HEALTH CARE AUTHORITY

COST DRIVERS IN HEALTH CARE & MEDICAID OVERSIGHT

RED RIVER CONVENTION CENTER

JULY 22, 2026

KARI ARMIJO, CABINET SECRETARY

ALANNA DANCIS, ACTING MEDICAID DIRECTOR

INVESTING FOR TOMORROW, DELIVERING TODAY.

AGENDA

- Turquoise Care Overview & Financing
- Medicaid Program Trends: New Mexico and National
- Managed Care Oversight and Performance
- Oversight Presbyterian's Care Delivery of Children in State Custody
- HR1 Potential Impacts on Health Care Costs

Kari Armijo
Secretary
505-249-8773
Kari.Armijo@hca.nm.gov

Alanna Dancis
Acting Medicaid Director
505-538-0555
Alanna.Dancis@hca.nm.gov

MISSION

We ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

HEALTH CARE AUTHORITY

VISION

Every New Mexican has access to affordable health care coverage through a coordinated and seamless health care system.

GOALS

LEVERAGE purchasing power and partnerships to create innovative policies and models of comprehensive health care coverage that improve the health and well-being of New Mexicans and the workforce.

BUILD the best team in state government by supporting employees' continuous growth and wellness.

ACHIEVE health equity by addressing poverty, discrimination, and lack of resources, building a New Mexico where everyone thrives.

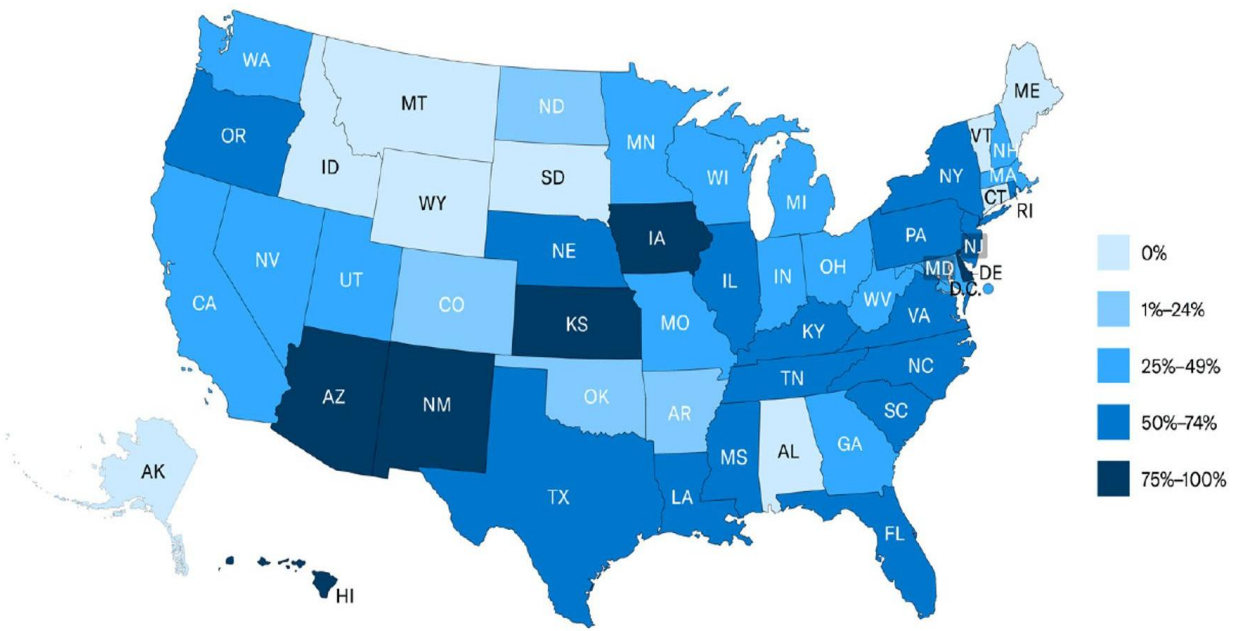
IMPLEMENT innovative technology and data-driven decision-making to provide unparalleled, convenient access to services and information.

TURQUOISE CARE OVERVIEW & FINANCING

MEDICAID MANAGED CARE AND AT-RISK CAPITATION

- Turquoise Care refers to NM's Medicaid managed care program; administered by four managed care organizations (MCOs) – BCBS, Presbyterian, United, and Molina
  - Fully integrated model covers all services and care coordination; required for most full-benefit Medicaid enrollees except Native Americans
- Under managed care, the State pays MCOs a fixed **per-member per-month (PMPM) capitation rate** to cover each enrollee's care.
- These payments are largely **"at-risk":** within certain contractual thresholds, the MCOs absorb losses when actual costs exceed the capitation rate and keep savings when costs come in lower.
- Capitation is intended to give the state **budget predictability and certainty**, converting variable healthcare spending into a fixed, forecastable payment over a 12-month period.
- The MCO contracts include **guardrails and risk-mitigation mechanisms** (e.g., medical loss ratios, risk corridors) that limit excess MCO gains or losses.

Share of Medicaid Spending in Comprehensive Managed Care by State (2024)



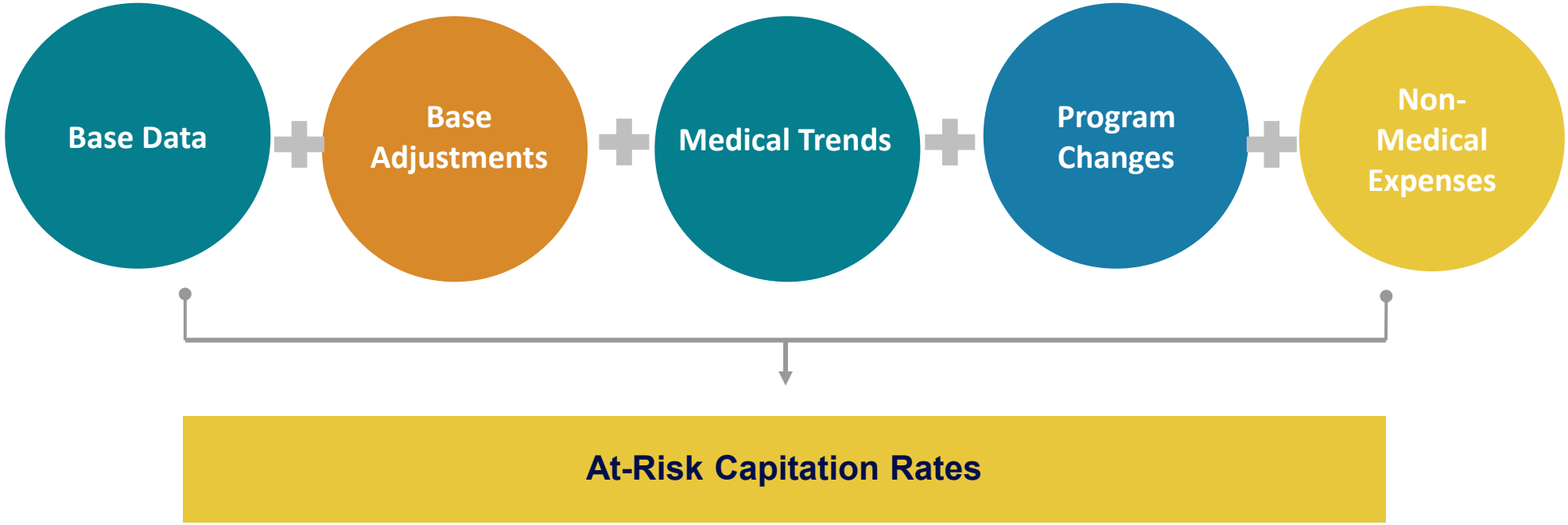
Source: manhattan.institute/article/reining-in-medicaid-managed-care

Capitation transfers actuarial risk to MCOs; guardrails share and mitigate that risk between MCOs and the State.

HEALTH CARE AUTHORITY

Investing for tomorrow, delivering today.

THE CAPITATION RATE DEVELOPMENT PROCESS USES BEST AVAILABLE DATA TO TRY TO PREDICT THE FUTURE



*__Rates are set annually on a calendar year basis.__ New rates occur in January. Sometimes the state does a midyear rate adjustment if major changes occur in the program, such as major enrollment fluctuations or new program initiatives such as provider rate increases.

*__NM uses the best available historical data to build the capitation rates, but there is generally some lag.__ For example, NM may have to use historical data from 2025 to build rates for calendar year 2027. This is due to run-out on claims filing by providers, length of patient treatment, and claims adjudication. (This is referred to as “claims lag”.)

*Actuaries give a range of PMPM rates. The state determines where in the range they want to fall. The middle of the range is called the “best estimate.” **Decisions about the rate range are made based on a variety of factors, including the HCA budget appropriation.**

*__Federal law requires that the rate must fall within the actuarial estimate__, and the capitation rates must be certified by an actuary.

WHAT GOES INTO ACTUARIAL MANAGED CARE RATES?

Actuarial rates are set to ensure plans have the resources needed to provide covered services to enrollees while meeting regulatory requirements.

1. MEMBER DEMOGRAPHICS & ELIGIBILITY

- Age
- Gender
- Geography
- Eligibility category
- Dual status / Disability

Defines who is in the population and expected utilization patterns.

2. UTILIZATION & COST DATA

- Historical claims data
- Encounter data
- Service mix
- Provider utilization
- Trend analysis

Estimates how much care the population is expected to use and at what cost.

3. TREND ASSUMPTIONS

- Medical trend
- Pharmacy trend
- Behavioral health trend
- Technology changes
- Unit cost trend

Projects how future costs will increase over time.

4. BENEFIT PLAN DESIGN

- Covered services
- Benefit limits
- Copays / Coinsurance
- Utilization management
- Network design

Defines what services are covered and how they are paid.

5. PROVIDER & DELIVERY SYSTEM ASSUMPTIONS

- Provider reimbursement levels
- Contract terms
- Network adequacy
- Delivery system changes

Accounts for how and where care is delivered and paid for.

6. OTHER DIRECT COSTS

- Pharmacy rebates
- Capitation / Fee-for-service mix
- Stop loss insurance
- Other medical costs

Includes costs outside of claims that impact total cost of care.

7. ADMINISTRATIVE COSTS & MARGINS

- Administrative expenses
- Quality improvement
- Risk adjustment
- Profit / Risk margin
- Reserves

Covers plan operating costs and ensures financial stability.

8. ACTUARIAL CALCULATION

Actuaries combine all assumptions and data to project the **Per Member Per Month (PMPM)** cost of providing covered services to the population.

RESULT: MANAGED CARE RATE

$ PMPM

The rate paid to the health plan to provide covered services.

WHAT THE RATE MUST ACHIEVE

- Adequate to cover expected costs
- Compliant with state & federal regulations
- Equitable across plans and populations
- Sufficient to ensure access to quality care
- Sustainable for long-term stability

KEY PRINCIPLES

- ✓ Based on best available data
- ✓ Prospective (looking forward)
- ✓ Updated regularly
- ✓ Transparent & documented

CONTRACTUAL RISK-SHARING & MITIGATION MECHANISMS

Medical Loss Ratio, Underwriting Gain Limit, Loss Protection Risk Corridor

Minimum Medical Loss Ratio (MLR)

Turquoise Care contracts require that **MCOs must spend no less than 90% of net capitation revenue on direct medical expenses** on an annual basis. The federal requirement is 85%.

An MCO will owe payment back to the state if the minimum MLR is not met.

Underwriting Gain (Profit) Limitation

Turquoise Care contracts allow that **MCOs may retain 100% of underwriting gain (profit) up to 3%** of net capitation revenue generated annually.

MCOs are required to share with HCA 50% of underwriting gain (profit) above 3%.

Loss Protection Risk Corridor – temporary since start of Turquoise Care

Turquoise Care MCO contracts include a risk corridor to protect MCOs against excessive losses due to unpredictability of Medicaid unwinding and higher member acuity.

HCA is responsible for 75% of losses within 3% to 6% and 90% of losses in excess of 6.0%.

HCA paid out on the risk corridor from July 2024-December 2025 due to significant MCO losses. Without the risk corridor, these losses could have catastrophically destabilized the Medicaid MCOs.

Transition in MCO Underwriting Margins Over Key Historical Periods

Time Period	Enrollment Trend	Composite MCO Margin	Key Financial Drivers
Pre-Pandemic (2019)	Stable	~ 0.3% → 0.9%	Normalized historical risk pools.
Pandemic Peak (2020–2023)	Surged to 87M	+2.5% → +3.5%	Continuous coverage; low service utilization.
The Unwinding (2024)	Steep Disenrollment	-0.6% → -0.9%	Adverse risk mix, inflation, and rate lag.
Post-Unwinding (2025–2026)	Shrinking Risk Pools	-0.1% → 0.0%	High acuity among remaining enrollees; slight margin stabilization.

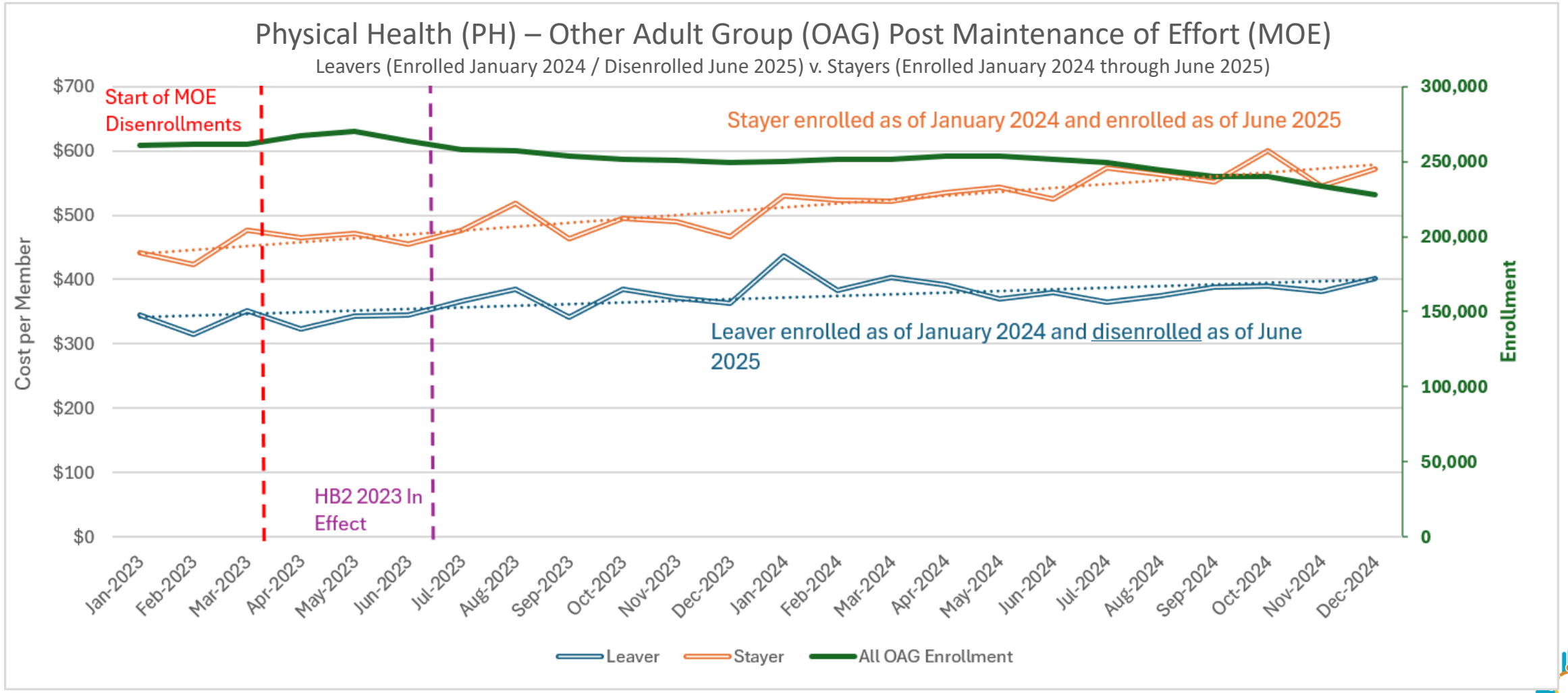
(Source: Data adapted from Milliman CY2024-2025 Financial Results and Health Management Associates).

MEDICAID PROGRAM TRENDS: NEW MEXICO AND NATIONAL

FROM PHE ENROLLMENT PEAK TO THE UNWINDING

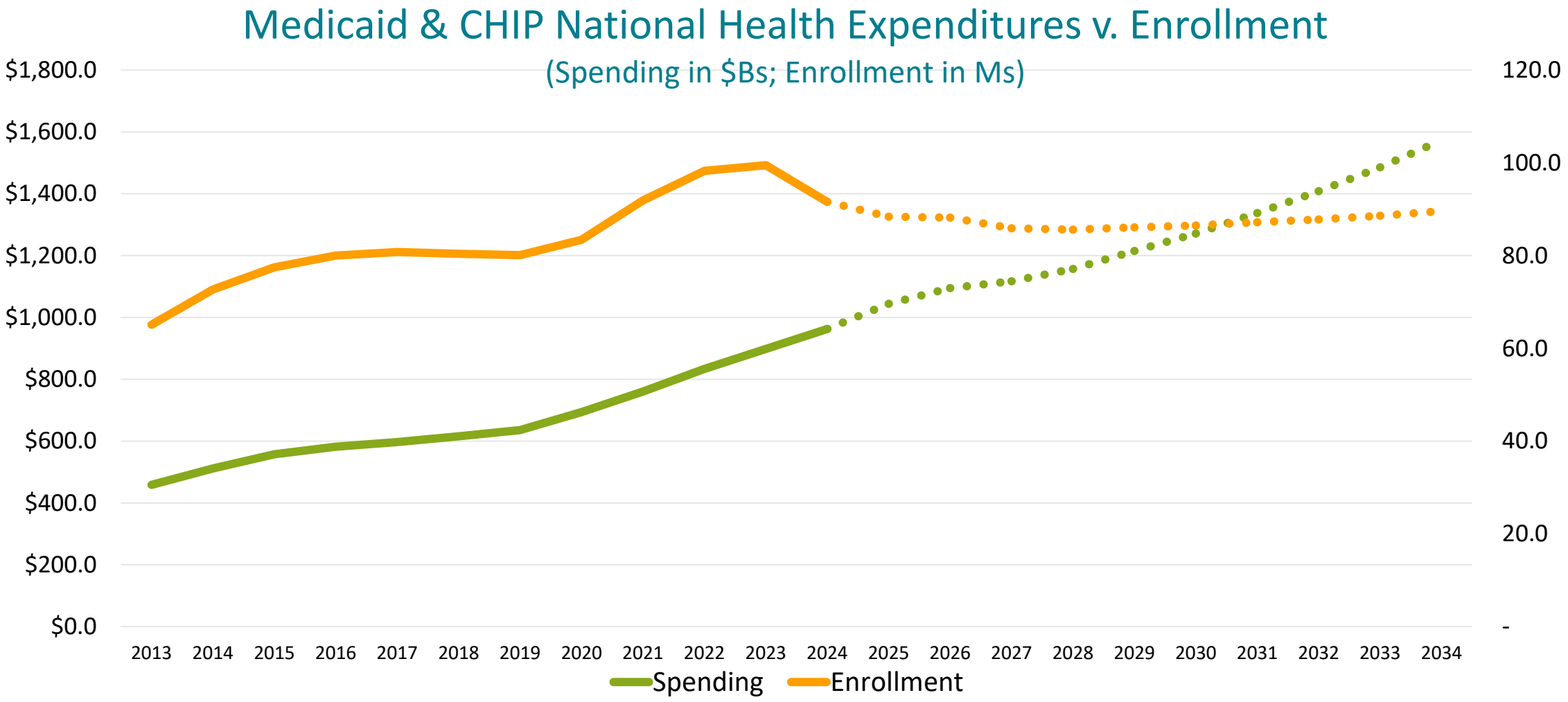
- During the COVID-19 public health emergency (PHE) beginning **March 2020**, federal rules suspended Medicaid redeterminations, keeping members continuously enrolled.
- This pause drove a historic increase in enrollment. NM Medicaid reached an all-time peak of over **1 million Medicaid members** in New Mexico immediately prior to the unwinding.
- PHE unwinding began **April 1, 2023**; redeterminations resumed and enrollment has been steadily declining ever since.
  - Current Medicaid enrollment = 818,515 (38.65% of NM's total population)
  - Exceptions in Long-Term Care, where enrollment is increasing due to aging population
- Even as enrollment falls, per-person program spending is rising due to multiple factors:
  - **Higher utilization trend** = more people are getting more visits
  - **Higher average acuity** = remaining members have higher relative health care needs, medical complexity, and expected costs
  - **Program initiatives** = rate increases (up to 150% of Medicare for most services) and new benefits (such as doula care, chiropractic coverage, community health workers, autism intervention services, and biomarker testing)
  - **Inflation** = Consumer Price Index (CPI-U) and Producer Price Index (PPI) for health/medical care is growing at a higher rate than overall annual inflation

MEMBERS WHO REMAINED ON MEDICAID POST-PHE COST MORE



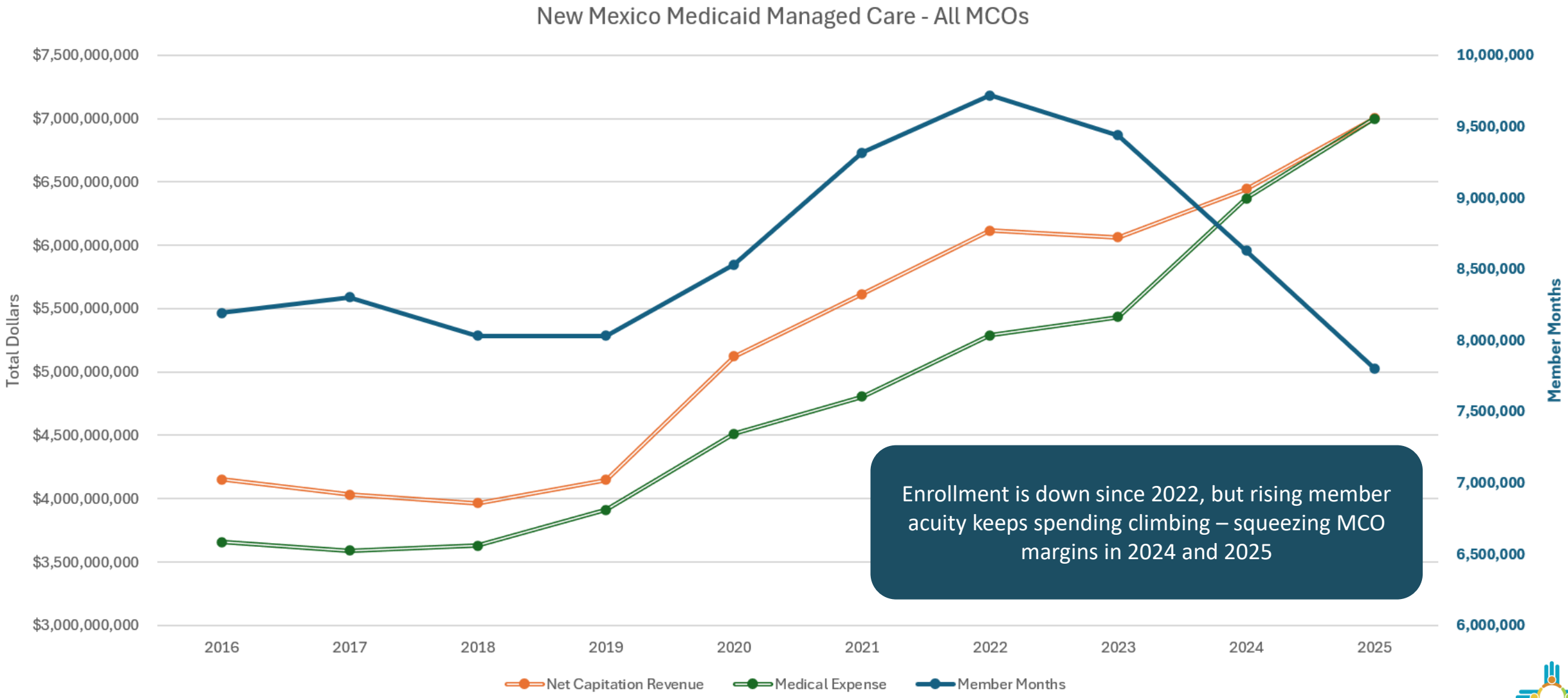
Source: Analysis of Medicaid MCO encounter data for the specified population and period, as prepared by Mercer

NATIONALLY, MEDICAID COSTS ARE INCREASING WHILE ENROLLMENT IS DECLINING



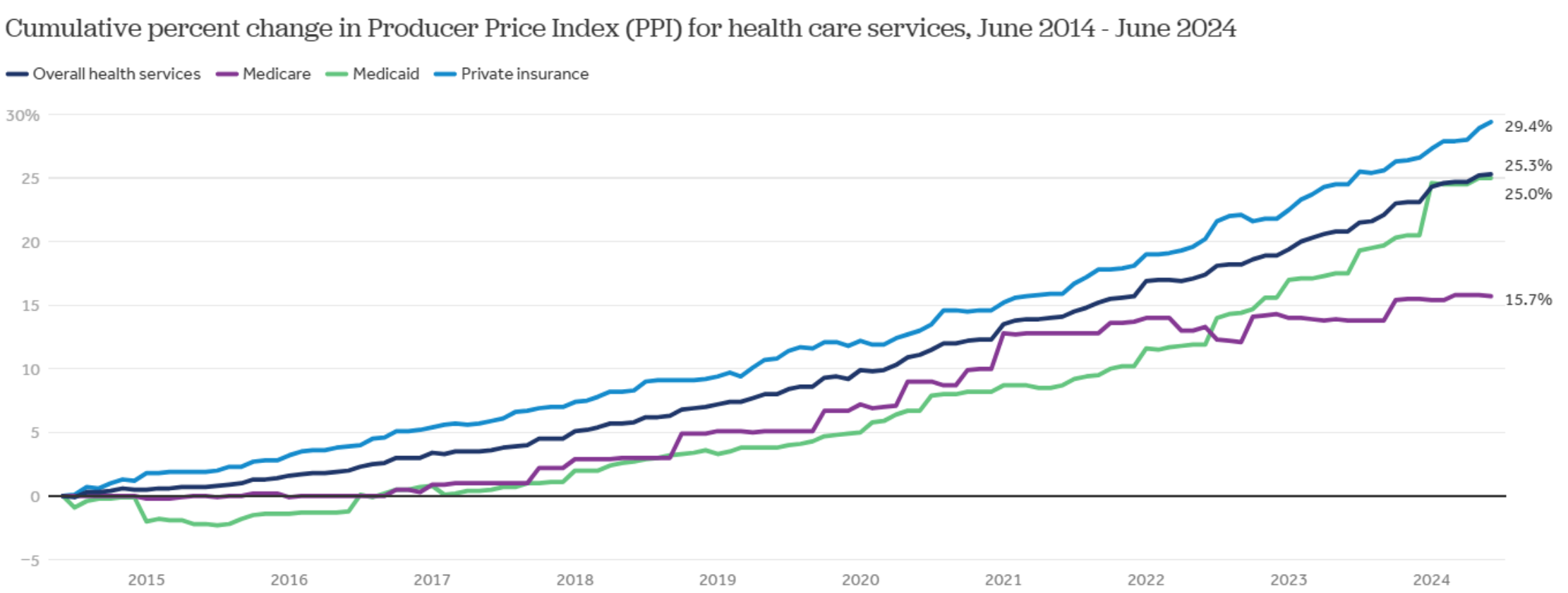
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

NEW MEXICO EXPERIENCE ALIGNS WITH NATIONAL TREND



Source: Annual Supplemental financial results and 2025 Q4 financial submissions from Medicaid MCOs, as compiled by Mercer

PRICES PAID BY PRIVATE INSURANCE GENERALLY OUTPACE THOSE PAID BY PUBLIC PROGRAMS



Note: Data are not seasonally adjusted.

Source: KFF analysis of Bureau of Labor Statistics (BLS) Producer Price Index (PPI) data • Get the data • PNG

Peterson-KFF Health System Tracker

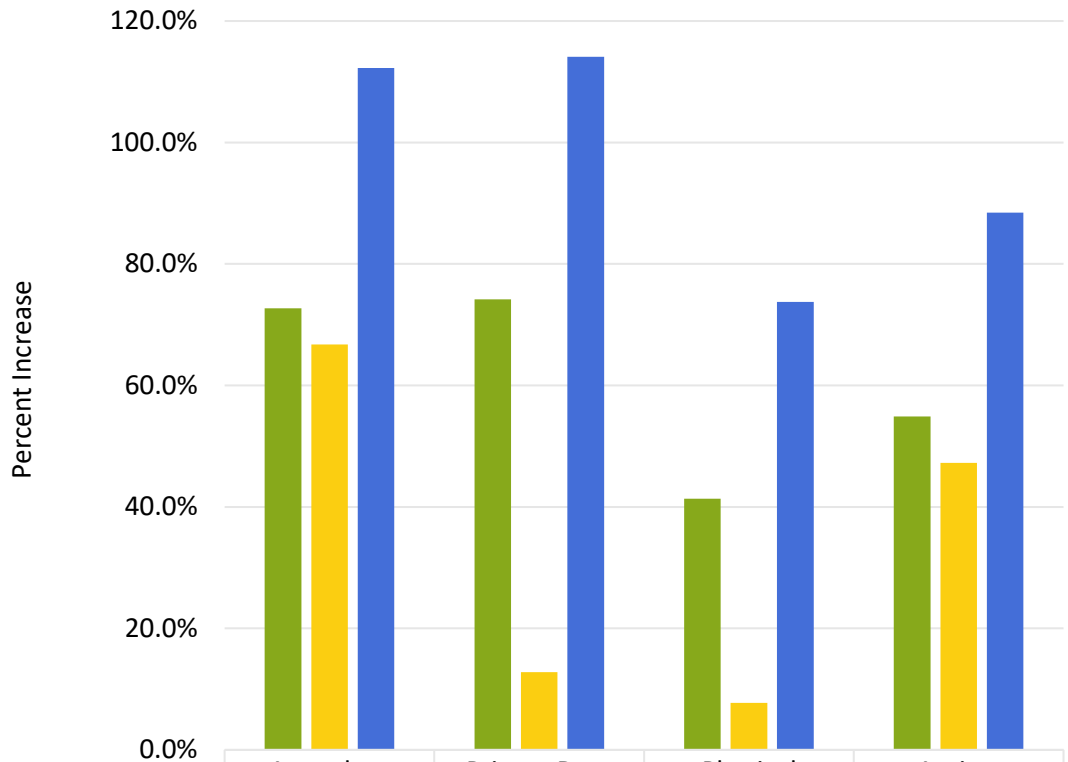
HEALTH CARE AUTHORITY

Investing for tomorrow, delivering today.

HB2 RATE INCREASES ARE WORKING: MORE PROVIDERS, MORE CARE FOR NEW MEXICANS

- HCA & Legislature increased Medicaid rates in 2023, 2024, and 2025.
  - In 2023, most rates with a Medicare equivalent went to 100%. Behavioral health, primary care and maternal/child health set at 120% of Medicare.
  - In 2024 all additional rates with a Medicare equivalent went to 100%. Behavioral health, primary care, and maternal/child health set at 150% of Medicare.
  - In 2025 several large rate increases for behavioral health rates with no Medicare equivalent.
- Increased rates created a larger number of providers enrolled in Medicaid and offering services.
- More members accessed services, including members who were currently in care and accessing more frequent services.

NM Medicaid Increase in Visits, Unique Members, and Visits per Member, CYs 2023 to 2025 (%)



	Attendant Care	Private Duty Nursing	Physical Therapy	Autism Services
% Increase in Visits	72.7%	74.2%	41.3%	54.9%
% Increase in Unique Members	66.8%	12.8%	7.7%	47.2%
% Increase in Visits per Member	112.3%	114.1%	73.8%	88.5%

MANAGED CARE OVERSIGHT AND PERFORMANCE

PERFORMANCE MEASURE OVERSIGHT

TARGETS

- Follow National Committee for Quality Assurance Measure (NCQA) Steward technical specifications for monitoring each MCO's performance.
- Target is 1% higher than the NCQA Quality Compass average for 2022.
- Annually, HCA reports audited mandatory and voluntary Core Set performance to the Federal Quality Measures database. See the Medicaid.gov State Scorecard
- Measures are used for CMS and LFC reports.
- Can stratify results by race/ethnicity, age, gender.

PENALTIES

- Penalty of up to 3% of annual capitation if performance measures are not met.
- No monetary penalties imposed in 2024 due to the organizational changes from Centennial Care 2.0 to Turquoise Care.
- Penalty Assessment of CY25 audited Healthcare Effectiveness Data and Information Set (HEDIS) performance rates will be in effect August 2026.
  - Expect findings and formal letters to be sent to each managed care organization in late September.
- In 2023, HCA recouped $34 million from the managed care organizations.

PERFORMANCE OVERSIGHT AND MONITORING

Target Category	Healthcare Effectiveness Data and Information Set (HEDIS) Performance Measures	MCO CY25 Quarterly Rates (Q4)				Q4 Target
		Blue Cross Blue Shield	Molina Health Care	Presbyterian Health Plan	United Healthcare	
Children	Well Child Visits – first 15 months	60.28%	61.07%	63.90%	45.71%	54.50%
	Well Child Visits – 30 months+	67.10%	61.47%	69.61%	56.71%	64.48%
	Lead Screening in Children	48.51%	50.95%	48.89%	42.08%	57.10%
	Dental Health	49.94%	49.71%	56.07%	38.32%	45.01%
	Immunizations for Adolescents	35.49%	34.15%	37.27%	24.00%	33.29%
Maternal Health	Timeliness of Prenatal Care	61.49%	61.17%	67.59%	57.40%	80.69%
	Postpartum Care	55.17%	65.63%	69.38%	57.93%	74.70%
Behavioral Health	Follow up After Hospitalization for Mental Illness	45.90%	38.90%	44.17%	33.78%	29.92%
	Pharmacotherapy for Opioid Use Disorder	17.01%	19.05%	25.75%	17.54%	25.22%
Disease Management	Diabetes management - kidney health evaluation	35.83%	36.57%	39.27%	39.53%	32.28%

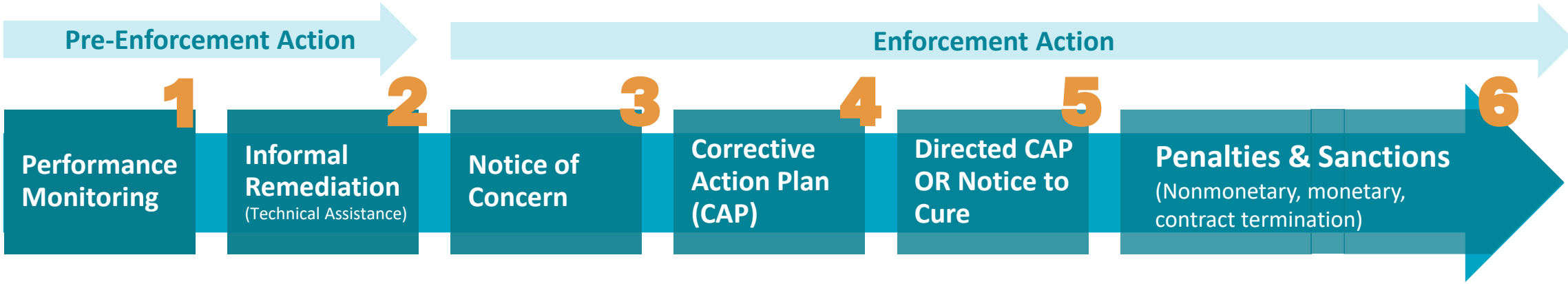
DELIVERY SERVICE IMPROVEMENT PERFORMANCE TARGETS (DSIPTS)

- Annual specific and measurable goals designed to enhance MCO service delivery to members; especially in areas tied to access, quality, coordination, and timeliness of care.
- Up to 2% withhold if DSIPTs are not met

DSIPT TYPE	METRIC(S)	STATUS
Behavioral Health Visit	Increase the number of unique members receiving outpatient behavioral health services CY26 Target (25%)	CY25 - BCBS, MHC, PHP, UHC all met the BH visit target.
Value-Based Purchasing	Increase number of value-based arrangements with providers	CY25 - BCBS, PHP, and UHC met all DSIPT Performance Measures. MHC did not fully meet.
Telemedicine	Increase the number of unique members with a Telemedicine visit	CY25 Q2-Q4 - BCBS, PHP, MHC and UHC met the 7% threshold. SFY25 total 109,446 is below the SFY26 LFC Target of 145,000. MCOs report that noncompliance in remote areas is due to patients' limited access to remote services, difficulty using digital tools, technical issues, and preference for in person visits.
Personal Care Services	Increase percent of agency based authorized PCS delivered to members.	CY25 - All MCOs met the minimum target of 90% CY 26 - Reporting is not yet completed. Target is 92%
Non-Emergency Medical Transportation	Complete 90% of eligible General NEMT trips upon request to and/or from medically necessary covered services annually	CY25 - All 4 plans met.

COMPLIANCE MONITORING AND OVERSIGHT

FRAMEWORK



Section 7.3 of the MCO contract outlines the consequences for failing to meet the contract requirements. It describes the penalties, corrective actions, and potential contract termination that may result if the contractor does not comply with the specified terms.

TURQUOISE CARE COMPLIANCE ACTIONS

Compliance Actions are posted on the Turquoise Care MCO Contracts web page

Notices of Concern:

- CARA care coordination
- Underpayments
- Single credentialing delay
- Pharmacy utilization management not adherent to prior authorization statute or contract requirements.

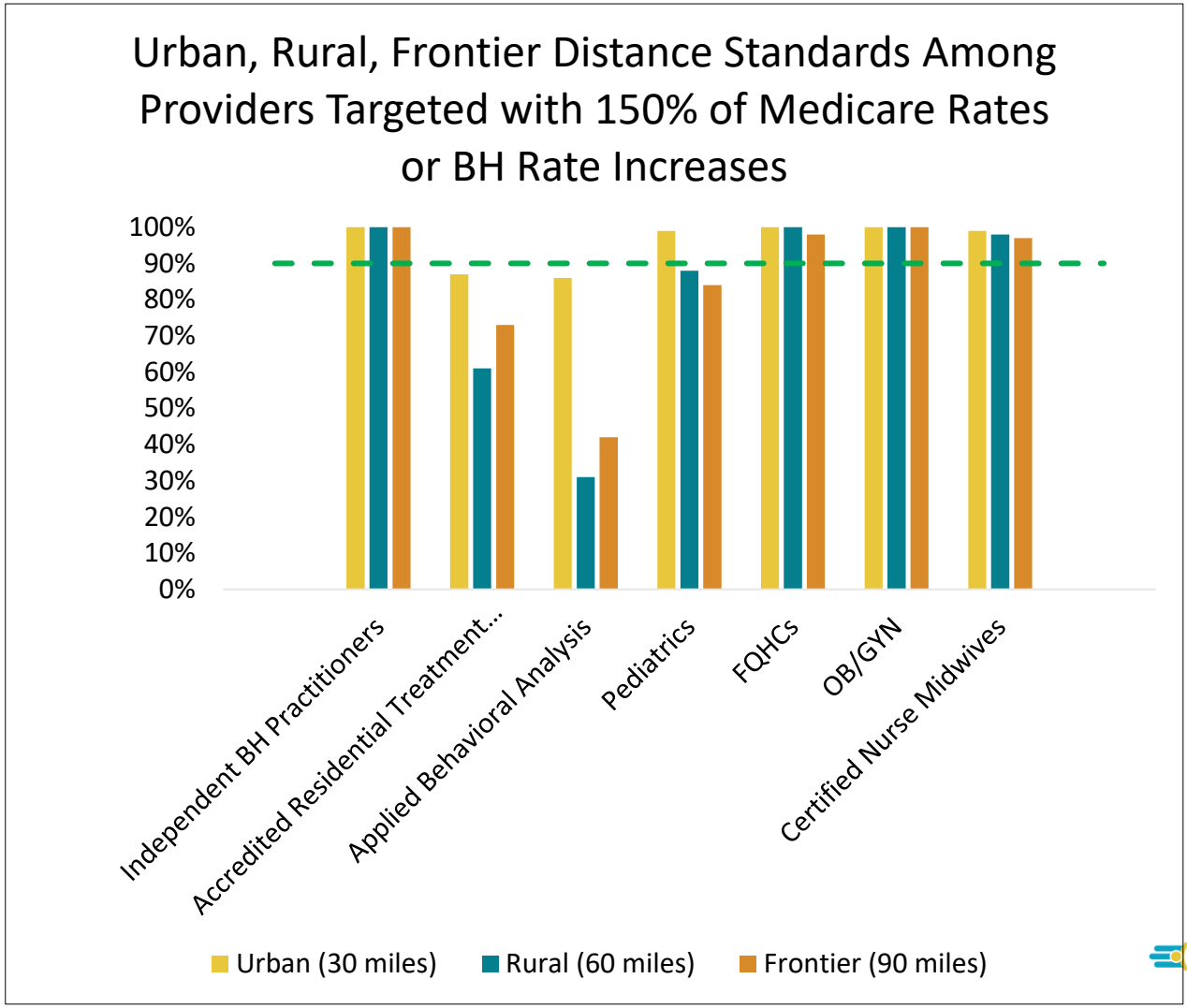
- Corrective Action Plan:
  - Children in State Custody

- Sanction:
  - Pharmacy utilization management not adherent to prior authorization statute or contract requirements

Note: Includes recent compliance actions pending MCO review and responses.

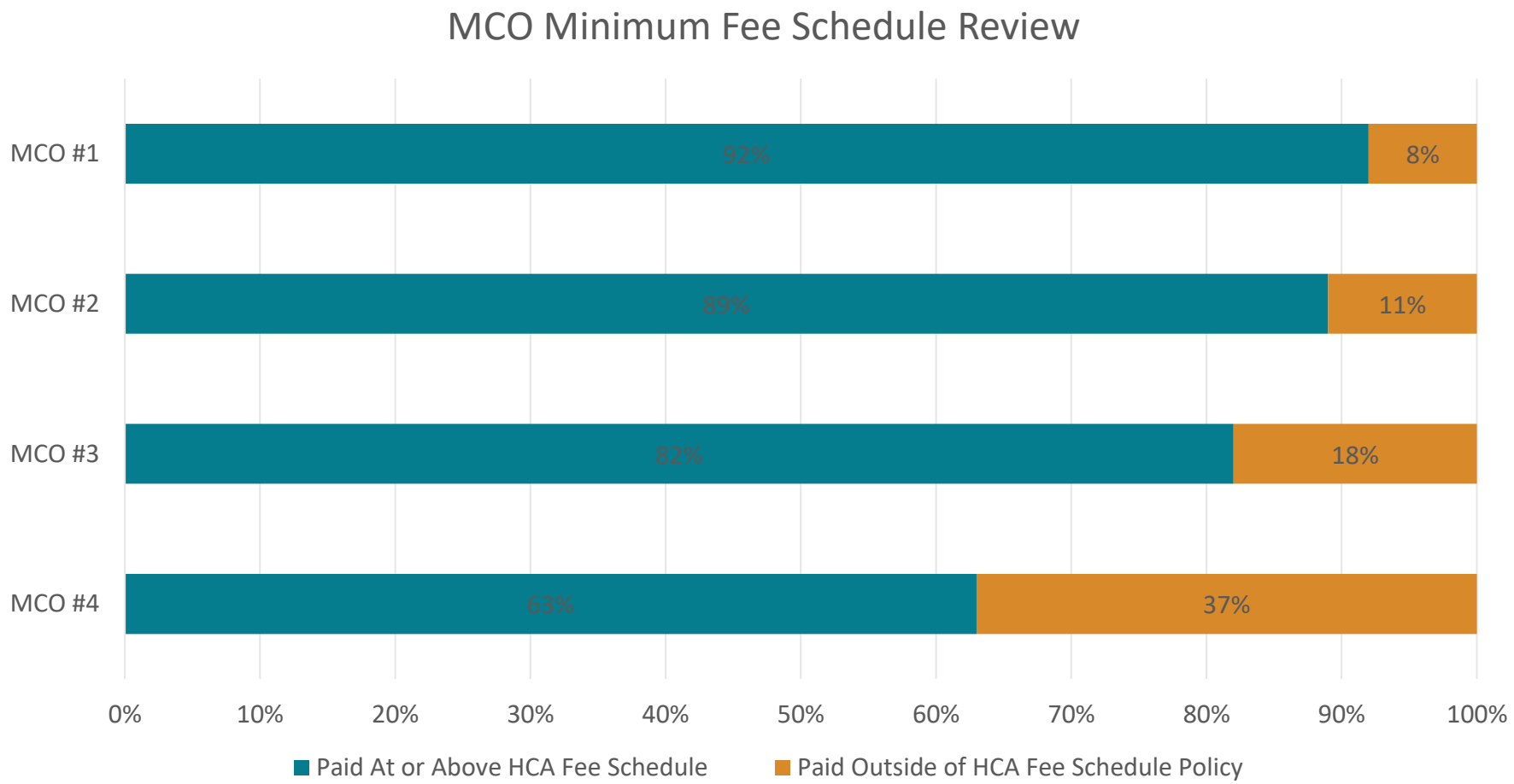
MCOS ARE RESPONSIBLE FOR NETWORK ADEQUACY

- Distance standards require that 90% of members are able to get to a provider of various specialties within a certain number of miles. 30 miles for urban, 60 miles for rural, 90 miles for frontier.
- Data reporting now available (previously relied on secret shopper surveys) on rigorous distance standards set in Turquoise Care contracts.
- HCA monitors network adequacy reports quarterly and will begin sharing their findings with MCOs, especially when some MCOs are able to meet network adequacy in a county while others are not.
- Single credentialing went live on April 21, 2026.



MCO FLOOR RATE AUDIT RESULTS – JAN. 2025

- The chart below identifies the sample claim review results by MCO. The results varied across the MCOs with one MCO payment accuracy rate at 92% while another MCO payment accuracy rate was at 63%.



MCO FLOOR RATE AUDIT RESULTS – JULY 2025

- With the removals of claims that appear to have acceptable justifications for payments below the minimum fee schedule, the eligible claim total for this analysis was 375,018.

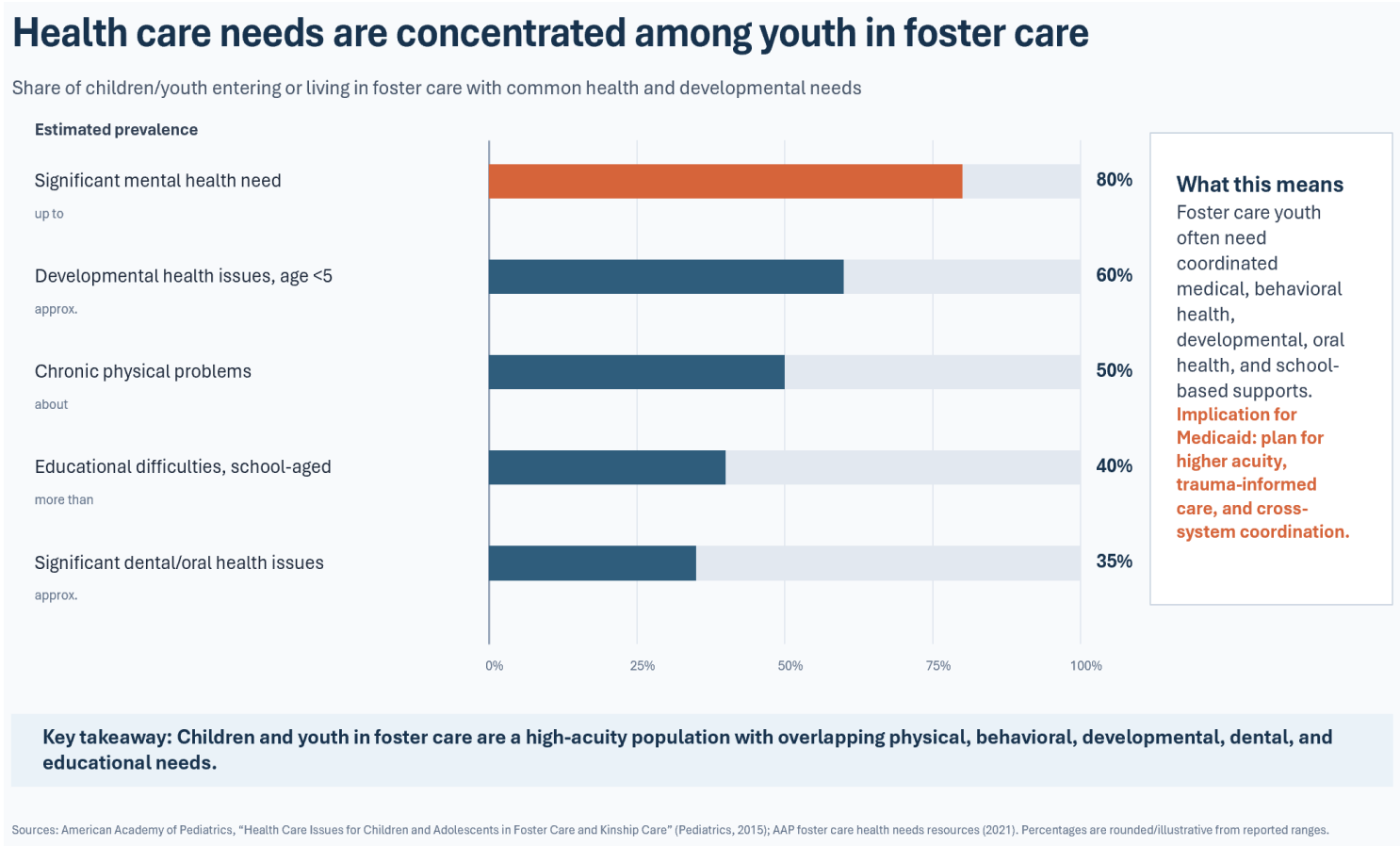
MCO Name	Count				Percentage		
	Total Eligible Claim Lines	Paid Below Schedule	Paid At Schedule	Paid Above Schedule	Paid Below Schedule	Paid At Schedule	Paid Above Schedule
Blue Cross Blue Shield of New Mexico	155,326	1,470	105,128	48,728	0.9%	67.7%	31.4%
Molina Healthcare of New Mexico	15,095	8,187	3,298	3,610	54.2%	21.9%	23.9%
Presbyterian Health Plan	195,573	488	82,245	112,840	0.2%	42.1%	57.7%
UnitedHealthcare Insurance Company	9,024	2,490	1,741	4,793	27.6%	19.3%	53.1%
Total	**375,018**	**12,635**	**192,412**	**169,971**	**3.4%**	**51.3%**	**45.3%**

- Blue Cross Blue Shield of New Mexico and Presbyterian Health Plan performed well with less than 1.0% of the claims paid below the FFS rates.
- United Healthcare and Molina performed below expectations based on the initial review.
  - United Healthcare had just under 2,500 claims or 27.6% of claims paid under the established FFS rates.
  - Molina had just under 8,200 claims or 54.2% of claims paid under the established FFS rates.

OVERSIGHT PRESBYTERIAN'S CARE DELIVERY OF CHILDREN IN STATE CUSTODY

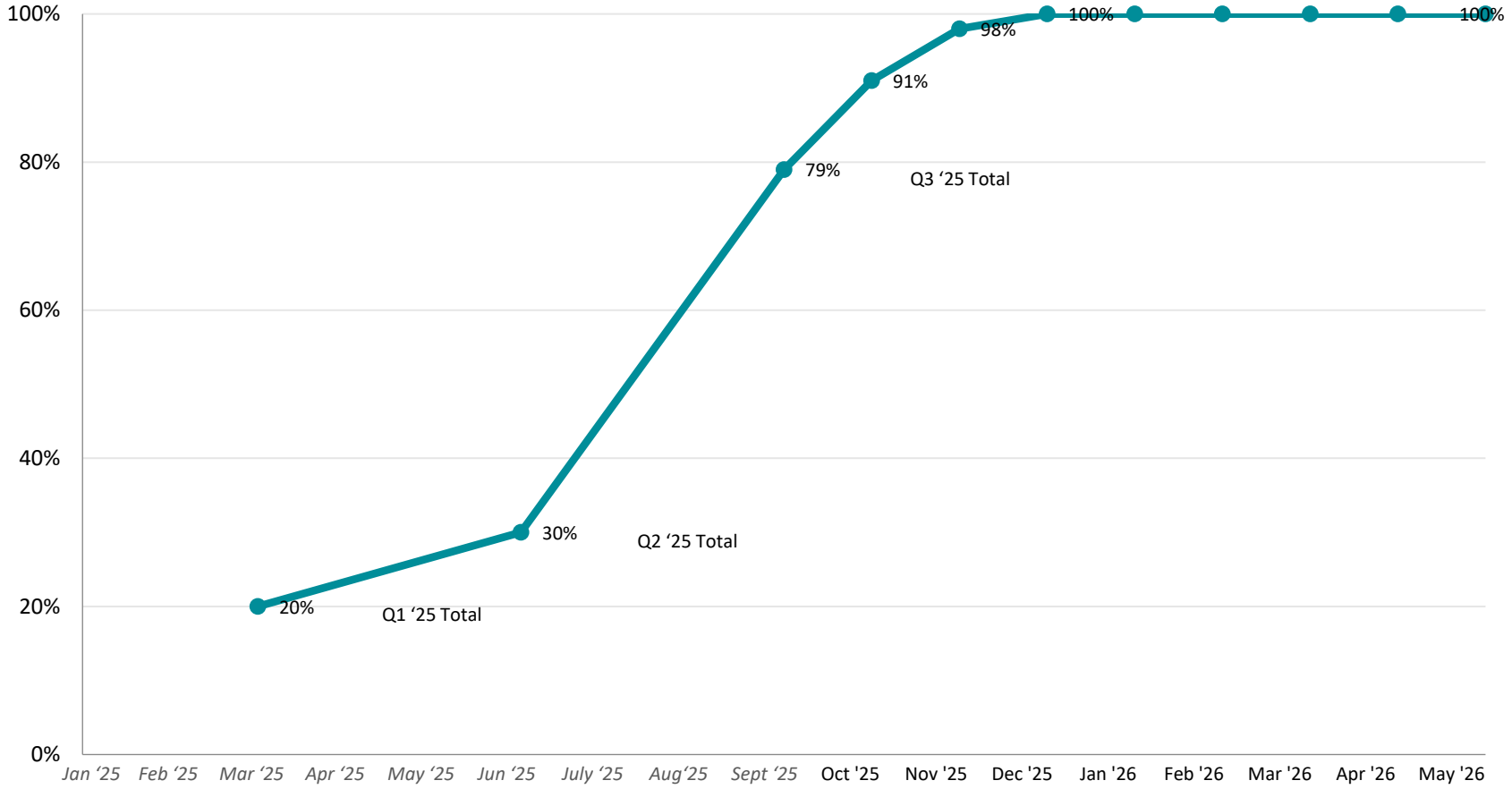
PHP CISC CORRECTIVE ACTION PLAN

- Behavioral health continuum
  - Long-term and short-term strategies to address provider shortages
  - Monitoring of appointment timeliness standards
- Efforts to bring children back to state of New Mexico
  - Specific plan for all children out of state for more than 90 days to bring children back in state.
- Pharmacy
  - Dashboard and oversight of polypharmacy and psychotropic medications in children.
- Network Adequacy
  - Increasing network for Treatment Foster Care and community-based mental health services
  - Maintaining 100% well child visits done within 30 days.



WELL-CHILD VISIT TREND: TIMELY COMPLETION

Percent of CISC receiving a WCV within 30 days of eligibility increased from 20% in Q1 2025 to 100% by December 2025 and remained at 100% through May 2026.



Percent of CISC which received WCV within 30 days of eligibility

Key readout

100%

Sustained compliance: WCV timely completion remained at 100% for six consecutive reported months

+80 percentage points in 2025 lead by collaborative efforts between HCA, CYFD, and PHP.

2025 work strengthened scheduling coordination, timely escalation, and cross-agency reporting.

Source: Validated claims data and provider clinical notes

Presbyterian Health Plan Corrective Action Plan 2025-2026

HCA is executing a corrective action plan to drive multi-domain performance improvement for PHP. Find contract compliance actions at Turquoise Care MCO Contracts web page.

May 2025 – September 2025

May 13, 2025: HCA's initial requirement for PHP to submit a corrective action plan covering 4 domains and 14 subdomains.

June 30, 2025: PHP submitted their initial CAP

August 22, 2025: HCA issued a response to PHP indicating:

1. Acceptance and closure of 5 subdomains
2. Contingent acceptance pending resubmission/additional reporting on 8 subdomains
3. Rejection of 1 subdomain

September 30, 2025: PHP resubmits CAP with revisions.

November 2025

November 26, 2025: HCA issued a response to PHP indicating:

1. Acceptance and closure of 2 additional subdomains
2. Contingent acceptance pending resubmission/additional reporting on 4 subdomains
3. Rejection of 3 subdomains requiring resubmission

December 31, 2025: PHP resubmitted their CAP in response to the 11/26/2025 HCA resubmission request.

February 2026

February 18, 2026:

- HCA notified PHP that their CAP response satisfied minimum requirements to be accepted.
- HCA initiated a period of intensified oversight of PHP to confirm timely and sustained execution of PHP's remediation strategy.
- HCA notified PHP that failure to meet any milestones will result in further enforcement actions including sanctions.

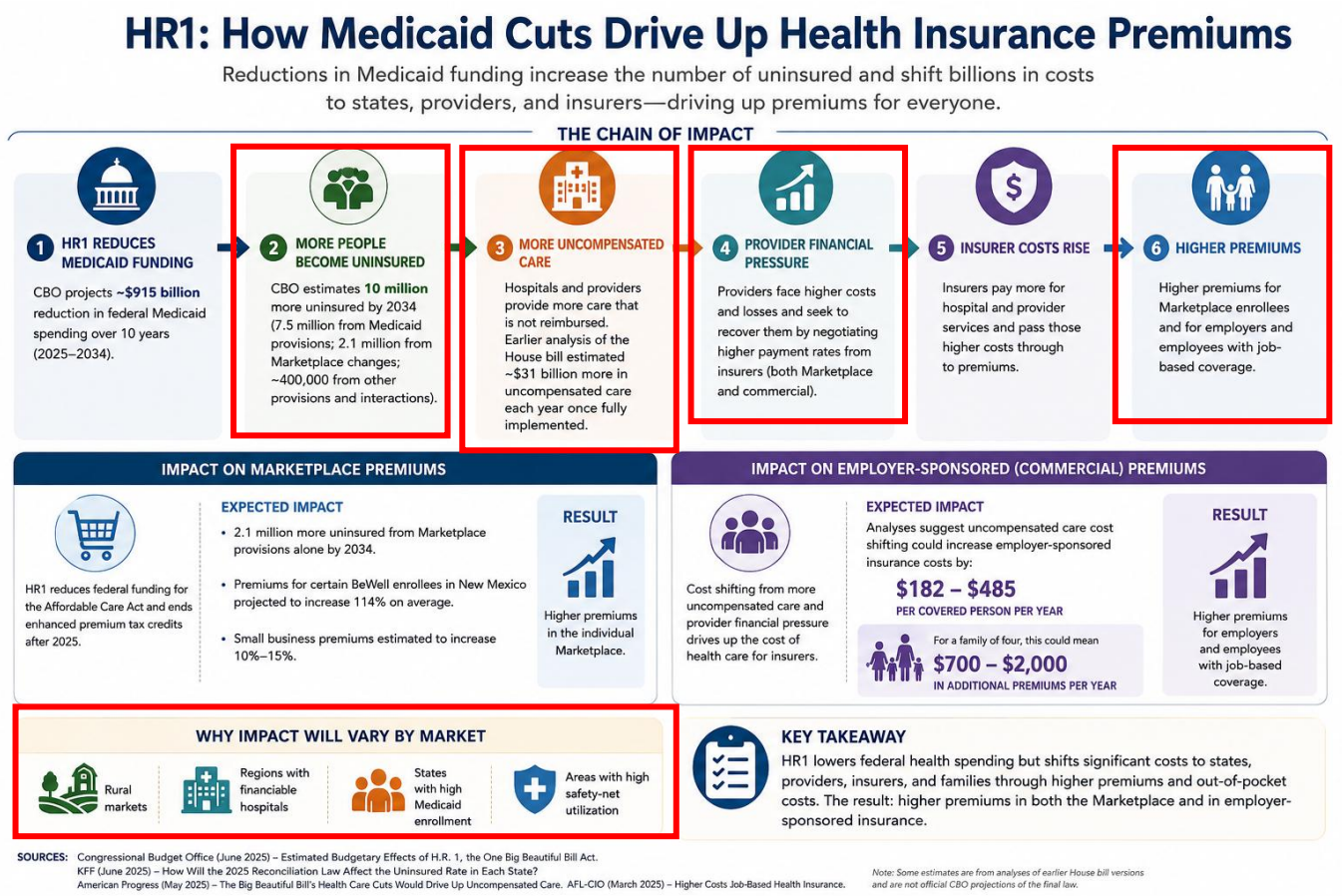
CAP Monitoring Progress

- HCA has facilitated 3 monitoring meetings with PHP between March and June.
- PHP demonstrated significant improvement at the 6/17/26 CAP monitoring meeting
- 7 subdomains are currently subject to ongoing monitoring & reporting
- 5 quantitative goals have shown sustained improvement over 6 months including:
  - 100% Well Child Visits completed for CISC within 30 days of entering custody since December 2025.
  - In Q1 of CY2026, 71% of CISC received a face-to-face care coordination visit, compared to 14% in Q1 2025
- 19 goals are currently being considered for acceptance/closure
- 7 goals are currently being considered to remain open for ongoing monitoring

HR1 POTENTIAL IMPACTS ON HEALTH CARE COSTS

HR1 WILL RESULT IN HIGHER COSTS ACROSS NM'S COMMERCIAL HEALTH CARE MARKET

- HR1 impacts will result in more uninsured New Mexicans and higher uncompensated care:
  - **~89,000** New Mexicans expected to lose coverage due to work requirements
  - **101,760** New Mexicans expected to churn off of coverage for at least two months due to more frequent reverification rules
  - **2,350** New Mexicans will lose federal Medicaid eligibility due to changes in covered immigration status
  - **5,648** New Mexicans expected to lose at least one month of coverage due to new limits on retroactive Medicaid
  - **$5.9B** loss in reimbursements to NM hospitals from 2028 to 2037
  - New proposed rules indicate further caps on provider payments that will impact **all rates** set above 100% of Medicare

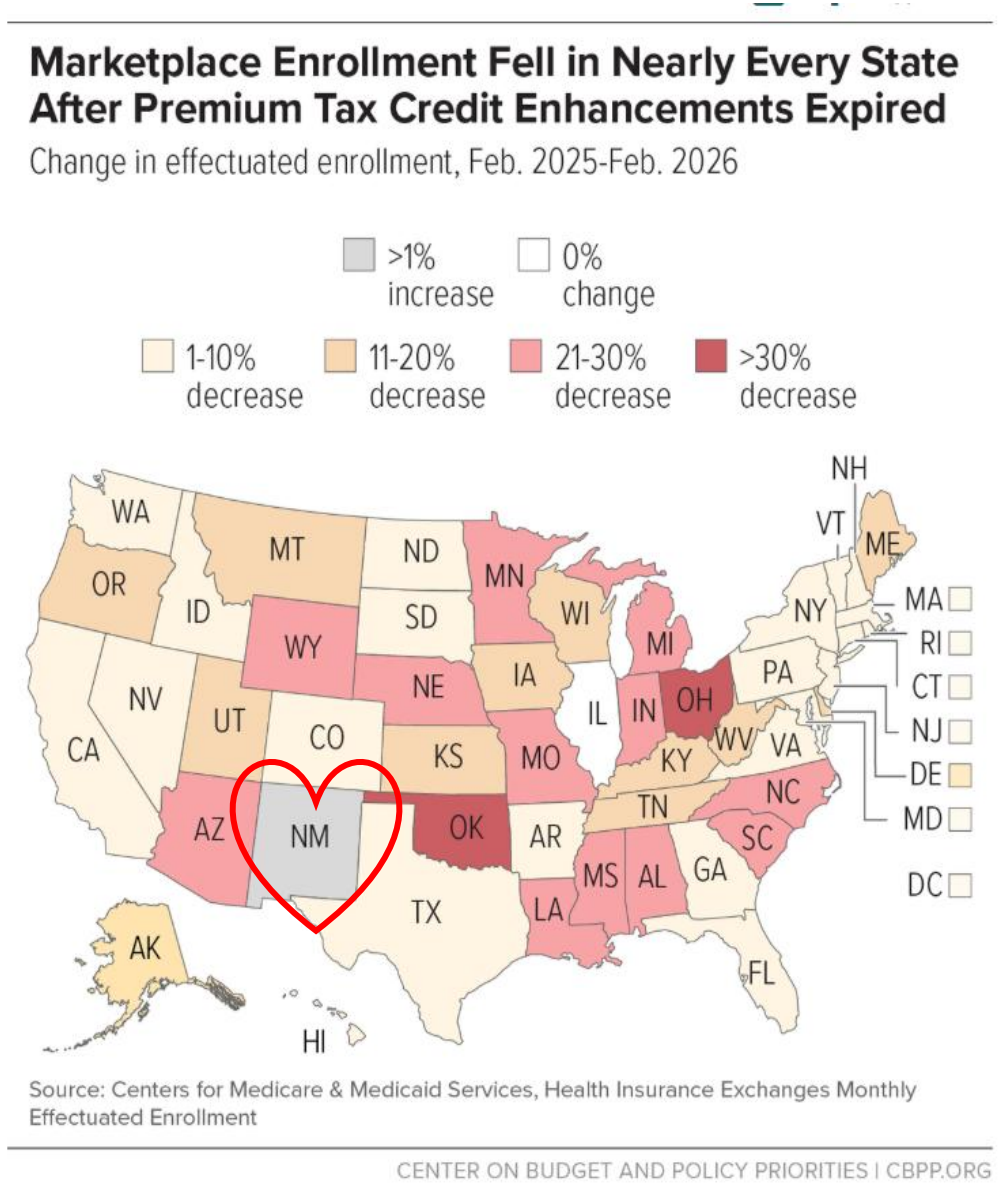


HEALTH CARE AUTHORITY

Investing for tomorrow, delivering today.

NM IS THE ONLY STATE THAT EXPERIENCED MARKETPLACE ENROLLMENT GROWTH

- Expiration of enhanced premium tax credits at the federal level drove a steep national decline in Marketplace enrollment and a sharp rise in monthly premiums.
- Each uninsured person produces approximately $1,400-$1,700 or more in uncompensated care and often enters the system later and through more expensive settings
- New Mexico is the exception: Marketplace enrollment increased 15.4% (82,407 New Mexicans)
  - 12,790 first-time consumers (14.2% increase)
- Enrollment growth directly attributable to affordability programs covered by the HCA's Health Care Affordability Fund (HCAF)



QUESTIONS