IN THE CIRCUIT COURT OF COLE COUNTY
STATE OF MISSOURI

ALLIANCE FOR COMMUNITY HEALTH, L.L.C., a Missouri Limited Liability Company, and MOLINA HEALTHCARE, INC.

Plaintiffs,

vs.

STATE OF MISSOURI,

Serve:
Attorney General Koster
Missouri Supreme Court Bldg.
207 W. High St.
Jefferson City, MO 65102

COMMISSIONER OF ADMINISTRATION FOR THE STATE OF MISSOURI,

Serve:
Honorable Douglas E. Nelson
Commissioner of Administration
State Capitol Building, Room 125
Jefferson City, MO 65102

and the MISSOURI DEPARTMENT OF SOCIAL SERVICES,

Serve at:
Office of the Director
Broadway State Office Building
221 W. High Street
Jefferson City, MO 65102

Defendants.

Case No. _____

PETITION FOR DECLARATORY JUDGMENT, PRELIMINARY AND PERMANENT INJUNCTIONS, AND OTHER RELIEF

Plaintiffs Alliance for Community Health, L.L.C., doing business as Molina Healthcare of Missouri, and Molina Health Care, Inc. (together, "Molina" or "Plaintiffs"), as and for their Petition for Declaratory Judgment, Preliminary and Permanent Injunctions, and Other Relief, state as follows:

1. Plaintiff Alliance for Community Health, L.L.C. ("ACH"), is a Missouri limited liability company and a wholly owned subsidiary of plaintiff Molina Healthcare, Inc. ACH is a managed care organization ("MCO") and provides managed care services to more than 80,000 Missouri Medicaid enrollees ("Molina's Members") pursuant to a contract with the State of Missouri. Not only does this membership make ACH the second largest Medicaid MCO in Missouri, it is the second largest MCO of any kind in the state.

2. Plaintiff Molina Healthcare, Inc. ("MHI"), is a national provider of managed care services to Medicaid enrollees. At present, Molina provides such services in ten states and covers approximately 1.8 million Medicaid enrollees nationwide. MHI and its subsidiaries provide managed care only for governmental programs; they do not offer such services to commercial clients.

3. Both ACH and MHI are Missouri taxpayers paying, directly or through affiliated entities, Missouri property taxes, income taxes, premium taxes and sales taxes.

4. Defendant the State of Missouri (the "State") has entered into, or intends to enter into, contracts with three MCO's, effective July 1, 2012, to provide managed care services to the State' Medicaid enrollees residing in three separate Regions containing 54

counties. These MCO's were selected through a competitive proposal process conducted by the Commissioner of Administration. Two incumbent MCO's were offered contracts in all three Regions, and one MCO with no relevant Missouri experience or network was awarded a contract in all three Regions. Molina was not offered a contract in any Region.

5. The Commissioner of the Office of Administration (referred to herein, together with the Division of Purchasing and Material Management and others working under the Commissioner's supervision and control, as the "Commissioner") is the only individual authorized by Missouri law to purchase supplies or services for the State of Missouri, including managed care services for Medicaid enrollees. Such authority may be delegated, but there was no such delegation concerning the procurement processes at issue in this case. On February 17, 2012, the Commissioner awarded contracts to three MCO's (the "Chosen MCO's") for such services. These contracts, collectively, are referred to herein as the "New Contracts."

6. The Missouri Department of Social Services, through its MO HealthNet Division ("MHN"), supervises the Missouri Medicaid program. Health care services are provided to Medicaid eligible and enrolled Missouri residents on a fee-for-service basis throughout most of the state, but those Medicaid enrollees residing in the 54 counties which comprise the Eastern, Central and Western Regions may only receive such services through an MCO. These individuals must select one of the MCO's with which the State has a contract to provide such services, or be assigned to an MCO by the State.

7. As set forth herein, the New Contracts were the result of multiple violations of law and regulation and therefore are invalid and void *ab initio*. In addition to

declaratory judgments that the New Contracts are invalid, Molina seeks preliminary and permanent injunctions against the State and MHN from making payments, providing services or otherwise implementing the New Contracts.

8. This Court has subject matter jurisdiction over each of Plaintiffs' claims and personal jurisdiction over every Defendant. As taxpayers, Plaintiffs have standing to challenge the validity of State contracts awarded as a result of an illegal procurement process, and ACH has standing as an unsuccessful bidder which would have been awarded a contract but for the violations of law and regulation identified herein. Venue for each of Plaintiffs' claims is proper in this Court under Sections 508.010, 527.010, and 536.050 RSMo.

Background – Medicaid Managed Care

9. Missouri was first granted a waiver to require Medicaid enrollees to participate in managed care in October of 1995, and the program was implemented shortly thereafter.

10. Molina's predecessor, Community Care Plus, was one of the first group of MCO's given contracts by the State to provide Medicaid managed care services in Missouri. Every time these services have been re-bid, the State has awarded contracts to Molina (and its predecessors) to continue to do so. Thus, Molina has served the State and its Medicaid enrollees continuously for sixteen years. Molina now provides health care services to more than 80,000 of Missouri's most vulnerable residents through its network of more than 13,000 providers in 25,000 locations. Molina has built this network over

time by developing strong relationships with providers that serve both the State and Molina's Members ably and well.

11. In 2011, ACH was certified by the National Committee for Quality Assurance, the independent "gold standard" rating agency for MCO's, with a "commendable" rating.

12. In 2011, the Department of Insurance, Financial Institutions, and Professional Registration certified that Molina's network was 100% compliant with the Department's exhaustive "access" regulations requiring the MCO to offer – for 42 separate provider categories – a certain number of providers within a certain number of miles of every single member enrolled with the MCO. Of the three Chosen MCO's, only one had such a certification. The Submission Version (defined below) of the RFP required MCO's to submit documentation demonstrating compliance with these standards. None of the Chosen MCO's did so, and one of them could not have done so under any circumstance.

13. The choice of an MCO has important consequences for a member's health care, not least because it is the MCO's network which determines in large measure the providers to which that member will have access. Therefore, MHN always has pursued a policy of giving Medicaid enrollees the broadest possible choice among qualified, competent MCO's. This policy encourages both the competition for members among the MCO's and the high quality care and member service that such competition ensures.

14. In 1995, the State contracted with seven MCO's to serve the Eastern Region, where the Medicaid managed care program began. The State has never limited

the number of MCO's in any Region but, because of mergers, acquisitions, and departures, only four MCO's were awarded contracts for the Eastern Region in 2009 when these services were last bid.

15. When the Missouri managed care program expanded to the Central Region in 1996, the State awarded contracts to three MCO's. No limitation in the number of MCO's was ever imposed and, in 2009, that State again awarded three MCO's contracts for the Central Region. Similarly, when the Missouri managed care program expanded to the Western Region in 1997, the State awarded contracts to four MCO's and, in 2009, the State again awarded contacts to four MCO's for the Western Region.

16. Prior to the issuance of the RFP in November 2011, however, MHN decided to change its policy of open competition. Instead, MHN decided to impose an arbitrary cap that no more than three MCO's would be allowed to compete for Medicaid enrollees in any one Region, regardless of the number of qualified and competent MCO's seeking that opportunity.

17. Federal law requires that states provide Medicaid enrollees with reasonable access to health care services and, where managed care is required, the State must offer enrollees a choice of MCO's. Because of the large market share of one of the Chosen MCO's, it is likely that MHN cannot comply with these federal laws with less than three MCO's in each Region – a conclusion confirmed by the Commissioner's award of a third MCO contract in the Central Region in March 2012.

18. Accordingly, prior to the release of the RFP in November 2011, MHN departed from the policy of open competition that had been followed since seven MCO

were first given contracts to serve the Eastern Region in 1996, and limited the number of contracts in any one Region to the minimum number of MCO's it thought would still comply with federal law.

19. On information and belief, MHN adopted this policy in order to artificially increase each MCO's market share and thus give each MCO's greater leverage over health care providers in order to enable them to force providers to accept prices or other terms advantageous to the MCO.

20. Whatever the merits of this new approach, MHN's new "cap" on MCO's is a generally applicable statement of policy which was required to be promulgated as a rule before becoming effective. MHN failed to promulgate its new "cap" rule using the "notice and comment" provisions of Chapter 536, it failed to subject this new rule to the legislative review required by Sections 208.001 and 536.024 RSMo, and it did not even seek the advice or consent of the managed care advisory committee created to review and advise the MHN Director on precisely this type of policy change. Accordingly, MHN's new "cap" rule is invalid and of no effect.

21. The Commissioner incorporated MHN's invalid "cap" rule in the RFP at Section 4.3.5, and the Commissioner gave effect to this invalid rule by awarding New Contracts to three – but never more than three – MCO's in each Region.

Background – Procurement Procedures

22. Ordinarily, the State procures goods and services through competitive bid process in which the Commissioner publishes a set of specifications and accepts sealed

bids from interested vendors. The Commissioner is required by law to award the contact(s) to the lowest and best bid.

23. When a competitive bid process is not practicable or advantageous to the State, the Commissioner may – after stating the basis for his decision in a written report which must be maintained in the Commissioner's records – procure goods or services through a competitive proposal process, i.e., negotiated procurement or the "RFP approach." Even when this RFP approach is used, however, the Commissioner must still award the contract(s) to the "lowest and best" proposal based upon the evaluation criteria established in the request for proposals and any subsequent negotiations.

24. On or about November 1, 2011, the State announced its intention to re-bid Medicaid managed care services for all three Regions, and issued Request For Proposals No. B3Z12055 (the "RFP"). On information and belief, however, the Commission failed to state the reasons for his determination that, after sixteen years of experience with this program, it was either impractical or disadvantageous for the State to employ the presumptively applicable competitive bid process, or to make a separate report of these reasons to be kept with the RFP records.

25. Pursuant to the RFP, proposals were due to the Commissioner on December 13, 2011. The RFP was amended twice prior to this submission deadline, however, and a true and accurate copy of the RFP reflecting Amendments No. 1 and 2 is attached[1]

[1] All Exhibits are available at http://oa.mo.gov/purch/webimaging/Homepage.htm and will be produced to the Court upon request, at the hearing on Plaintiffs' Motion for Preliminary Injunction, and at trial. Due to the volume of this and other Exhibits, however, Plaintiffs are omitting them from the Court's pleadings file. Copies are being

hereto as Exhibit A, and incorporated herein by this reference. This version, which was the version on the RFP in effect on the date that the proposals were submitted, is referred to herein as the "Submission Version."

26. Seven MCO's submitted proposals on December 13, 2011: (a) the three Chosen MCO's, which all proposed to provide managed care services in all three Regions, (b) ACH and one other MCO, which also proposed to provide services in all three Regions, and (c) two more MCO's, which proposed only to provide services in one Region.

27. On or about February 1, 2012, the Commissioner sent a letter to each MCO (the "BAFO Letters") offering to enter into "negotiations" and requesting each MCO to submit its "best and final offer" by February 7, 2012. A true and correct copy of Molina's BAFO Letter is attached hereto as Exhibit B and incorporated herein by this reference. [*See* Note 1, supra.]

28. Attached to some – but not all – of the other BAFO Letters from the Commissioner was a list of "areas identified in [the MCO's] proposal as concerns, areas requiring clarifications, and areas of deficiency which may not comply with the requirements of the RFP."

29. Also attached to the BAFO Letters was a copy of the RFP containing new amendments, i.e., the Commissioner's BAFO amendments. The version of the RFP reflecting the Commissioner's BAFO amendments made ***after*** the MCO's proposals had

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provided to Defendants' counsel electronically at the same time as, or prior to, service of the Petition.

been submitted is referred to herein as the "Post-Submission Version." A true and accurate copy of the Post-Submission Version is attached hereto as Exhibit C and incorporated herein by this reference. [*See* Note 1, supra.]

30. The Commissioner's BAFO amendments did not affect the portions of the RFP setting forth the contractual requirements. Instead, even though the Commissioner made more than eighty (80) separate amendments, all of these amendments were made to Section 4.4 of the RFP which, in the Submission Version, had been entitled "**PROPOSAL SUBMISSION REQUIRED INFORMATION**." In other words, the Commissioner's BAFO amendments did not alter the requirements of the contract, they only changed the section of the RFP setting forth what must be included in the Proposals – even though the proposals already had been submitted. These BAFO amendment, therefore, we an attempt to turn non-responsive proposals into responsive ones.

31. The Commissioner's BAFO amendments changed the Post-Submission Version of the RFP to eliminate virtually every mandatory submission element identified in the Submission Version of the RFP. Emblematic of these post-hoc changes, the Commissioner even removed the word "**REQUIRED**" from the title of Section 4.4.

32. The Commissioner did not evaluate the merits of the MCO's seven proposals received in December 2011. Instead, the Commissioner delegated this responsibility to four individuals, none of whom are employees of the Commissioner or the Office of Administration, who are involved with the day-to-day administration of the Medicaid managed care program or are involved in the regulation and oversight of MCO's generally. This committee is referred to herein as the "Evaluation Committee."

33. After receiving the Evaluation Committee's analysis, the Commissioner asked the MHN Director to make a recommendation as to which MCO's should be awarded contracts. The contracts awarded by the Commissioner on February 17, 2012, followed the MHN Director's recommendation without exception or deviation.

COUNT I – Declaratory Judgment

Procurement Process Relied on MHN's Invalid, Unpromulgated Rule

34. The allegations in the preceding paragraphs are incorporated by reference as if fully set forth at this point.

35. MHN is granted rulemaking authority in Section 208.001.4, which provides that any MHN statement of general applicability that implements MHN policy shall only become effective if promulgated in compliance with the notice and comment provisions of Chapter 536 and the legislative oversight provisions of Section 536.024.

36. Prior to November 1, 2011, MHN adopted a policy limiting the number of MCO's that would be allowed to compete for members in any Region to nor more than three. MHN, however, did not discuss this new rule with the managed care advisory committee which, pursuant to Section 208.201.6(7) is required to "consult with and advise [MHN] with respect to policies incident to the administration" of the managed care program. MHN did not promulgate this new policy using the mandatory "notice and comment" procedures set forth in Section 536.021. And, MHN did not seek or obtain legislative review of this new policy pursuant to Sections 208.001 and 536.024 RSMo before putting this new rule into effect.

37. Therefore, pursuant to Sections 536.021.9 and 536.050, Molina is entitled to a declaratory judgment that MHN's new rule imposing a "cap" of no more than three MCO's in any Region is invalid and no effect, and Molina is entitled to an award of its reasonable attorneys fees relating to the need for and obtaining such a judgment, as provided for in Chapter 536.

38. In addition, the Commissioner gave force and effect to MHN's invalid "cap" rule by including it in the RFP at MHN's request and by complying with this rule in awarding three – but not more than three – contracts in each Region. Plaintiff ACH would have been awarded a contract by the Commissioner but for MHN's new "cap" rule, which was invalid and of no effect when the Commissioner relied upon it in awarding the New Contracts and denying a contract to ACH. Accordingly, Plaintiffs also are entitled to a declaratory judgment that the New Contracts are void ab initio because they were the result of an invalid rule or, in the alternative, that the Commission must offer a New Contract to ACH.

WHEREFORE, Plaintiffs seek declaratory judgments (1) that the MHN rule imposing a "cap" of no more than three MCO's in any Region is invalid because MHN failed to properly promulgate this rule under Chapter 536 RSMo, (2) that the Commissioner's reliance upon this invalid rule in by including it in the RFP and complying with it in awarding the New Contracts renders the New Contracts invalid and void ab initio, and Plaintiffs seek an award of their reasonable attorneys fees to be determined pursuant to Section 536.050.

COUNT II – Declaratory Judgment

Procurement Process Violated State Law

39. The allegations in the preceding paragraphs are incorporated by reference as if fully set forth at this point.

40. Chapter 34 and the Commissioner's own procurement regulations prohibit awarding a contract to a non-responsive bid or proposal.

41. The Submission Version of the RFP contained extensive provisions in Section 4.4 of the RFP entitled "**PROPOSAL SUBMISSION REQUIRED INFORMATION**." This Section did not include contractual requirements with which the MCO must comply if awarded a contract. Section 4.4 only provided the mandatory contents and disclosures that must be made in an MCO's proposal in order to be considered responsive and thus eligible to be awarded a contract at all.

42. Each of the Chosen MCO's submitted proposals that did not comply with the mandatory submission requirements in Section 4.4 of the Submission Version of the RFP, and at least one of the Chosen MCO's could not have complied with at least one of these requirements. Rather than reject these non-responsive proposals, or list the shortcomings in the Chosen MCO's BAFO Letters, the Commissioner made more than eighty separate amendments to Section 4.4 to remove virtually every mandatory proposal submission requirements.

43. No statute or properly promulgated rule permits the Commissioner to alter mandatory requirements or specifications after proposals have been submitted, presumably because such post-hoc alterations of the submission requirements could the give rise to an obvious inference of favoritism. Section 34.042 does not authorize such

amendments, and insists that all participants be accorded fair and equal treatment in a negotiation process. The Commissioner's procurement regulation, 1 C.S.R. § 40.-1.050(18), does not permit amendments to the responsiveness requirements after proposals are submitted and, even if it did, such a Rule would exceed the Commissioner's authority under Chapter 34. Therefore, the Commissioner's attempt to lower the bar in order to make non-responsive proposals into responsive ones was invalid and without effect.

44. When the Commissioner's post-hoc, invalid BAFO amendments are set aside, it is clear that the Commissioner awarded contracts to MCO's which had submitted non-responsive proposals in violation of Chapter 34 and the Commissioner's own procurement regulations.

WHEREFORE, Plaintiffs seek declaratory judgments (1) that the Commissioner's attempt to change the RFP submission requirements after the proposals had been submitted and reviewed violated Chapter 34 and the Commissioner's own procurement regulations, and (2) that the New Contracts awarded to the Chosen MCO's on the basis of non-responsive proposals are invalid and void ab initio.

COUNT III – Declaratory Judgment

Procurement Process Violated State Law

45. The allegations in the preceding paragraphs are incorporated by reference as if fully set forth at this point.

46. Chapter 34 and the Commissioner's own procurement regulations require proposals submitted in the course of a competitive proposal procurement process to be

evaluated in a manner that is both provided for by statute and regulations, and that is described in the request for proposals.

47. The Commissioner employed an evaluation process that is not provided for in statute or regulation, and was not described in the RFP.

48. Other than to award preference points for participation by MBE/WBE companies, disabled veterans organizations, sheltered workshops, or Organizations for the Blind, the Commissioner did not analyze any of the seven proposals submitted by MCO's responding to the RFP.

49. Instead, the Commissioner delegated the review of those proposals to the Evaluation Committee to assess the MCO's Organizational Experience, Quality, Method of Performance, and Access to Care. The Committee was comprised of four individuals from outside the Office of Administration who worked closely with the Medicaid managed care program or MCO's generally.

50. The Commissioner, and only the Commissioner, is authorized by Chapter 34 to evaluate bids and proposals and to determine the "best and lowest" offer. Nothing in Chapter 34 authorizes the Commissioner to delegate the evaluation of proposals to individuals or agencies outside of the Office of Administration. Neither do the Commissioner's procurement regulations authorize such a delegation. Finally, nothing in the RFP gave notice to the MCO's that the Commissioner would be delegating the evaluation of proposals to individuals or agencies outside of the Office of Administration.

51. Therefore, the use of the Evaluation Committee was a violation of the procurement provisions of Chapter 34 and the Commissioner's procurement regulations.

WHEREFORE, Plaintiffs seek declaratory judgments (1) that the Commissioner's unauthorized delegation of responsibility for evaluating the proposals to individuals or agencies outside of the Office of Administration was a violation of the procurement provisions of Chapter 34 and the Commissioner's regulations, and (2) that the New Contracts awarded as a result of this invalid process are invalid and void ab initio.

COUNT IV – Declaratory Judgment

Procurement Process Violated State Law

52. The allegations in the preceding paragraphs are incorporated by reference as if fully set forth at this point.

53. Chapter 34 requires the competitive proposal procurement process to be evaluated in a manner provided for by statute or regulation, and described in the request for proposals.

54. The Commissioner employed an evaluation process that is not provided for in statute or regulation, and was not described in the RFP.

55. On February 16, 2012, the Commissioner delegated to the MHN Director the authority to decide the number of contracts to be awarded in each Region and the MCO's to which such contracts would be awarded. Even if the Commissioner merely sought a recommendation – which is what was claimed but which is not supported by the facts – nothing in the Chapter 34 or the procurement regulations allows the Commissioner to seek such a recommendation, nor was there any notice given in the RFP that the Commission would employ such a process.

56. On February 16, 2012, the same day the MHN Director was told to make the decision, the MHN told the Commissioner to award two contracts in the Central Region, and three contracts in Eastern and Western Region, and that the contacts should be awarded to the Chosen MCO's. The following day, the Commissioner awarded the contracts precisely as the MHN Director indicated.

57. The Commissioner, and only the Commissioner, is authorized by Chapter 34 to evaluate bids and proposals and to determine the "best and lowest" offer. Nothing in Chapter 34 authorizes the Commissioner to delegate this decision to the director of the agency that will oversee the performance of the contracts.

58. Section 34.100 permits the Commissioner to delegate the procurement process and the authority to make the "best and lowest" decision to individual departments, including the authority to conduct negotiated procurements under Section 34.042. However, this delegation must be express and the Commissioner must find that the delegation is in the best interest of the State.

59. If no express delegation is made – and no such delegation was made regarding the Medicaid managed care contracts – the Commissioner cannot later delegate to a department or its director the authority to decide which proposals were the "best and lowest."

60. Here, the Commissioner failed to make any analysis of the substance of the seven MCO's proposals, delegating instead that authority to an improper Evaluation Committee. Then, the Commissioner improperly delegated the final decision-making authority to the MHN Director who, in a single day, supposedly assimilated all of the

Evaluation Committee's work, as well as the many thousands of pages of proposals, and reached a decision regarding the number of contacts to be awarded and the MCO which should receive them.

61. The Commissioner's improper delegations were violations of the procurement provisions of Chapter 34 and the Commissioner's own procurement regulations.

WHEREFORE, Plaintiffs seek declaratory judgments (1) that the Commissioner's unauthorized delegation of authority to the MHN Director to decide upon the "best and lowest" proposals and determine the number of contracts to be awarded in each Region violated Chapter 34 and the Commissioner's procurement regulations, and (2) that the New Contracts awarded as a result of this invalid process are invalid and void ab initio.

COUNT V – Declaratory Judgment

MHN's "Cap" Violates Federal Law

62. The allegations in the preceding paragraphs are incorporated by reference as if fully set forth at this point.

63. 42 U.S.C. § 1396u–2(1)(A)(ii) provides that a State may only limit the number of MCO's in its Medicaid managed care program by way of a State Plan Amendment, which must be approved by the Director of Health and Human Services before it is effective. Even though Missouri operates its managed care program under a §1915(b) waiver, this provision – like the provision in § 1396 requiring the State to give each Medicaid enrollee a choice between at least two MCO's – applies nonetheless and

requires MHN to have federal approval prior to implementing its arbitrary "cap" of no more than three MCO's per Region.

64. On information and belief, MHN did not seek or obtain prior federal approval of its new rule capping the number of MCO's at no more than three per Region.

65. As set forth in Count I, the Commissioner gave force and effect to MHN's invalid "cap" rule by including it in the RFP at MHN's request and by complying with this rule in awarding three – but not more than three – contracts in each Region. Plaintiff ACH would have been awarded a contract by the Commissioner but for MHN's new "cap" rule, which was invalid and of no effect when the Commissioner relied upon it in awarding the New Contracts and denying a contract to ACH.

66. Accordingly, Plaintiffs also are entitled to a declaratory judgment that the New Contracts are void ab initio because they were the result of an invalid rule or, in the alternative, that the Commission must offer a New Contract to ACH.

WHEREFORE, Plaintiffs seek declaratory judgments (1) that the MHN rule imposing a "cap" of no more than three MCO's in any Region is invalid for failure to obtain federal approval prior to implementing such a rule, and (2) that the Commissioner's reliance upon this invalid rule by including it in the RFP and complying with it in awarding the New Contracts renders the New Contracts are invalid and void ab initio.

COUNT VI – Preliminary and Permanent Injunctions

Enjoining Open Enrollment Based upon Illegal and Invalid Contracts

67. The allegations in the preceding paragraphs are incorporated by reference as if fully set forth at this point.

68. The New Contracts are invalid and void ab initio as a result of all or any of the violations of Missouri procurement laws and regulations, as well as the promulgation requirements of Chapter 536 relevant to Count I above.

69. Accordingly, the State and MHN must be permanently enjoined from implementing the New Contracts, making payments to the Chosen MCO's under those contracts, or relying upon them in any way. If the State does not extend the current contracts, it will have to conduct an RFP process for these services that complies with State law before it can award new contracts.

70. However, the foregoing declaratory judgments and a permanent injunction are not, by themselves, adequate remedies for Molina. Instead, Molina also is entitled to a Preliminary Injunction prohibiting the State and MHN from taking any further steps to implement the New Contracts or to transition members away from the current MCO's (including, but not limited to Molina) to the Chosen MCO's under the New Contracts.

71. Molina is in imminent danger of irreparable harm in the absence of such a preliminary injunction. Moreover, a preliminary injunction will benefit – not prejudice – the State, the Chosen MCO's, the other unsuccessful MCO's, health care providers, and most importantly the Medicaid enrollees.

72. The State, through MHN, and the MCO's which were awarded the New Contracts, are actively working to implement these invalid contracts effective July 1, 2012. Prior this effective date, however, the State will conduct an "open enrollment" process by which the Medicaid enrollees in all three Regions will have an opportunity to select their MCO for the coming year. If an enrollee does not elect an MCO, that enrollee is assigned to an MCO by a process overseen by MHN. On information and belief, the "open enrollment" process for the year beginning July 1, 2012, will begin on April 16 and runs through June 16, 2012.

73. In preparation for this "open enrollment" process, the State already has notified the 80,000 Molina Members that they will not be allowed to choose Molina as they have in the past. Molina's Members also were informed that, if they do not select one of the New Contract MCO's during the "open enrollment" process, the State will assign an MCO's to them.

74. If the State is allowed to proceed with this "open enrollment" process, the anxiety and, in some cases, fear created by the State's notice that Molina's Members will not be able to rely on Molina as they have in the past will blossom into confusion and lost membership when these members begin choosing an MCO other than Molina after the "open enrollment" process begins. Even if the New Contracts are later declared invalid and Molina continues providing managed care services while the Commissioner conducts the RFP process anew, there will be no way to relieve this confusion or restore the status quo ante. Molina will lose members in such a whipsaw, to say nothing of the needless anxiety and fear for the Medicaid enrollees. This loss of members will be accompanied

by a loss of regard that some may members may have for Molina resulting from the confusion and anxiety for which such members will understandably – but incorrectly – blame Molina.

75. Molina has gross annual receipts in excess of $200 million relating to the managed care services it provides the State and the Molina Members. In addition to the intangible and uncompensatable damages above, lost membership for Molina resulting from the confusion caused by starting and then stopping the invalid "open enrollment" process will translate directly into lost revenue for Molina. However, it is likely that Molina can never be compensated for such damages because it will be difficult or impossible to determine their amount with sufficient certainty.

76. A preliminary injunction also serves the interest of State, the other MCO's, the health care providers, and the Medicaid enrollees. If the Court determines that Molina is likely to succeed on the merits of its claims, the State can proceed with a new RFP and re-bid these services in a manner that complies with state law.

77. The Chosen MCO's need to know if their New Contracts are valid, and the other unsuccessful MCO's need to know whether they may need to continue providing services past July 1, 2012, until the new RFP process is complete. Health care providers need to know whether the Chosen MCO's have valid State contracts before they can decide whether and which MCO's networks it is willing to join. One Chosen MCO is scrambling to negotiate 10,000 or more provider contracts, and the providers do not know for certain whether that MCO even has a contract with the State. Similarly, Molina's 13,000 providers want to continue to have Molina be their point of access to the Medicaid

enrollees in these three Regions, but do not know whether or for how long Moline will be permitted to continue providing these services.

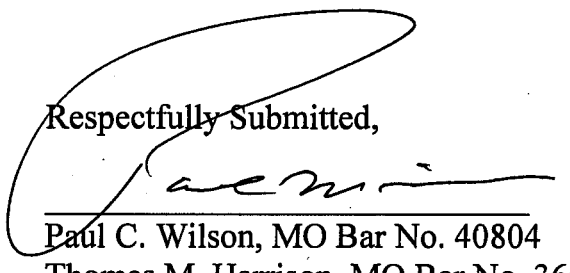
78. Finally, and most important, more than 100,000 Missouri Medicaid enrollees have been told that they cannot continue to use the same MCO that they have relied upon in the past for health care providers, as well as health information and support. Molina's Members constitute more than 80,000 of these enrollees, but other incumbent MCO's were denied contracts as well. Of all the individuals and entities affected by the State's failures to comply with procurement laws and regulations, these 100,000 enrollees are the least deserving of the confusion that will ensue if the transition to the invalid New Contracts is allowed to continue and then stopped in the middle of, or after, the "open enrollment" process.

79. The public policy and balance of harms weigh heavily in favor of a Preliminary Injunction in this case to prevent any further irreparable harm to Molina and prejudice to Molina's Members, health care providers, other MCO's, and other affected parties.

WHEREFORE, Plaintiffs seek both a Preliminary Injunction and Permanent Injunction preventing any further implementation of, or transition to, the New Contracts under a Final Judgment and Permanent Injunction is entered in this case.

Dated: March 29, 2012,

Respectfully Submitted,



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