITA compliance

Fiscal Agent Contract Re-Competes [1]

Year	State
2011	Rhode Island Vermont Alabama Oklahoma Alaska West Virginia[2]
2012	New York Delaware Kentucky Nevada
2013	New Mexico Florida Kansas New Jersey[2]
2014	DC Virginia Indiana Montana Louisiana[2]
2015	Connecticut Pennsylvania Colorado Oregon Washington
2016	Iowa Wyoming

Next 2 years $1.2B

Notes:
1. Expiration dates include optional extension years.
2. Contracts currently held by Molina Medicaid Solutions.

Source: Centers for Medicare and Medicaid Services. MMIS Fiscal Agent Contract Status Report May 21, 2010.

MOLINA HEALTHCARE

Molina: General new market entry criteria

Molina Healthcare Plans	Molina Medicaid Solutions
Larger states	Smaller states
Mandatory managed care	Favorable system architecture
Competitive provider environment	System replacement with no "takeovers"
Favorable regulatory environment	Metrics complement systems with favorable risk factors
Strategic and tactical acquisitions	Future revenue opportunities

MOLINA HEALTHCARE

Differentiation through strong systems solution

Health Pas

Definitions:
- COTS – Commercial-off-the-shelf
- MITA – Medicaid Information Technology Architecture

- **Integration of COTS products**
  - Products can be stand-alone or used together as needed
  - Products can be bolted on to existing legacy systems to enhance functionality
- **MITA-aligned**
- **Unified database**
  - Immediate access to all data
  - Eliminate non-integrated data storage stovepipes
- **Configurable components**
  - Quick adaptability to policy changes with no programming
- **Rules-based engine**
  - Written in understandable language
  - User configurable settings

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Revenue opportunities

2010 Medicaid regulatory requirements

5010 Level 1 Compliance	ICD 10	e-Prescribing integration with MMIS
New Fraud and Abuse Reporting Requirements	Health Information Exchange & Electronic Health Record	Patient Protection and Affordable Care Act (PPACA)

MOLINA HEALTHCARE

Revenue opportunities

Fiscal agent and health plan synergies

Care Management:

Quality based offering which improves patient compliance and clinical outcomes

- **Care Coordination**
  - Welcome call to patient, health risk screening and identify desired outcome of patient
- **iClinical Telephone Services for ER**
  - Intake notification for ER/UC for visits, admissions and interventions
- **PAY4Performance**
  - Enhanced payment to medical community for improved metric outcomes - immunizations, HA1C or asthma protocols

Benefit Cost Containment:

Offerings which enable Medicaid to lower benefit cost without impacting provision of quality care

- **Length of Hospital Stays (LOS) deploying InterQual**
  - Assignment of LOS for hospital stays utilizing InterQual criteria by RNs
  - MD-to-MD conferences for additional LOS consideration
- **Rx Management**
  - Prior authorization and improved medication utilization by RNs and PDs
  - Drug interchange, dosage selection and utilization reviews

MOLINA HEALTHCARE

Strategic fit of fiscal agent & health plan business

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

MOLINA HEALTHCARE

Panel 2 Q&A

MOLINA HEALTHCARE

New York, New York
January 26, 2011

Minimum MCR Requirements

Joseph White, CPA
Chief Accounting Officer

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Minimum MLR Requirements

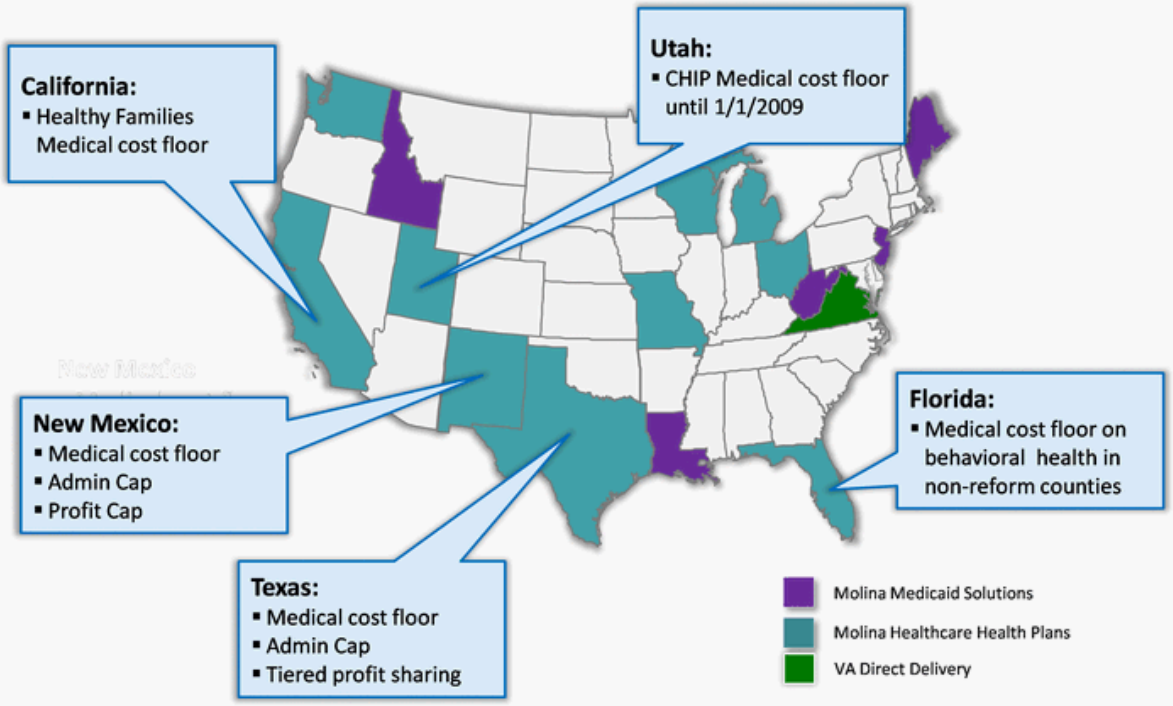
Section 2718 of the Public Health Services Act (as added by section 1001(5) of the Patient Protection and Affordable Care Act (ACA), is entitled, "Bringing Down the Cost of Health Care Coverage."

- **Requirement of Interim Financial Regulation (45 CFR Part 158):**
  - Individual and small group market minimum 80% MLR
  - Large group market minimum 85% MLR
  - **Excludes Medicaid Companies**
- **Effective :**
  - January 1, 2011
- **Action:**
  - Rebates to all enrollees if MLR does not meet minimum requirement
- **Implementation:**
  - Based on NAIC model regulation
  - Calendar year reporting
  - Three year average beginning with 2013
  - Credibility adjustment
  - Reporting based on State-of-Issue
  - States can require higher ratios

MOLINA HEALTHCARE

Contract provisions

Molina experience with expense and profit contract provisions and regulations



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How does ACA calculate an MLR?

The Denominator

- **Premiums Earned are increased by:**
  - Federal and State Taxes
  - Premium taxes
  - Regulatory authority licenses and fees
  - Subsidies received from Federal and State high risk pools
  - Revenue earned from the assumption of business from another entity
  - Adjustments for experience rating refunds

- **Premiums Earned are decreased by:**
  - Premiums refunded to members for wellness programs
  - Assessments paid to Federal and State high risk pools

MOLINA HEALTHCARE

How does ACA calculate an MLR?

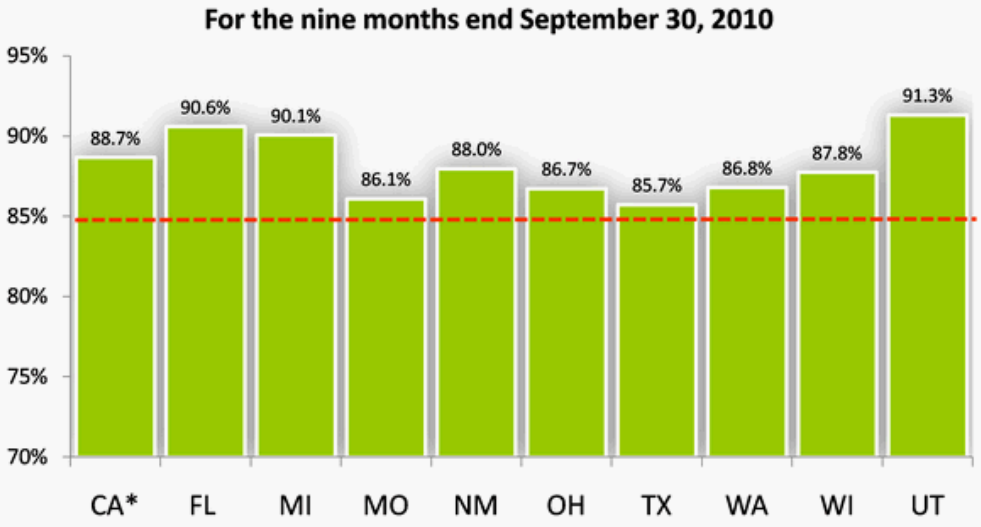
The Numerator:

- **Paid Claims (adjusted for IBNP) are reduced by:**
  - RX rebates
  - Claims-over payments recovered
- **Paid Claims (adjusted for IBNP) are increased by:**
  - Cost of Fraud and Abuse prevention – to the extent it lowers medical costs
  - Provider bonuses and incentives
  - State stop-loss, market stabilization and claim/census based assessments
  - **Cost of activities that improve health care quality**
  - **Cost of health information technology required to support quality efforts**
- **Paid Claims (adjusted for IBNP) must exclude:**
  - **Amounts paid for secondary network savings**
  - **Amounts paid for network development and administration**
  - Rebates paid to members under ACA

MOLINA HEALTHCARE

Estimated Molina MLRs Based on ACA Standards

As of September 30, 2010 all Molina health plans had MLRs in excess of 85% based on the Company's interpretation of ACA standards.



Estimated MLRs based on the Company's interpretation of ACA MLR regulations as of January 26, 2011, and subject to limitations in the Company's existing reporting systems and procedures with respect to MLR calculation methodologies.

MOLINA HEALTHCARE

New York, New York
January 26, 2011

2011 & 2012 Outlook

John C. Molina
Chief Financial Officer

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Cautionary Statement

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This slide presentation contains numerous "forward-looking statements" regarding the Company's expected results for fiscal years 2011 and 2012. All of our forward-looking statements are based on our current expectations and assumptions, including, but not limited to, the assumptions stated in the slide presentation. Actual results could differ materially due to the unexpected failure of one or more of our assumptions, or due to adverse developments related to numerous risk factors, including but not limited to the following:

- significant budgetary pressures on state governments and their potential inability to fully fund Medicaid or CHIP in 2011 or 2012, to maintain the currently agreed-upon payment rates to our health plans, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate, the effect of various implementing regulations, and uncertainties regarding the likely impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with upcoming state requests for proposals (RFPs) in both existing and new states, and our ability to grow our revenues consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid enrollees;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- the continuation and renewal of the government contracts of our health plans and of Molina Medicaid Solutions and the terms on which such contracts are renewed;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions;
- additional administrative costs and the potential payment of additional amounts to providers as a result of MMIS system issues in Idaho;
- government audits and reviews, including the audit of our Medicare plans by CMS;
- 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;
- 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 resolution of litigation or arbitration matters;
- restrictions and covenants in our credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;
- 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;

and numerous other risk factors, including those discussed in our periodic reports and filings with the Securities and Exchange Commission. These reports can be accessed under the investor relations tab of our Company website or on the SEC's website at www.sec.gov. Given these risks and uncertainties, we can give no assurances that our forward-looking statements will prove to be accurate, or that any other results or events projected or contemplated by our forward-looking statements will in fact occur, and we caution investors not to place undue reliance on these statements. All forward-looking statements in this slide presentation represent our judgment as of January 26, 2011, and we disclaim any obligation to update any forward-looking statements to conform the statement to actual results or changes in our expectations.

MOLINA HEALTHCARE

2011 Guidance Issued

Please refer to the Company's cautionary statement.

	2011G
Premium Revenue	$4.5B
Service Revenue	$170M
Investment Income	$7.5M
Medical Care Costs	$3.8B
Medical Care Ratio	84.8%
Service Costs	$145M
Service Revenue Ratio	84.3%
G&A Expense	$390M
G&A Ratio	8.4%
Premium Tax Expense	$145M
Depreciation	$34M
Amortization	$20M
Interest Expense	$15M
Income Before Tax	$110M
Income Tax	$41.8M
Net Income	$68.2M
Diluted EPS	$2.20
Weighted Average Diluted Shares Outstanding	31.0M
EBITDA	$210M
Effective Tax Rate	38%

Note: "G" denote guidance. Amounts are estimates and subject to change. Actual results may differ materially. See cautionary statement.

MOLINA HEALTHCARE

Key assumptions for 2011 Guidance

Please refer to the Company's cautionary statement.

- **Revenue**
  - Membership increases (TX and CA ABD) are main driver
  - Minimal rate increases
  - MMS ME & ID Certification
  - Flat investment rates
- **Medical Costs**
  - Typical Flu Season
  - Medicare Cost Improvements
  - FL, WI Cost Improvements
- **Administrative Costs**
  - MMS ME & ID Stabilization

MOLINA HEALTHCARE

What's not included in 2011 Guidance

Please refer to the Company's cautionary statement.

Not included in 2011 Guidance

- **Rate decreases except for Wisconsin**
- Acquisitions
- Managed Care RFPs
- Increase in interest rates greater than 25 bps
- Potential Tax Benefits from new incentives
- **Rate decreases due to State Budget shortfalls**

MOLINA HEALTHCARE

2009 – 2011G* Rate Changes

Please refer to the Company's cautionary statement.

Health Plan	2009	2010	2011G*
California	3.0%	6.0%	5.0% (1)
Florida	3.0%	2.0%	0.0%
Michigan	2.0% (PREV 4.0%)(2)	1.5%	0.0%
Missouri	4.0%	(1.0%)	0.0%
New Mexico	(7.0%)(3)	(6.0%)(3)	0.0%
Ohio	4.0%	5.0%	4.5%
Texas	0.0%	(1.0%)	0.0%
Utah (Medicaid only)	n/a	7.0%	0.0%
Washington	(1.0%)/(3.7%)/(7.0%)(4)	2.5%	0.0%
Wisconsin	n/a	n/a	(11.0%)

Note: * "G" denotes 2011 guidance. All numbers are approximate .
We can give no assurances that these estimated rate adjustments will be obtained and we caution investors not to place undue reliance on these estimates.

(1) The 2011 rate increase in California represents an increase effective 1/1/11 and anticipated increases effective 10/1/11.
(2) In Michigan, the 2009 4.0% rate increase was retroactively reduced to an effective rate of 2.0% during 2010.
(3) The 2009 rate change in New Mexico is a blending of rate decreases effective 7/1/09 , 10/1/09, and 12/1/09. The 2010 rate change in New Mexico is a blending of rate decreases effective 7/1/10 and 11/1/10.
(4) The 2009 rate changes in Washington reflect Healthy Options rates decreases effective 1/1/09, 2/1/09 and 8/1/09.

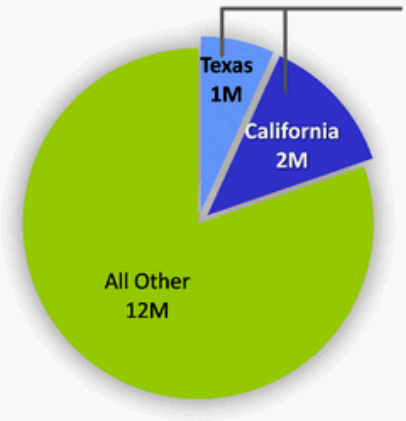
MOLINA HEALTHCARE

Guidance includes expansion in existing markets

Solidifying footprint in States with largest Medicaid markets

Please refer to the Company's cautionary statement.

14.7M Elderly and Disabled Medicaid Enrollees Nationally*



California and Texas account for **20%** of all Elderly and Disabled Medicaid Enrollees*

California:	**12,000 New ABD Lives by 12/31/11**
Texas:	**25,000 new ABD lives effective 2/1/11**

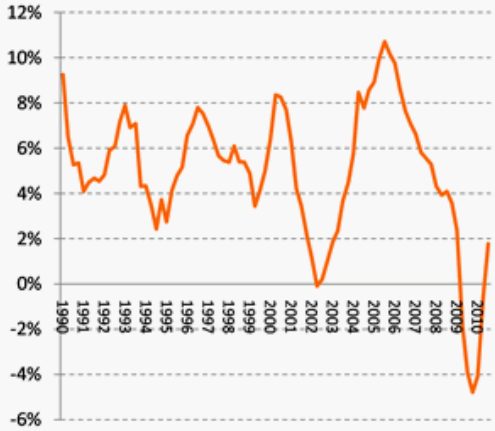
Source: *Kaiser Health Facts: Distribution of Medicaid Enrollees by Enrollment Group, FY2007.

MOLINA HEALTHCARE

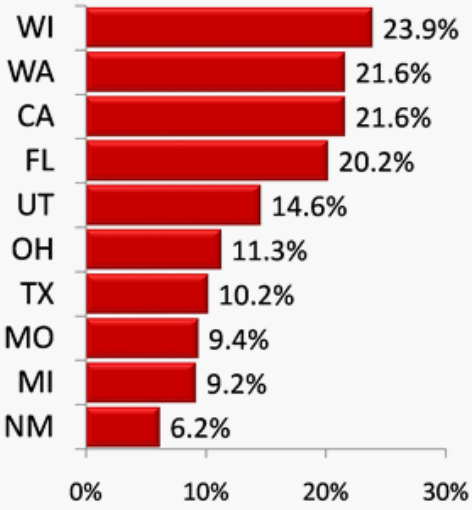
States Under Pressure

Guidance does not include rate decreases except in Wisconsin. State budgets remain under pressure. States in which Molina health plans participate are expected to fall short of their budgets for FY2011.

Change in State tax revenues*



Total Gap as % of FY11 Budget** Molina States



Source: * National Totals of State and Local Tax Revenue, Annual data, US Census Bureau, 9/30/2010
** SFY2011 Budget Shortfall www.statehealthfacts.org

MOLINA HEALTHCARE

Seasonality of Earnings

Please refer to the Company's cautionary statement.

Historical*

2011 Guidance

- New populations
- MMS Stabilization Costs
- ID & ME Certification and revenue recognition

Note: "Historical" denotes the allocation of earnings from 2003-2010

MOLINA HEALTHCARE

2011 MOH Segment Guidance

Please refer to the Company's cautionary statement.

	MMS	Health Plans	Total
Premium Revenue	-	$4.5B	$4.5B
Service Revenue	$170M	-	$170M
Investment Income	-	$7.5M	$7.5M
Medical Care Costs	-	$3.8B	$3.8B
Service Costs	$145M	-	$145M
G&A Expense	$10M	$380M	$390M
Premium Tax Expense	-	$145M	$145M
Depreciation	-	$34M	$34M
Amortization	$5M	$15M	$20M
Interest Expense	-	$15M	$15M
Income Before Tax	$10M	$100M	$110M
Income Tax	$3.8M	$38.0M	$41.8M
Net Income	$6.2M	$62.0M	$68.2M
Diluted EPS	$0.20	$2.00	$2.20
Weighted Average Diluted Shares Outstanding	31.0M	31.0M	31.0M
EBITDA	$46M	$164M	$210M

Note: Amounts are estimates and subject to change. Actual results may differ materially. See cautionary statement.

MOLINA HEALTHCARE

Opportunities in New and Existing States after 2011

Please refer to the Company's cautionary statement.





	AZ[1]	TX	GA	FL	IL
Total covered population	1.3M	3.4M	1.8M	3.2M	2.6M
Population up for bid	27K	3.2M	1.5M	1.6M	1.8M
Effective Date	10/11	3/12	7/12	> 2012	>2012
MOH Expected Membership Prior to Expansion[(2)]	-	125K	-	72K	-
MOH Expected Additional Membership	**3K**	**220K**	**140K**	**n/a**	**n/a**
Total Expected MOH Membership	3K	345K	140K	n/a	n/a
MOH Expected Market Penetration	< 1%	10%	8%	n/a	n/a
MOH Expected Incremental Annualized Revenue	**$136M**	**$663M**	**$355M**	**unknown**	**unknown**

1. Incremental lives as a result of the re-procurement of ALTCS program (Acute + Long Term Services).
2. Denotes estimated membership at 12/31/11, included in 2011 guidance. Amounts are estimates and subject to change.

MOLINA HEALTHCARE

Looking to 2012…

Please refer to the Company's cautionary statement.

- **Revenue will grow substantially:**
  - ABD expansions carried over from 2011 – CA and TX
    - Anticipated 20,000 additional CA ABD members 1/1/2012
  - Managed care expansions in existing markets– TX, FL
  - New States – GA, AZ
  - Small increase in rates on invested assets can dramatically help the bottom line
  - **State budgets will remain a concern**
  - **We will need to retain current business (WA Health Plan RFP and LA MMS RFP)**

- **Higher revenue will drive increases in EBITDA**
  - Increased revenue should contribute to increased dollar medical margin even if MCR increases
  - Higher revenue provides an opportunity for more administrative cost leverage
  - Long DDI lead times mean that new MMS States will have little impact on revenue or profitability through 2012

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What could go wrong with 2012 guidance?

Please refer to the Company's cautionary statement.

- 2011 projections not achieved
- Lose existing contracts
- State rate cuts
- Don't win RFPs
- Acute flu season
- Other identified risk factors

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Where are we going in 2012?

Please refer to the Company's cautionary statement.

	2011G	2012G
Total Revenue	$4.7B	$5.0B-$6.0B
Medical Care Ratio	84.8%	85.0%-85.5%
G&A Ratio	8.4%	7.8%-8.3%
EBITDA	$210M	$230M-$280M
EBITDA %	4.5%	4.5%

Note: "G" denotes guidance. Amounts are estimates and subject to change.

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Q&A

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