To the New Mexico Department of Health:

I am a Marine Corps veteran and a New Mexico resident living in Albuquerque. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

New Mexico has high rates of suicide, particularly among veterans and first responders. Psychedelic access is suicide prevention, but only if people can reach the program.

I ask the department to make the following changes in the final rule.

1. The certifying clinician, 7.35.3.8 and 7.35.3.9(D)

I ask the department to consider these solutions:

a) Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation, from a clinician whose scope of practice fits that risk, that screening was conducted and benefits outweigh risks. Allow the patient's own treating provider to serve that role.

b) At minimum, delete the controlled substance number requirement at 7.35.3.9(D)(2), so that any New Mexico provider licensed to diagnose the qualifying condition may certify.

This is how both operating state programs work. Screening happens inside the care relationship, and referral follows when a risk exceeds the provider's scope, the same way it does everywhere else in medicine.

The design misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time prescriber gateway misses them. It also goes stale. The in-person exam behind a certification may already be six months old (7.35.3.13(A)), and enrollment then lasts two years (7.35.3.8(E)). A patient could be dosed on the strength of a physical exam up to two and a half years old, signed by a clinician who has not seen them since. The practitioner who sees the patient the week of the session has no role at entry.

The gate also degrades the screening it exists to perform. Full disclosure is not the default when someone is clearing a gate. A patient who must satisfy a stranger has every reason to leave things out. Disclosure is more complete inside an ongoing relationship with the providers who will actually be in the room.

The credential is the wrong proxy. The certifying clinician completes eight hours of psilocybin training (7.35.3.18(B)). Practitioners and facilitators complete at least 70

didactic hours, 10 hours of simulated patient experience, and 100 to 120 practicum hours (7.35.3.18(C) through (E); 7.35.3.19), covering drug interactions, pharmacology, and psychedelic emergencies. The certifying module even includes education on diagnosing the qualifying conditions (7.35.3.18(B)(4)), which is the core scope of the licensed counselors and social workers this rule excludes. Under 7.35.3.9(E) and 7.35.3.14(A), a licensed counselor or clinical social worker may be the practitioner who administers psilocybin and manages the entire session. That same provider may not certify the patient.

The design exceeds the Act. The Act defines a clinician as a New Mexico licensed health care provider permitted by the department to provide medical services, meaning preparation, administration, and integration (26-2D-3(B) and (D)). A qualified patient is one "whose clinician has judged" them to be a medically appropriate candidate based on a diagnosis of a qualifying condition (26-2D-3(H)). That judgment belongs to the clinician who provides the patient's care. Nothing in the Act requires prescriptive authority, and the Legislature removed psilocybin from the state's Schedule I for this use (30-31-6(E)). The rule instead requires a controlled substance registration from a clinician who provides none of the medical services the Act describes.

Few prescribers will accept the role. The certifying clinician is the first signature in the chain of liability. For the next two years the patient may work with any certified team at any location, and the certifying clinician does not choose that team, supervise it, or see the patient again. There is no established standard of care for psilocybin services, and many malpractice carriers exclude federally illegal activity. That is liability without authority, in a state where 32 of 33 counties are federally designated Health Professional Shortage Areas. A safety requirement that qualified providers decline to perform is an empty chair at the front of the program. Veterans are hit hardest. VA providers are federal employees and cannot certify, so a veteran whose care has always run through the VA starts from nothing.

The entry encounter is unlikely to be covered. It is a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks. The adjacent program bears this out. In a survey our team conducted this summer of the medical cannabis certification market, no provider in New Mexico could be confirmed to bill any insurer for a certification visit, and certification businesses are not enrolled Medicaid providers. The Act seats a Health Care Authority representative on the advisory board (26-2D-8(A)), a sign that coverage was part of the design. A cash-only front door defeats it.

2. The patient application, 7.35.3.8

I ask the department to consider these solutions:

a) Strike the patient application process.

b) At minimum, make enrollment effective when the clinician's certification is filed, with the department retaining its authority to audit, investigate, and act on problems after the fact.

The department should be a recipient of program information, not the arbiter of admission.

The Act does not call for it. A qualified patient is defined by the clinician's judgment alone (26-2D-3(H)), and the Act's protections attach to that status (26-2D-5). The Lynn and Erin Compassionate Use Act was built around a state-issued registry identification card. The Legislature did not build this program that way.

The cannabis rationale does not carry over. The cannabis registry rules state that their requirements exist so the state can distinguish authorized use from unauthorized use under its criminal laws (7.34.3.2 NMAC). That makes sense for a substance patients possess and use at home. Under these rules psilocybin may only be consumed at a certified location (7.35.3.20(C)), in a supervised session, tracked by chain of custody (7.35.3.14(D)). There is nothing left for a patient registry to distinguish.

The information already reaches the department. Practitioners and facilitators report dates of service, administration, product identification, dosage, integration, and adverse events (7.35.3.13(C)). Healing centers and other approved locations keep patient lists and daily logs in the department's system (7.35.3.20(A) and (E)) and report adverse events within two days (7.35.3.20(M)). Data collection under the Act (26-2D-9) does not require an approval gate.

It lengthens the wait for care. After a licensed clinician has made a professional judgment, the department reserves up to thirty days to approve or deny admission (7.35.3.8(C)). The department has not examined the patient and holds no clinical information the clinician lacks. There is no expedited path, and end-of-life care is a qualifying condition. Enrollment then expires after two years and the process repeats (7.35.3.8(E)).

It creates a store of sensitive data the program does not need. The application collects a copy of photo identification, full contact information, and a signed release of medical information (7.35.3.8(A)), and allows the department to contact clinicians and review medical records (7.35.3.8(C)(2)). The result is a single database linking named individuals to diagnoses of PTSD, depression, substance use disorder, and terminal illness, tied to a substance that remains federally illegal. That database can be breached, or reached by legal process, without the patient's consent. The Act points the other way. It requires that program data be reported so no individual patient can be identified (26-2D-9), and it treats condition petitions as confidential personal health information (26-2D-8(B)(3)).

It further stigmatizes patients. Requiring people with PTSD, depression, or a substance use disorder to register with the state before they may receive care treats that care as something to be permitted rather than provided. Behavioral health care is health care.

It also burdens the department, which must review every application within thirty days, handle informal reviews and appeals, and process re-enrollment every two years, time better spent overseeing providers and locations.

3. The property-owner statement, 7.35.3.11(B)(9)

I ask the department to consider these solutions:

a) Add to paragraph (B)(9) of 7.35.3.11: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

b) Delete paragraph (B)(9) of 7.35.3.11.

Other approved locations exist for the patients who cannot reach a healing center: those who cannot be physically transported, those with other medical necessity, and those in rural and frontier counties (7.35.3.11(B)). This requirement falls hardest on exactly those patients.

The landlord interests that justify restrictions on cannabis, such as smoke, odor, residue, fire risk, and home cultivation, are not present in a supervised psilocybin session. Nothing is burned, nothing is grown, and certified providers are present throughout. Federal illegality alone does not justify it either. New Mexico has already chosen to depart from federal law on this (30-31-6(E); 26-2D-5). Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and invites challenge under state protections against disability discrimination.

The provision also inverts the default. Property owners can already restrict conduct on their property. This rule requires their written sign-off in advance, so an owner who simply does not respond has blocked care. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

The statement is itself a disclosure. It tells the person who controls a patient's housing that the patient is in a program limited to people with PTSD, depression, substance use disorder, or a terminal illness. That disclosure alone can put a tenancy at risk.

For some patients, asking is dangerous. The Act requires the department's annual assessment to consider the needs of patients living in federal subsidized housing (26-2D-9). Landlords of federally assisted housing operate under federal rules that treat

illegal drug use, including use permitted under state law, as grounds to deny or end tenancy. For those patients, requesting the signature may put their housing at risk.

Long-term care facilities will not sign. A nursing home or assisted living facility that depends on Medicare and Medicaid certification has every reason to refuse, and its residents, many near the end of life, often have no practical way to reach a healing center.

Thank you for considering my comment.

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