ataACTION
Telehealth Policy to Transform Healthcare

November 6, 2026

New Mexico Health Care Authority
Office of the Secretary
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

RE: ATA Action Comments on Proposed Amendments to 8.310.2 NMAC — Subsection M, Telehealth Services

To the Medical Assistance Division,

On behalf of ATA Action, I am writing to comment on the proposed amendments to 8.310.2 NMAC, General Benefit Description. Our comments address Subsection M, Telehealth Services. Several of the proposed changes would narrow telehealth coverage for New Mexico Medicaid recipients relative to the rule currently in effect, and we respectfully urge the Division to reconsider them before adoption**.**

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy and accelerating the adoption of technology-enabled healthcare. Working collaboratively with federal and state legislators and policymakers, our organization drives industry momentum by influencing legislative and regulatory developments in telehealth, virtual care, remote patient monitoring, artificial intelligence in health, health data privacy, private sector healthcare investment, and more. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

Provisions ATA Action Supports

We note at the outset that the Division has retained several provisions that reflect sound telehealth policy. Subsection M(3) continues to reimburse store-and-forward services and expressly recognizes asynchronous encounters, a recognition that many state Medicaid programs still lack. Subsection M(1)(d) retains payment parity, reimbursing professional services at the originating and distant sites at the same rate as when furnished without a telecommunication system. The rule continues to provide that a certified Medicaid provider need not be physically present with the recipient at the originating site, and the addition of rural emergency hospitals as an eligible originating site at M(1)(a)(xv) is a useful expansion. We support each of these.

ATA Action is also supportive of the amendments that will expand coverage for lactation services (8.310.2.12 D. (5)) and medically tailored meals and grocery boxes (8.310.2.12 L.(8)(b)). Recognizing that integrating nutrition services into virtual care models can have transformative impacts on health outcomes and reduce healthcare costs, ATA Action launched the Virtual Foodcare Coalition to support the enactment of state and federal telehealth policies that expand access to foodcare, including lactation services. Both of these amendments will make meaningful changes in health outcomes for expecting mothers with diabetes, new mothers and their children.

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I. The Amendment Narrows Audio-Only Coverage

Under the rule currently in effect, Subsection M(2) provides that "MAD will reimburse eligible providers for limited professional services delivered by telephone without video." That provision carries no restriction on where the recipient must be located and no precondition regarding the availability of video. The proposed amendment strikes it.

In its place, new Subsection M(1)(2) permits audio-only delivery only where the service is "furnished to a patient in their home," and only "provided that the furnishing physician or practitioner is technically capable of using audio-video communication technology and that the beneficiary is not capable of or does not consent to using audio-video communication technology." The provision closes by restating that "in general, audio-only telehealth services are only permitted if the beneficiary is in their home."

We recognize that the new provision reaches "any telehealth service" rather than the "limited professional services" covered today, and that this is a broadening in one respect. But it is a narrowing in two others, and we believe the net effect disadvantages the recipients most in need.

The home-only limitation works against the circumstances in which audio-only delivery matters most. A recipient uses audio-only because video is unavailable to them, because they lack broadband at home, because their device cannot support video or because the connection where they are is insufficient. Confining audio-only to the home excludes the recipient who travels to a relative's house, a workplace, a library or a parking lot precisely because that is where a usable connection exists. In a state with New Mexico's geography and connectivity profile, that is not a marginal population.

The second condition treats audio-only as a modality of last resort rather than a clinically appropriate choice. Coverage turns on whether the recipient is "not capable of" using video, which invites a documentation inquiry into the recipient's equipment and connectivity at each encounter, and on whether the provider is "technically capable" of video, which has no bearing on the quality of the service the recipient receives. Neither condition asks the question that matters, whether audio-only delivery is clinically appropriate to meet the standard of care for the service being furnished.

We note that New Mexico's own Telehealth Act defines telehealth to include both "interactive audio" and "store-and-forward technologies," without qualification as to the recipient's location or the availability of video.[1]

II. The New Conditions Are Drawn from Medicare, Which Does Not Constrain Medicaid

The conditions in new Subsection M(1)(2) closely track the narrow audio-only allowance Medicare applies to certain behavioral health services furnished in the home. The originating-site list at M(1)(a) is likewise drawn from Medicare, with each entry cited to a section of the Social Security Act governing Medicare telehealth.

Medicare's telehealth restrictions exist because Congress wrote them into the Medicare statute. No parallel constraint applies to Medicaid. The Centers for Medicare & Medicaid Services has advised that states "have broad flexibility in designing the parameters of telehealth delivery methods," and that

[1] NMSA 1978, § 24-25-3

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telehealth "can also be conducted via audio-only, as states deem appropriate."[2] A state that reimburses telehealth on the same basis as an in-person service need not submit a separate state plan amendment to do so.

New Mexico is therefore arbitrarily importing limitations it is not required to adopt. We respectfully suggest that the Division consider whether Medicare's framework is the right model for a Medicaid program serving a largely rural state.

None of these changes would expand the services New Mexico Medicaid covers. Every service delivered by telehealth would remain subject to the same medical necessity standards, program restrictions, coverage limitations and provider requirements that apply when the service is furnished in person. What the changes preserve is the ability of recipients to reach those services through the modality available to them.

Thank you for the opportunity to comment. We would welcome the opportunity to provide any additional information that may be useful to the Division. If you have any questions or would like to discuss the telehealth industry's perspective further, please contact me at hyoung@ataaction.org.

Kind regards,

Hunter Young

Hunter Young
Head of State Government Relations
ATA Action

[2] Centers for Medicare & Medicaid Services, Telehealth, Medicaid.gov, https://www.medicaid.gov/medicaid/benefits/telehealth