CROWN CASTLE INTERNATIONAL CORP
Form SC 13G/A
February 14, 2013

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

SCHEDULE 13G

Under the Securities Exchange Act of 1934
(Amendment No. 2)*

Crown Castle International Corp.
(Name of Issuer)

COMMON STOCK
(Title of Class of Securities)

228227104
(CUSIP Number)

December 31, 2012
(Date of Event which Requires Filing of this Statement)

Check the appropriate box to designate the rule pursuant to which this Schedule is filed:

¨ Rule 13d-1(b)

x Rule 13d-1(c)

¨ Rule 13d-1(d)

* The remainder of this cover page shall be filled out for a reporting person's initial filing on this form with respect to the subject class of securities, and for any subsequent amendment containing information which would alter disclosures provided in a prior cover page.

The information required on the remainder of this cover page shall not be deemed to be "filed" for the purpose of Section 18 of the Securities Exchange Act of 1934 ("Act") or otherwise subject to the liabilities of that section of the Act but shall be subject to all other provisions of the Act (however, see the Notes).

Persons who respond to the collection of information contained in this form are not required to respond unless the form displays a currently valid OMB control number.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

SPO Partners II, L.P.

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

Delaware

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 8,930,449(1)
	6.	Shared Voting Power 0
	7.	Sole Dispositive Power 8,930,449(1)
	8.	Shared Dispositive Power 0

9. Aggregate Amount Beneficially Owned by Each Reporting Person

8,930,449

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

3.1%

12. Type of Reporting Person (See Instructions)

(PN)

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(1) Power is exercised through its sole general partner, SPO Advisory Partners, L.P.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

SPO Advisory Partners, L.P.

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

Delaware

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 8,930,449(1)(2)
	6.	Shared Voting Power 0
	7.	Sole Dispositive Power 8,930,449(1)(2)
	8.	Shared Dispositive Power 0

9. Aggregate Amount Beneficially Owned by Each Reporting Person

8,930,449

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

3.1%

12. Type of Reporting Person (See Instructions)

(PN)

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(1) Solely in its capacity as the sole general partner of SPO Partners II, L.P.

(2) Power is exercised through its sole general partner, SPO Advisory Corp.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

San Francisco Partners, L.P.

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

California

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 357,800(1)
	6.	Shared Voting Power 0
	7.	Sole Dispositive Power 357,800(1)
	8.	Shared Dispositive Power 0

9. Aggregate Amount Beneficially Owned by Each Reporting Person

357,800

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

0.1%

12. Type of Reporting Person (See Instructions)

(PN)

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(1) Power is exercised through its sole general partner, SF Advisory Partners, L.P.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

SF Advisory Partners, L.P.

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

Delaware

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 357,800(1)(2)
	6.	Shared Voting Power 0
	7.	Sole Dispositive Power 357,800(1)(2)
	8.	Shared Dispositive Power 0

9. Aggregate Amount Beneficially Owned by Each Reporting Person

357,800

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

0.1%

12. Type of Reporting Person (See Instructions)

(PN)

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(1) Solely in its capacity as the sole general partner of San Francisco Partners, L.P.

(2) Power is exercised through its sole general partner, SPO Advisory Corp.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

SPO Advisory Corp.

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

Delaware

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 9,288,249(1)(2)
	6.	Shared Voting Power 0
	7.	Sole Dispositive Power 9,288,249(1)(2)
	8.	Shared Dispositive Power 0

9. Aggregate Amount Beneficially Owned by Each Reporting Person

9,288,249

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

3.2%

12. Type of Reporting Person (See Instructions)

(CO)

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(1) Solely in its capacity as the sole general partner of SPO Advisory Partners, L.P. with respect to 8,930,449 of such shares; and solely in its capacity as the sole general partner of SF Advisory Partners, L.P. with respect to 357,800 of such shares.

(2) Power is exercised through its two controlling persons, John H. Scully and Edward H. McDermott.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

John H. Scully

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

USA

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 503,777(1)
	6.	Shared Voting Power 9,519,049(2)
	7.	Sole Dispositive Power 503,777(1)
	8.	Shared Dispositive Power 9,519,049(2)

9. Aggregate Amount Beneficially Owned by Each Reporting Person

10,022,826

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

3.4%

12. Type of Reporting Person (See Instructions)

(IN)

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(1) Of these shares, 125,377 shares may be deemed to be beneficially owned by Mr. Scully solely in his capacity as the trustee for the John H. Scully Living Trust, dated 10/1/03; 82,200 shares are held in Mr. Scully's Individual Retirement Accounts, which are self-directed; and 296,200 shares may be deemed to be beneficially owned by Mr. Scully solely in his capacity as controlling person, sole director and executive officer of Phoebe Snow Foundation, Inc.

(2) Of these shares, 9,288,249 shares may be deemed to be beneficially owned by Mr. Scully solely in his capacity as one of two controlling persons of SPO Advisory Corp., and 230,800 shares may be

deemed to be beneficially owned by Mr. Scully solely in his capacity as the trustee for the John H. Scully Living Trust, dated 10/1/03 which is one of the general partners of Netcong Newton Partners, L.P.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

Edward H. McDermott

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

USA

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 11,100(1)
	6.	Shared Voting Power 9,288,249(2)
	7.	Sole Dispositive Power 11,100(1)
	8.	Shared Dispositive Power 9,288,249(2)

9. Aggregate Amount Beneficially Owned by Each Reporting Person

9,299,349

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

3.2%

12. Type of Reporting Person (See Instructions)

(IN)

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(1) Of these shares, 1,100 shares are held in Mr. McDermott's Individual Retirement Accounts, which are self-directed, and 10,000 shares are held in Mr. McDermott's individual account.

(2) These shares may be deemed to be beneficially owned by Mr. McDermott solely in his capacity as one of two controlling persons of SPO Advisory Corp.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

The John H. Scully Living Trust, dated 10/1/03

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

California

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 125,377(1)
	6.	Shared Voting Power 230,800(2)
	7.	Sole Dispositive Power 125,377(1)
	8.	Shared Dispositive Power 230,800(2)

9. Aggregate Amount Beneficially Owned by Each Reporting Person

356,177

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

0.1%

12. Type of Reporting Person (See Instructions)

(OO)

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(1) Power is exercised through its trustee, John H. Scully.

(2) These shares may be deemed to be beneficially owned by the John H. Scully Living Trust, dated 10/1/03 solely in its capacity as one of the general partners of Netcong Newton Partners, L.P.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

Phoebe Snow Foundation, Inc.

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

California

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 296,200(1)
	6.	Shared Voting Power 0
	7.	Sole Dispositive Power 296,200(1)
	8.	Shared Dispositive Power 0

9. Aggregate Amount Beneficially Owned by Each Reporting Person

296,200(1)

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

0.1%

12. Type of Reporting Person (See Instructions)

(CO)

(1) Power is exercised through its controlling person, sole director and executive officer, John H. Scully.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

Netcong Newton Partners, L.P.

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

California

Number of Shares Beneficially Owned by Each Reporting Person With:	5.	Sole Voting Power 230,800(1)
	6.	Shared Voting Power 0
	7.	Sole Dispositive Power 230,800(1)
	8.	Shared Dispositive Power 0

9. Aggregate Amount Beneficially Owned by Each Reporting Person

230,800

10. Check if the Aggregate Amount in Row (9) Excludes Certain Shares (See Instructions) ¨

11. Percent of Class Represented by Amount in Row (9)

**0.1%

12. Type of Reporting Person (See Instructions)

(PN)

** Denotes less than

(1) Power is exercised through one of its general partners, the John H. Scully Living Trust, dated 10/1/03.

CUSIP No. 228227104

1. Names of Reporting Persons.
I.R.S. Identification Nos. of above persons (entities only).

Eli J. Weinberg

2. Check the Appropriate Box if a Member of a Group (See Instructions)
(a) ¨ (b) x

3. SEC Use Only

4. Citizenship or Place of Organization

USA

Number of Shares Beneficially Owned by Each Reporting Person With:	5. Sole Voting Power	960
	6.	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; and
changes in general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2010, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management s Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2010.

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 comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development,

implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. We also have a direct delivery business that currently consists of 16 primary care community clinics in California and two primary care community clinics in Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of March 31, 2011. 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.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM. 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. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions 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 report our financial performance based on the following two reportable segments: Health Plans; and Molina Medicaid Solutions.

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First Quarter Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the three months ended March 31, 2011. Comparable metrics for the first quarter of 2010 are also shown. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended March 31,	
	2011	2010
	(Dollar amounts in thousands, except per-share data)	
Earnings per diluted share	$ 0.56	$ 0.41
Premium revenue	$ 1,081,438	$ 965,220
Service revenue	$ 36,674	$
Operating income	$ 31,300	$ 20,438
Net income	$ 17,388	$ 10,590
Total ending membership	1,647,000	1,482,000
Premium revenue	96.6%	99.8%
Service revenue	3.3	
Investment income	0.1	0.2
Total revenue	100.0%	100.0%
Medical care ratio	84.5%	85.3%
General and administrative expense ratio	8.4%	8.2%
Premium tax ratio	3.4%	3.6%
Operating income	2.8%	2.1%
Net income	1.6%	1.1%
Effective tax rate	37.2%	38.0%

Our first quarter of 2011 was marked by strong membership growth, flat PMPM revenue, and lower medical costs. Compared with the first quarter of 2010, earnings per share in the first quarter of 2011 were up 37%, premium revenues were up 12%, operating income was up 53%, and aggregate membership grew by 11%. Meanwhile, the aggregate medical care ratio of our health plans declined by 80 basis points. Our larger and more established health plans performed the strongest in the quarter, with each of California, Ohio, Utah, and Washington having lower medical care ratios compared with the first quarter of 2010. Our Florida and Wisconsin health plans continue to face challenges, which we are working to address. Medicare enrollment exceeded 24,000 members at March 31, 2011, and Medicare premium revenue for the quarter was $85.4 million compared with $50.3 million in the first quarter of 2010. With respect to our Molina Medicaid Solutions business, our system stabilization efforts in Idaho and Maine are taking longer and are more costly than we had anticipated. However, our profit margins in our fiscal agent contracts in New Jersey, Louisiana, and West Virginia remain stable.

We remain concerned about state budget deficits, which are not expected to improve during the remainder of 2011. Accordingly, the rate environment for our health plans remains uncertain. However, our Missouri health plan has received notification that it will receive a blended rate increase of approximately 5% effective July 1, 2011. On May 5, 2011, we learned that our responsive bid in Arizona in connection with the re-procurement of the ALTCS program (Acute + Long Term Care Services) was not successful. The Company is in the process of reviewing and evaluating the bid scores and may file a protest as warranted. We continue to await the results of Molina Medicaid Solutions

responsive bid in Louisiana to retain its MMIS contract in that state.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in Critical Accounting Policies below, is not generally subject to significant accounting estimates. For the three months ended March 31, 2011, we received approximately 94% of our premium revenue as a fixed per-member per-month, or PMPM, amount, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the three months ended March 31, 2011, we received approximately 6% of our premium revenue in the form of birth income a one-time payment for the delivery of a child from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children s Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the Temporary Assistance for Needy Families, or TANF, Medicaid population the Medicaid group that includes mostly mothers and children PMPM premiums range between approximately $100 in California to $230 in Missouri. Among our Medicaid Aged, Blind or Disabled, or ABD, membership, PMPM premiums range from approximately $320 in Utah to $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums, at nearly $1,200 PMPM.

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The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	March 31, 2011	December 31, 2010	March 31, 2010
Total Ending Membership by Health Plan:			
California	347,000	344,000	353,000
Florida	66,000	61,000	52,000
Michigan	225,000	227,000	226,000
Missouri	82,000	81,000	78,000
New Mexico	90,000	91,000	92,000
Ohio	248,000	245,000	228,000
Texas	128,000	94,000	40,000
Utah	80,000	79,000	75,000
Washington	341,000	355,000	338,000
Wisconsin(1)	40,000	36,000	
Total	1,647,000	1,613,000	1,482,000
Total Ending Membership by State for our Medicare Advantage Plans(1):			
California	5,300	4,900	2,700
Florida	600	500	300
Michigan	6,700	6,300	4,200
New Mexico	700	600	600
Ohio	400		
Texas	600	700	500
Utah	6,700	8,900	7,100
Washington	3,300	2,600	1,600
Total	24,300	24,500	17,000
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	14,100	13,900	13,400
Florida	10,300	10,000	8,900
Michigan	32,000	31,700	32,700
New Mexico	5,600	5,700	5,800
Ohio	28,200	28,200	26,700
Texas	51,200	19,000	18,100
Utah	8,200	8,000	7,900
Washington	4,300	4,000	3,500
Wisconsin(1)	1,700	1,700	
Total	155,600	122,200	117,000

(1) We acquired the Wisconsin health plan on September 1, 2010. As of March 31, 2011, the Wisconsin health plan had approximately 2,400 Medicare Advantage members that are ceded 100% under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

Molina Medicaid Solutions MMIS contracts extend over a number of years, and cover the life of the MMIS from inception through at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds. In some circumstances, revenue recognition may be delayed for long periods while we await formal customer acceptance of our products and/or services. In those circumstances, recognition of a portion of our costs may also be deferred.

Under our contracts in Louisiana, New Jersey, and West Virginia, we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue on a straight-line basis over the remaining term of the contract. In Maine, we completed the DDI phase of our contract effective September 1, 2010. In Idaho, we expect to complete the DDI phase of our contract during 2011. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in 2012.

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Additionally, Molina Medicaid Solutions provides pharmacy rebate administration services under a contract with the state of Florida.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

Fee-for-service Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.

Capitation Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.

Pharmacy Expenses for all drug, injectible, and immunization costs paid primarily through our pharmacy benefit manager.

Other Expenses for medically related administrative costs of approximately $24.4 million, and $19.6 million, for the three months ended March 31, 2011, and 2010, respectively, including certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See Critical Accounting Policies below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Louisiana, Maine, New Jersey, West Virginia, and Florida, as well as certain selling, general and administrative expenses. Additionally, certain indirect costs incurred under our contracts in Maine (prior to exiting the DDI phase of that contract in September, 2010) and Idaho are also expensed to cost of services.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contact costs in 2012, in a manner consistent with our anticipated recognition of revenue.

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Results of Operations

Three Months Ended March 31, 2011 Compared with the Three Months Ended March 31, 2010

Health Plans Segment

Premium Revenue

Premium revenue grew 12% in the three months ended March 31, 2011 compared with the three months ended March 31, 2010, due to a membership increase of 11%. Consolidated premium revenue increased by approximately 1% on a PMPM basis. Medicare enrollment exceeded 24,000 members at March 31, 2011, and Medicare premium revenue was $85.4 million for the three months ended March 31, 2011, compared with $50.3 million for the three months ended March 31, 2010.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended March 31,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 655,884	$ 133.78	71.8%	$ 566,879	$ 128.06	68.9%
Capitation	128,682	26.25	14.1	137,132	30.98	16.7
Pharmacy	91,576	18.68	10.0	90,071	20.35	10.9
Other	37,390	7.63	4.1	28,734	6.48	3.5
Total	$ 913,532	$ 186.34	100.0%	$ 822,816	$ 185.87	100.0%

The medical care ratio decreased to 84.5% in the three months ended March 31, 2011, compared with 85.3% for the three months ended March 31, 2010. Total medical care costs increased less than 1% PMPM, while medical care costs for our Medicaid membership decreased by approximately 2% PMPM.

Pharmacy costs (adjusted for the state s retention of the pharmacy benefit in Ohio effective February 1, 2010) increased approximately 5% PMPM.

Capitation costs decreased approximately 15% PMPM, primarily due to the transition of members in Michigan and Washington into fee-for-service networks.

Fee-for-service costs increased approximately 4% PMPM, partially due to the transition of members from capitated provider networks into fee-for-service networks. Fee-for-service and capitation costs combined increased less than 1% PMPM.

Hospital admissions per thousand members per year decreased approximately 7%.

Pharmacy utilization was essentially flat, with the increase in costs being driven by higher costs per prescription.

The medical care ratio of the California health plan decreased to 84.3% in the three months ended March 31, 2011, from 86.8% in the three months ended March 31, 2010, as higher premium revenue PMPM more than offset an increase of approximately 27% in pharmacy costs and an increase of approximately 5% in fee-for-service costs.

The medical care ratio of the Florida health plan increased to 96.6% in the three months ended March 31, 2011, from 88.7% in the three months ended March 31, 2010, primarily due to higher fee-for-service and capitation costs, which more than offset lower pharmacy costs. We have undertaken a number of measures focused on both utilization and unit cost reductions to improve the profitability of the Florida health plan. The Florida health plan s medical care ratio decreased from 100.2% in the fourth quarter of 2010.

The medical care ratio of the Michigan health plan increased to 81.2% in the three months ended March 31, 2011, from 80.8% in the three months ended March 31, 2010, as higher physician and outpatient facility fee-for-service costs and higher pharmacy costs more than offset lower capitation costs.

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The medical care ratio of the Missouri health plan increased to 93.6% in the three months ended March 31, 2011, from 83.5% in the three months ended March 31, 2010, due to higher fee-for-service costs.

The medical care ratio of the New Mexico health plan increased to 82.8% in the three months ended March 31, 2011, from 77.4% in the three months ended March 31, 2010, as lower fee-for-service costs failed to offset the impact of a premium rate decrease of approximately 8.5% PMPM.

The medical care ratio of the Ohio health plan decreased to 74.6% in the three months ended March 31, 2011, from 79.1% in the three months ended March 31, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011, and flat fee-for-service costs.

The medical care ratio of the Texas health plan increased to 91.1% in the three months ended March 31, 2011, from 82.5% in the three months ended March 31, 2010. Effective February 1, 2011, we added approximately 30,000 ABD Medicaid members in the Dallas-Fort Worth area, and effective September 1, 2010, we added approximately 54,000 members state-wide who are covered under CHIP.

The medical care ratio of the Utah health plan decreased to 79.3% in the three months ended March 31, 2011, from 105.0% in the three months ended March 31, 2010, primarily due to reduced fee-for-service costs in the outpatient facility and physician categories and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010. Lower fee-for-service costs were the result of both lower unit costs and lower utilization.

The medical care ratio of the Washington health plan decreased to 86.6% in the first quarter of 2011 from 90.3% in the three months ended March 31, 2010. Lower capitation costs more than offset higher fee-for-service and higher pharmacy costs. Pharmacy costs for the Washington health plan s Medicaid members grew approximately 22% PMPM.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 118.1% in the three months ended March 31, 2011. The Wisconsin health plan recorded a premium deficiency reserve of $3.35 million in the first quarter of 2011. Absent that premium deficiency reserve, the Wisconsin health plan s medical care ratio would have been approximately 98% for the three months ended March 31, 2011.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended March 31, 2011						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,041	$ 134,976	$ 129.63	$ 113,737	$ 109.24	84.3%	$ 1,902
Florida	192	49,222	256.63	47,568	248.01	96.6	17
Michigan	678	164,760	243.06	133,728	197.28	81.2	9,846
Missouri	245	55,166	225.33	51,608	210.79	93.6	
New Mexico	271	84,606	311.93	70,038	258.21	82.8	1,965
Ohio	737	230,340	312.68	171,752	233.15	74.6	17,775
Texas	349	80,811	231.49	73,615	210.88	91.1	1,340
Utah	236	67,935	287.77	53,839	228.06	79.3	
Washington	1,034	195,272	188.81	169,116	163.52	86.6	3,642
Wisconsin(2)	120	16,417	137.25	19,380	162.02	118.1	
Other(3)		1,933		9,151			63
	4,903	$ 1,081,438	$ 220.58	$ 913,532	$ 186.34	84.5%	$ 36,550

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	Three Months Ended March 31, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,062	$ 123,910	$ 116.67	$ 107,561	$ 101.28	86.8%	$ 1,628
Florida	154	39,088	253.45	34,687	224.91	88.7	6
Michigan	675	155,345	230.13	125,449	185.85	80.8	9,939
Missouri	234	52,143	223.01	43,516	186.11	83.5	
New Mexico	280	95,598	341.02	74,015	264.03	77.4	2,004
Ohio	673	218,363	324.35	172,625	256.41	79.1	17,005
Texas	121	39,200	324.08	32,331	267.29	82.5	681
Utah	221	58,540	265.51	61,460	278.76	105.0	
Washington	1,007	181,054	179.84	163,510	162.42	90.3	3,262
Wisconsin(2)							
Other(3)		1,979		7,662			21
	4,427	$ 965,220	$ 218.04	$ 822,816	$ 185.87	85.3%	$ 34,546

(1) A member month is defined as the aggregate of each month s ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) Other medical care costs also include medically related administrative costs at the parent company.

Days in Medical Claims and Benefits Payable

The days in medical claims and benefits payable were as follows:

	March 31, 2011	Dec. 31, 2010	March 31, 2010
Days in claims payable fee-for-service only	41 days	42 days	44 days
Number of claims in inventory at end of period	185,300	143,600	153,700
Billed charges of claims in inventory at end of period (in thousands)	$ 250,600	$ 218,900	$ 194,000

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment for the three months ended March 31, 2011 was as follows:

	(In thousands)
Service revenue before amortization	$ 38,860
Less: amortization of contract backlog recorded as contra-service revenue	(2,186)
Service revenue	36,674
Cost of service revenue	31,221
General and administrative costs	2,477
Amortization of customer relationship intangibles recorded as amortization	1,282
Operating income	$ 1,694

Consolidated Expenses

General and Administrative Expenses

General and administrative, or G&A, expenses, were $94.4 million, or 8.4% of total revenue, for the three months ended March 31, 2011 compared with $78.9 million, or 8.2% of total revenue, for the three months ended March 31, 2010.

Premium Tax Expense

Premium tax expense decreased to 3.4% of premium revenue in the three months ended March 31, 2011 from 3.6% in the three months ended March 31, 2010.

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Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in Depreciation and Amortization in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading Depreciation and Amortization;
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of Service Revenue; and
- Depreciation is recorded within the heading Cost of Service Revenue.

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue, and reconciles that amount to the consolidated statements of cash flows.

	Three Months Ended March 31,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Depreciation	$ 7,401	0.7%	$ 6,412	0.7%
Amortization of intangible assets	5,266	0.4	3,649	0.3
Depreciation and amortization reported in the consolidated statements of income	12,667	1.1	10,061	1.0
Amortization recorded as reduction of service revenue	2,186	0.2		
Depreciation recorded as cost of service revenue	3,241	0.3		
Depreciation and amortization reported in the consolidated statements of cash flows	$ 18,094	1.6%	$ 10,061	1.0%

Interest Expense

Interest expense increased to $3.6 million for the three months ended March 31, 2011, from $3.4 million for the three months ended March 31, 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $1.3 million and $1.2 million for the three months ended March 31, 2011, and 2010, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 37.2% for the three months ended March 31, 2011 compared with 38.0% for the three months ended March 31, 2010. The lower rate in 2011 was primarily due to lower state income taxes.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

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Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our premium revenue or our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of March 31, 2011, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased slightly to $1.6 million for the three months ended March 31, 2011, compared with $1.5 million for the three months ended March 31, 2010.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect to incur significant losses due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our unregulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the three months ended March 31, 2011 was $84.1 million compared with $26.2 million used in operating activities for the three months ended March 31, 2010, an increase of $110.3 million. The change is primarily attributable to the advance premium payment made in March 2011 by the state of Ohio to our Ohio health plan in the amount of $72.7 million. Deferred revenue, which was a use of operating cash totaling $90.7 million in three months ended March 31, 2010, was a source of operating cash totaling $84.2 million in the three months ended March 31, 2011. The change in deferred revenue was offset by changes in other current assets and liabilities.

Reconciliation of Non-GAAP(1) to GAAP Financial Measures

EBITDA(2)

	Three Months Ended March 31,	
	2011	**2010**
	(In thousands)	
Operating income	$ 31,300	$ 20,438
Add back:		
Depreciation and amortization reported in the consolidated statements of cash flows	18,094	10,061
EBITDA	$ 49,394	$ 30,499

(1) GAAP stands for U.S. generally accepted accounting principles.

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

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Capital Resources

At March 31, 2011, the parent company Molina Healthcare, Inc. held cash and investments of approximately $25.6 million, compared with approximately $65.1 million of cash and investments at December 31, 2010. This decline was primarily due to capital contributions and/or advances to our Florida, Texas, and Wisconsin health plans in the first quarter of 2011.

On a consolidated basis, at March 31, 2011, we had working capital of $399.6 million compared with $392.4 million at December 31, 2010. At March 31, 2011, we had cash and investments of $870.8 million, compared with approximately $813.8 million of cash and investments at December 31, 2010.

We believe that our cash and credit resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the Credit Facility) for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As of March 31, 2011, and December 31, 2010, there was no outstanding principal debt balance under the Credit Facility. However, as of March 31, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the contract of MMS with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At March 31, 2011, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio under the Credit Facility is required to be no less than 3.00x.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.50 to 1.0 for the first and second quarters of 2010 and through August 14, 2010 (on a pro forma basis). Effective as of August 15, 2010, the maximum consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering. As a result of the offering described below, we may now offer up to $182.5 million of our securities from time to time under the shelf registration statement.

In August 2010, we sold 4,350,000 shares of common stock covered by this registration statement. The public offering price for this sale was $25.65 per share, net of the underwriting discount. Our proceeds from the sales totaled approximately $111.1 million, net of the issuance costs. We used the proceeds from these sales to repay the Credit Facility and for general corporate purposes. Also in August 2010, the Molina Siblings Trust, as a selling stockholder,

sold 250,000 shares of outstanding common stock covered by this registration statement.

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Convertible Senior Notes

As of March 31, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the Notes) remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $432.4 million at March 31, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At March 31, 2011, our health plans had aggregate statutory capital and surplus of approximately $441.6 million, compared to the required minimum aggregate statutory capital and surplus of approximately $274.1 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2011. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2011.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;
- The deferral of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

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Revenue Recognition Health Plans Segment

Certain components of premium revenue of our Health Plans segment are subject to accounting estimates, and are therefore subject to retroactive revision. Chief among these are:

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At March 31, 2011, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At March 31, 2011, we had recorded a liability of $7.0 million under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

New Mexico Health Plan At-Risk Premium Revenue: Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan s revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. For the state fiscal year ending June 30, 2011 (the only contract year currently open for determination of at-risk premium revenue), our New Mexico health plan has received $1.9 million in at-risk revenue as of March 31, 2011. To date, we have recognized $0.9 million of that amount as revenue, and recorded a liability of approximately $1.0 million as of March 31, 2011, for the remainder. If the state of New Mexico disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

Ohio Health Plan At-Risk Premium Revenue: Under our contract with the state of Ohio, up to 1% of our Ohio health plan s revenue may be refundable to the state if certain performance measures are not met. Effective February 1, 2010 an additional 0.25% of the Ohio health plan s revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Ohio s fiscal year ends June 30, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending June 30, 2011, our Ohio health plan has received $8.5 million in at-risk revenue as of March 31, 2011. To date, we have recognized $4.7 million of that amount as revenue and recorded a liability of approximately $3.8 million as of March 31, 2011, for the remainder. If the state of Ohio disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required. For example, during the third quarter of 2010, we reversed the recognition of approximately $3.3 million of at-risk revenue of which $1.9 million and $1.4 million were initially recognized in 2010, and 2009, respectively.

Utah Health Plan Premium Revenue: Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to

fee-for-service Medicaid during the period 2003 through August 31, 2009. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million.

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Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. On April 19, 2011, the Director of the Utah Department of Health issued a Final Agency Order in an administrative proceeding initiated by our Utah health plan relating to the proper interpretation of the savings sharing language in the parties state fiscal year 2006 contract. Pursuant to that Order, the Department adopted the administrative law judge s finding that the Utah health plan s interpretation of the contract was correct and that the savings sharing amount due to the Utah health plan should be calculated under the health plan s interpretation. The parties are in the process of calculating the net amounts due to the health plan for fiscal year 2006 and for all other years covered by the savings sharing language.

The final resolution of this matter, and the amount that may be realized by the Utah health plan, is currently uncertain and contingent upon future events. When additional information is known or agreement is reached with the state regarding the appropriate savings sharing payment amount, we will recognize that amount of savings sharing revenue, if any, in our financial statements. No receivables for saving sharing revenue have been established at March 31, 2011.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas there is a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of March 31, 2011, we had an aggregate liability of approximately $0.1 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2010 and 2011 contract years (ending August 31st of each year). Because the final settlement calculations include a claims run-out period of nearly one year, an adjustment to the amounts owed may be required.

Texas Health Plan At-Risk Premium Revenue: Under our contract with the state of Texas, up to 1% of our Texas health plan s revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures established by the state. The time period for the assessment of these performance measures had previously followed the state s fiscal year, but effective January 1, 2011, it follows the calendar year. As of March 31, 2011, our Texas health plan has received $0.6 million in at-risk revenue, none of which has been recognized as revenue as of March 31, 2011. If the state of Texas disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

Medicare Premium Revenue: Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member s medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns, there is no liability related to the potential recoupment of Medicare premium revenue at March 31, 2011. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

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Deferral of Service Revenue and Cost of Service Revenue Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services, we also provide the state with the third contracted element training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solutions contracts are multiple-element arrangements. The following discussion applies to our contracts with multiple elements entered into prior to January 1, 2011, before our prospective adoption of *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) Multiple-Deliverable Revenue Arrangements*.

For those contracts entered into prior to January 1, 2011, we have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services, which vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our newer contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. Although the length of the DDI phase for any MMIS contract can vary considerably, the DDI phase typically takes about two years to complete. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services, or training and support services) until the contingency had been removed. In these circumstances, we would also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the contract (whether DDI, BPO services, or training and support services) on which revenue recognition is being deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

For all new or materially modified revenue arrangements with multiple elements entered into on or after January 1, 2011, which we expect will consist of contracts entered into by our Molina Medicaid Solutions segment, we will apply the guidance contained in ASU No. 2009-13. For these arrangements, we will allocate total arrangement consideration to the elements of the arrangement, which are expected to be DDI, BPO, and training and support, because this is consistent with the current elements included in our Molina Medicaid Solutions contracts. The arrangement allocation will be performed using the relative selling-price method. When determining the selling price of each element, we will first attempt to use VSOE if available. If VSOE is not available, we will attempt to use third-party evidence, or TPE, of vendors selling similar services to similarly situated customers on a standalone basis, if available. If neither VSOE nor TPE are available, we will use our best estimate of the selling price for each element. We will then evaluate whether, at each stage in the life cycle of the contract, we are able to recognize revenue associated with that element. To the extent that our revenue arrangements have provisions that allow our state customers to refuse acceptance of services performed, we will still be required to defer revenue recognition until such state customers accept our performance. Once this acceptance is achieved, we will immediately recognize the revenue associated with any delivered elements which differs from our current practice for arrangements entered into prior to

January 1, 2011, where the revenue associated with delivered elements is recognized over the final service element of the arrangement because VSOE for the other elements does not exist. As such, we expect that the adoption of ASU No. 2009-13 will result in an overall acceleration of revenue recognition with respect to any multiple-element arrangements entered into on or after January 1, 2011.

We began to recognize revenue and related deferred costs associated with our Maine contract in September 2010. In Idaho, we expect to begin recognition of deferred contact costs in 2012, in a manner consistent with our anticipated recognition of revenue. Molina Medicaid Solutions deferred revenue totaled $36.1 million at March 31, 2011, and $10.9 million at December 31, 2010, and unamortized deferred contract costs were $37.9 million at March 31, 2011, and $28.4 million at December 31, 2010.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the long-lived asset is written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the long-lived asset to zero, any remaining deferred contract costs are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets and deferred contract costs exceed the fair value of those assets.

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Medical Claims and Benefits Payable Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	March 31, 2011	Dec. 31, 2010
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 273,378	$ 275,259
Capitation payable	43,738	49,598
Pharmacy	16,953	14,649
Other	17,313	14,850
	$ 351,382	$ 354,356

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are Incurred But Not Paid, or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $273.4 million of our total medical claims and benefits payable of $351.4 million as of March 31, 2011. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider s monthly capitation payment), our IBNP liability at March 31, 2011, was $267.4 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

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The following table reflects the change in our estimate of claims liability as of March 31, 2011 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding March 31, 2011 by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 83,261
(4)%	55,507
(2)%	27,754
2%	(27,754)
4%	(55,507)
6%	(83,261)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of March 31, 2011 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (67,651)
(4)%	(45,101)
(2)%	(22,550)
2%	22,550
4%	45,101
6%	67,651

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 30.8 million diluted shares outstanding for the three months ended March 31, 2011. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at March 31, 2011, net income for the three months ended March 31, 2011 would increase or decrease by approximately $8.7 million, or $0.28 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at March 31, 2011, net income for the three months ended March 31, 2011 would increase or decrease by approximately $7.0 million, or $0.23 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $43.4 million, or $1.41 per diluted share, and $35.2 million, or $1.14 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same

direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $8.7 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the

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provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2010, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 15.7%.

As shown in greater detail in the table below, the amounts ultimately paid out on our prior period liabilities in fiscal years 2010 and through March 31, 2011, were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized a benefit from prior period claims development in the amount of $44.4 million for the three months ended March 31, 2011 (see table below). This amount represents our estimate as of March 31, 2011 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2010 was due primarily to the following factors:

- We overestimated the impact of an increase in pending high dollar claims at our Ohio health plan.
- We underestimated the lower cost associated with changes to provider fee schedules (primarily for outpatient facility costs) in New Mexico effective November 1, 2010.

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The following developments partially offset the overestimation of our claims liability at December 31, 2010:

- In Missouri, delays in claims processing late in the fourth quarter of 2010 led us to underestimate the size of our claims liability at December 31, 2010.
- We underestimated the costs associated with our assumption of risk for a new population in Texas (rural CHIP members) effective September 1, 2010.

We recognized a benefit from prior period claims development in the amount of $38.5 million, and $49.4 million for the three months ended March 31, 2010, and the year ended December 31, 2010, respectively (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at March 31, 2011, we adjusted our base calculation to take account of the following factors that we believe are reasonably likely to change our final claims liability amount:

- The assumption of risk for a new population by our Texas health plan (Dallas-Fort Worth area ABD members) effective February 1, 2011.
- The transition of certain members by our Washington and Michigan health plans from full-risk capitated provider arrangements to fee-for-service providers effective December 31, 2010. This change had the effect of transferring back to the Company risk that had previously been assumed by capitated medical providers.
- A substantial decline in claims inventory at our Florida and New Mexico health plans.
- A substantial increase in claims inventory at our Michigan, Missouri, and Texas health plans.
- Our liability for an unknown number of maternity related claims that were mistakenly paid on our behalf by the state of Michigan.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the underestimation or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2010 and through March 31, 2011, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both periods, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

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The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for *Components of medical care costs related to:* Prior years represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,		Year Ended
	2011	2010	Dec. 31, 2010
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of year	$ 354,356	$ 315,316	$ 315,316
Balance of acquired subsidiary			3,228
Components of medical care costs related to:			
Current year	957,909	861,271	3,420,235
Prior years	(44,377)	(38,455)	(49,378)
Total medical care costs	913,532	822,816	3,370,857
Payments for medical care costs related to:			
Current year	646,428	581,389	3,085,388
Prior years	270,078	230,970	249,657
Total paid	916,506	812,359	3,335,045
Balances at end of year	$ 351,382	$ 325,773	$ 354,356
Benefit from prior years as a percentage of:			
Balance at beginning of year	12.5%	12.1%	15.7%
Premium revenue	4.1%	4.0%	1.2%
Medical care costs	4.9%	4.7%	1.5%
Claims Data:			
Days in claims payable, fee for service only	41	44	42
Number of members at end of period	1,647,000	1,482,000	1,613,000
Fee-for-service claims processing and inventory information:			
Number of claims in inventory at end of period	185,300	153,700	143,600
Billed charges of claims in inventory at end of period	$ 250,600	$ 194,000	$ 218,900
Claims in inventory per member at end of period	0.11	0.10	0.09
Billed charges of claims in inventory per member at end of period	$ 152.16	$ 130.90	$ 135.71
Number of claims received during the period	4,342,200	3,493,300	14,554,800
Billed charges of claims received during the period	$ 3,386,600	$ 2,760,500	$ 11,686,100

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health

care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures, and programs that we have not yet identified.

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Item 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years or less and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company s disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the Exchange Act)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission s rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the three months ended March 31, 2011 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

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PART II OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. Based upon the evaluation of information currently available, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. There has been no material change to the risk factors identified in Part 1, Item 1A Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2010 as filed with the SEC on March 8, 2011.

Item 6. ***Exhibits***

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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SIGNATURES

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 thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 9, 2011

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer
and President (Principal Executive Officer)

Dated: May 9, 2011

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

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