

MOLINA HEALTHCARE INC

Form 10-K

March 08, 2011

Table of Contents

**SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549**

Form 10-K

(Mark One)

- þ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010**
- or**
- o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934**

Commission File Number 1-31719

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

Delaware
*(State or other jurisdiction of
incorporation or organization)*

13-4204626
*(I.R.S. Employer
Identification No.)*

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

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

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, \$0.001 Par Value	New York Stock Exchange
Securities registered pursuant to Section 12(g) of the Act:	
None	

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐ Yes ☒ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☒ No

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☐ Yes ☒ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

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

Large accelerated filer ☐ Accelerated filer ☒ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

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

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2010, the last business day of our most recently completed second fiscal quarter, was approximately \$324 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2010).

As of March 2, 2011, approximately 30,523,000 shares of the registrant's Common Stock, \$0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2010 Annual Meeting of Stockholders to be held on April 27, 2011, are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

Table of Contents
Form 10-K

	Page
<u>PART I</u>	
<u>Item 1.</u> <u>Business</u>	1
<u>Item 1A.</u> <u>Risk Factors</u>	13
<u>Item 1B.</u> <u>Unresolved Staff Comments</u>	32
<u>Item 2.</u> <u>Properties</u>	32
<u>Item 3.</u> <u>Legal Proceedings</u>	32
<u>Item 4.</u> <u>Reserved</u>	32
<u>PART II</u>	
<u>Item 5.</u> <u>Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities</u>	33
<u>Item 6.</u> <u>Selected Financial Data</u>	36
<u>Item 7.</u> <u>Management's Discussion and Analysis of Financial Condition and Results of Operations</u>	38
<u>Item 7A.</u> <u>Quantitative and Qualitative Disclosures About Market Risk</u>	66
<u>Item 8.</u> <u>Financial Statements and Supplementary Data</u>	67
<u>Item 9.</u> <u>Changes in and Disagreements with Accountants on Accounting and Financial Disclosure</u>	114
<u>Item 9A.</u> <u>Controls and Procedures</u>	114
<u>Item 9B.</u> <u>Other Information</u>	114
<u>PART III</u>	
<u>Item 10.</u> <u>Directors, Executive Officers and Corporate Governance</u>	116
<u>Item 11.</u> <u>Executive Compensation</u>	116
<u>Item 12.</u> <u>Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters</u>	116
<u>Item 13.</u> <u>Certain Relationships and Related Transactions, and Director Independence</u>	117
<u>Item 14.</u> <u>Principal Accountant Fees and Services</u>	117
<u>PART IV</u>	
<u>Item 15.</u> <u>Exhibits and Financial Statement Schedules</u>	118
<u>Signatures</u>	119
<u>EX-10.27</u>	
<u>EX-12.1</u>	
<u>EX-21.1</u>	
<u>EX-23.1</u>	
<u>EX-31.1</u>	
<u>EX-31.2</u>	
<u>EX-32.1</u>	
<u>EX-32.2</u>	

Table of Contents

PART I

Item 1: *Business*

Overview

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 business focuses exclusively on government-sponsored health care programs, and includes our Health Plans segment, our Molina Medicaid Solutionssm segment, and our smaller direct delivery line of business. Our Health Plans segment consists of licensed health maintenance organizations serving Medicaid populations in ten states. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. Our direct delivery line of business consists of 16 primary care community clinics in California and two primary care community clinics in Washington, and we also manage three county-owned primary care community clinics under a contract with Fairfax County, Virginia. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today we remain a provider-focused company led by his son, Dr. J. Mario Molina.

Our Health Plans segment operates Medicaid managed care plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin that serve a total of approximately 1.6 million members. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our Health Plans segment derives its revenue principally in the form of premiums paid under Medicaid contracts with the states in which our health plans operate. While the health plans receive fixed per-member per-month, or PMPM, premium payments from the states, the health plans are at risk for the medical costs associated with their members' health care. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements which limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS, a core information technology tool used to support the administration of state Medicaid and other health care entitlement programs. Our Molina Medicaid Solutions segment currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in May 2010 to expand our product offerings to include support of state Medicaid agency administrative needs; to reduce the variability in our earnings resulting from fluctuations in medical care costs; to improve our operating profit margin percentages; and to improve our cash flow by adding a business for which there are no restrictions on dividend payments.

From a strategic perspective, we believe our two business segments and our direct delivery business line allow us to participate in an expanding sector of the economy and continue our mission of serving low-income families and individuals eligible for government-sponsored health care programs. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

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Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is www.molinahealthcare.com.

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to Molina Healthcare, the Company, we, our, and herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge on our website, www.molinahealthcare.com, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, Corporate Governance and Nominating Committee, and Compliance Committee Charters, are also available on our website. Such information is also available in print upon the request

Table of Contents

of any stockholder to our Investor Relations department at the address of our executive offices set forth above. In accordance with New York Stock Exchange, or NYSE, rules, on June 2, 2010, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Molina Healthcare, the Molina Healthcare logo, Molina Medicaid Solutionssm, motherhood matters!sm, breathe with ease!sm, and Healthy Living with Diabetessm are registered servicemarks of Molina Healthcare, Inc.

Our Industry

The Medicaid and CHIP Programs. The Medicaid program is a federal entitlement program administered by the states. Medicaid provides health care and long-term care services and support to low-income Americans. Subject to federal rules, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states prior to FY 2009 was 57 percent, but ranged from a federally established FMAP floor at 50 percent to as high as 76 percent. With the passage of the American Recovery and Reinvestment Act, or ARRA, stimulus package in 2009, FMAP rates for all states increased by a minimum of 6.2 percentage points between October 1, 2009 and December 31, 2010, plus an additional increase adjusted quarterly based on the state's unemployment rate. Congress has extended through June 2011 the increased FMAP, but at a reduced rate from the previous ARRA enhancement.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced "TAN-if"). Another common state-administered Medicaid program is for the aged, blind or disabled, or ABD, Medicaid members. In addition, the Children's Health Insurance Program, or CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.

As a result of recently enacted health care reform legislation, the Patient Protection and Affordable Care Act, the Medicaid and CHIP population is expected to grow from approximately 60 million people today to approximately 82 million people by 2019. Over that same period, total Medicaid and CHIP expenditures are expected to grow from approximately \$427 billion to approximately \$896 billion.

Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a

fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. The federal government typically reimburses the states for 90% of the costs incurred in the

Table of Contents

design, development, and implementation of an MMIS and for 50% of the costs incurred in operating an MMIS. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we now actively participate in this market.

In certain instances, states have elected to provide medical benefits to individuals and families who are not served by Medicaid. In New Mexico and Washington, our health plan segment participates in programs that are administered in a manner similar to Medicaid and CHIP, but without federal matching funds.

Medicare Advantage Plans. During 2010, each of our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, and Washington operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name, Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name, Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operate a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans at December 31, 2010 was approximately 24,500 members. Our 2010 premium revenues from Medicare across all health plans represented approximately 6.6% of our total premium revenues.

Overall, approximately 82% of our members are TANF, 9% are CHIP, 8% are ABD, and 1% are Medicare.

Our Strengths

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. Additionally, we support state Medicaid agencies by providing them with comprehensive solutions to their MMIS development and operating needs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, and cost management through our Health Plans segment, to state-level MMIS administration through our Molina Medicaid Solutions segment, to the direct delivery of health care services at our clinics. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. Our Molina Medicaid Solutions platform is based upon commercial off-the-shelf technology, or COTS. As a result, we believe that our Molina Medicaid Solutions platform has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our health plan segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The successful acquisition of our New Mexico, Missouri, and Wisconsin health plans demonstrated our ability to expand into new states. The establishment of our health plans in Utah, Ohio, Texas,

and Florida reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Table of Contents

Recognition for Quality of Care. The National Committee for Quality Assurance, or NCQA, has accredited eight of our ten Medicaid managed care plans. Our Missouri health plan is currently seeking NCQA accreditation, and our recently acquired Wisconsin plan will be seeking NCQA accreditation in the future. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our Company in 1980 to serve the Medicaid population in Southern California through a small network of primary care clinics, we have increased our membership to 1.6 million members, expanded our Health Plans segment to ten states, and added our Molina Medicaid Solutions segment. Our experience over the last 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Our Strategy

Our objective is to provide a comprehensive suite of Medicaid-related services to meet the health care needs of low-income families and individuals and the state Medicaid agencies that serve them. To achieve our objective, we intend to:

Continue to expand within existing markets. We plan to continue our growth in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, extending our services to new populations (including the aged, blind, or disabled), maintaining positive provider relationships, and integrating members from other health plans.

Continue to enter new strategic markets. We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. For example, on September 1, 2010, we acquired for approximately \$15.5 million Abri Health Plan, a provider of Medicaid managed care services in Wisconsin. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size and, where practicable, mandated Medicaid managed care enrollment.

Continue to provide quality cost-effective care. We plan to use our strong provider networks and the knowledge gained through the operation of our clinics to further develop and utilize effective medical management and other coordinated programs that address the distinct needs of our members and improve the quality and cost-effectiveness of their care.

Leverage operational efficiencies. We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost.

Deliver administrative value to state Medicaid agencies. As Medicaid expenditures increase, we believe that an increasing number of states will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. For example, we can apply analytics to improve the functionality of care management processes. We believe that we can help strengthen these tools in ways that translate into both better care and cost containment. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs.

Open additional primary care clinics. During 2010, we became more diversified and more efficient by expanding our involvement in the direct delivery of primary care. The community clinic model offers an integrated approach that helps us improve both the quality and cost-effectiveness of the care our members receive. In 2010 we opened two clinics in Washington so that we can serve our members' needs for primary and behavioral health services in one place. We also expanded the capacity of our existing clinics in California in anticipation of increases in the numbers of ABD members in our plans. Approximately 20% of our California health plan's membership is now being served by the health plan's 16 primary care clinics. The growth and aging of the population of the United States foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to

Table of Contents

worsen this shortage. We believe the shortage will be felt most acutely among already underserved populations, such as the low income families and individuals we serve. We therefore intend to expand on the direct delivery component of our business by developing additional community care clinics at certain of our health plans during 2011. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging this capability selectively we can improve access for our plan members in areas that are most underserved by primary care providers.

Pursue opportunities presented by ICD-10 conversion requirements. Over the next three years, health insurance plans are required to upgrade their systems for diagnosis, medical procedure coding, and claims processing under the tenth revisions of the International Statistical Classification of Diseases, or ICD-10. The United States Department of Health and Human Services will require payers and providers to transition to ICD-10 by October 2013. For many smaller health plans with less than one million members, the costs of making the necessary systems upgrades will be substantial. For companies like ours, the benefits of scale in this environment will be significant. We believe we will be positioned to reduce the cost per member for compliance with ICD-10. At the same time, the new requirements will create revenue opportunities for Molina Medicaid Solutions.

Prepare for health care reform. In preparation for the large scale changes associated with federal health care reform, we have organized a dedicated business unit to address issues of strategy, policy, reform readiness, and implementation. Health care reform opportunities include an estimated 16 million more members eligible for Medicaid by 2019, 30 million more individuals covered by health insurance exchanges, and increasing demand for long-term care and behavioral health services. In the next three years, we anticipate that many states will be offering new Medicaid RFP expansions in order to avoid disruptions in 2014 in connection with the full implementation of health care reform. For instance, several states are currently evaluating transitioning their ABD populations into managed care. Pursuant to a Section 1115 waiver expansion in California, we will be enrolling new ABD members in California by year end 2011.

Medicaid Contracts

With the exception of our Missouri health plan, which does not serve ABD or Medicare members, and our Wisconsin health plan, which does not serve Medicare members, all of our health plans serve TANF, CHIP, ABD, and Medicare members. For its Medicare members, each health plan enters into a one-year annually renewable contract with the Centers for Medicare and Medicaid Services, or CMS. For its other members, each health plan enters into a contract with the state's Medicaid agency. The contractual relationship with the state is generally for a period of one- to two-years and renewable on an annual or biannual basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

Our contracts with the state determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and disenrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring

by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

We are usually paid a negotiated PMPM amount, with the PMPM amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also

Table of Contents

paid an additional amount for each newborn delivery from the Medicaid programs in all of our state health plans, except with respect to our New Mexico health plan.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations, or IPAs. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California health plan operates 16 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a non-licensed subsidiary in Virginia which manages three health care clinics for Fairfax County, and our Washington health plan operates two Company-owned primary care clinics.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach

both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*sm is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*sm is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*sm is a diabetes

Table of Contents

disease management program. *Heart Health Living* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

Provider Self Services. Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/Submit Authorizations.

Member Self Services. Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/PCP.

File Exchange Services. Various trading partners such as service partners, providers, vendors, management companies, and individual IPAs are able to exchange data files (such as those that may be required by the

Health Insurance Portability and Accountability Act of 1996, or HIPAA, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness Data and Information Set, or HEDIS, and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Eight of our ten health plans are accredited by the NCQA.

Table of Contents

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 3.4 system), with the exception of our newly acquired Wisconsin plan which we expect will be migrated to the Molina standard platform in January 2012.

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan's ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

Multi-Product Managed Care Organizations National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.

Medicaid HMOs National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.

Prepaid Health Plans Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.

Primary Care Case Management Programs Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network,

the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, or CSC, and CNSI.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules can occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and

Table of Contents

rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organization, including those operating in the Medicaid and Medicare programs.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC, and are administered by the states. Our Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin health plans are subject to RBC requirements. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established in 1965 under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state governments jointly fund it, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states award contracts to any applicant demonstrating that it meets the state's requirements. Other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the

specific needs of the Medicaid population. For example:

We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;

Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;

We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;

We must be able to meet the needs of the disabled and others with special needs;

Table of Contents

Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and

Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services, or CMS. Medicare beneficiaries have the option to enroll in a Medicare Advantage plan. Under Medicare Advantage, managed care plans contract with CMS to provide benefits that are comparable to original Medicare in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, made numerous changes to the Medicare program, including expanding the Medicare program to include a prescription drug benefit. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan. Plans are not required to offer the same benefits, but are required to provide coverage that is at least actuarially equivalent to the standard drug coverage delineated in the MMA.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, or MIPPA, became law and, in September 2008, CMS promulgated implementing regulations. MIPPA impacts a broad range of Medicare activities and impacts all types of Medicare managed care plans. MIPPA and subsequent CMS guidance place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. MIPPA also establishes certain restrictions on agent and broker compensation.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,

Afford privacy to patient health information, and

Protect the privacy of patient health information through physical and electronic security measures.

The Patient Protection and Affordable Care Act of 2010, or ACA, created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal

background checks for higher risk providers. On September 23, 2010, CMS issued proposed regulations designed to implement these requirements. It is not clear at this time the degree to which managed care providers would have to comply with these new requirements, many of which resemble procedures that we already have in place.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. The U.S. Department of Health and Human Services, as required by the HITECH Act, has issued interim final rules that set forth the breach notification obligations applicable to covered entities and their business associates (the HHS Breach Notification Rule). The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are

Table of Contents

in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as fraud and abuse laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as *qui tam* actions, can be brought by any individual on behalf of the government and such individuals (known as relators or, more commonly, as whistleblowers) may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Action of 2005 (DRA) encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2010, we had approximately 4,200 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Executive Officers of the Registrant

J. Mario Molina, M.D., 52, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 46, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 30 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He was recently named to the Los

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Angeles branch of the Federal Reserve Bank of San Francisco's board of directors. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Terry P. Bayer, 60, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has 26 years of health