NEW MEXICO DEPARTMENT OF HEALTH

PROPOSED ADOPTION OF NEW RULE 7.35.3 NMAC

AND

PROPOSED AMENDMENT OF 7.35.2 NMAC

RULEMAKING HEARING

REPORT OF HEARING OFFICER

Public Hearing:	Proposed Adoption of New Rule 7.35.3 NMAC and Proposed Amendments of 7.35.2.7 NMAC, 7.35.2.10 NMAC, and 7.35.2.24 NMAC
Actions in Question:	Rule Promulgation Hearing
Hearing Date:	October 2, 2026
Report Date:	November 13, 2026

Introduction

A public hearing was held on Friday, October 2, 2026, at 9:00 a.m. in person at the Harold Runnels Building located at 1190 St. Francis Drive, Santa Fe, New Mexico, via the Microsoft Teams web conference platform, and via telephone. The hearing was held for the purpose of considering the Department of Health's ("DOH" or "the Department") proposed adoption of new rule 7.35.3 NMAC ("New Mexico Psilocybin Program—Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs") and the proposed amendments of 7.35.2.7 NMAC ("Definitions"), 7.35.2.10 NMAC ("General Producer Requirements"), and 7.35.2.24 NMAC ("Requirements Concerning the Transportation of Psilocybin") in the New Mexico Department of Health's rules.

The Notice of Public Hearing

The Notice of Public Hearing ("the Notice") states that the public hearing would be conducted to receive public comments regarding the proposed new rule 7.35.3 NMAC concerning the New Mexico Psilocybin Program (DOH Exhibit 1), and the proposed amendments to 7.35.2.7 NMAC, 7.35.2.10 NMAC, and 7.35.2.24 NMAC (DOH Exhibit 2). The hearing was held pursuant to NMSA 1978, §9-7-6(E) of the Department of Health Act; and NMSA 1978, §26-2D-7 of the Medical Psilocybin Act (DOH Exhibit No. 3.)

The Notice of Public Hearing further states that the purpose of the proposed adoption of the new rule and the proposed amendments to the rule is to implement the Medical Psilocybin Act at Section 26-2D7, NMSA 1978, which requires the Department to establish:

- Appropriate qualifying conditions for qualified patients;

- Necessary initial and ongoing training for producers and clinicians;
- Treatment protocols, including patient selection criteria, medical service standards, dosage standards and approved settings for administration of psilocybin to patients;
- Safety protocols for transporting, storing and handling psilocybin and treating patients;
- Other best practices for producers and clinicians;
- Requirements for data collection to evaluate the program and the use of best practices by producers and clinicians; and
- Other requirements, restrictions and limitation to ensure an efficacious program.

See DOH Exhibit No. 3.

Summary of Proceedings

Craig T. Erickson presided as Hearing Officer at the October 2, 2026 hearing. The DOH was represented by Chris Woodward, Deputy General Counsel for the Department. The other participants in the hearing included the following individuals:

1. Dominick Zurlo, Director of the Center for Medical Cannabis & Psilocybin at the DOH;

2. Jacob Clark, law clerk and office manager of the Office of General Counsel at the Department.

The proceeding was recorded via Microsoft Teams, and began at approximately 9:02 a.m.

The Hearing Officer opened the proceeding by introducing himself and Mr. Woodward. The Hearing Officer also introduced Dr. Zurlo. The Hearing Officer stated that he had been appointed to act as hearing officer in this matter by Cabinet Secretary Gina DeBlassie. The Hearing Officer then explained that the purpose of the hearing was to give the public an opportunity to comment on the proposed new rule 7.35.3 NMAC and the proposed amendments to 7.35.2 NMAC.

The Hearing Officer noted that, pursuant to notice, this matter was heard on the 2nd day of October, in-person, via a Microsoft Teams video conference platform, and via telephone. Also, pursuant to notice, the Hearing Officer stated that the public had been given the opportunity to comment on the proposed rule in-person, via Microsoft Teams, and telephonically. The Hearing Officer also stated that opportunity was given to the public to submit written comments via email messages through the close of business on the day of hearing.

Also, the Hearing Officer stated that pursuant to notice, the public had been given the opportunity to comment on the proposed rule in person and via the live web conference platform and telephonically. The opportunity was also given to the public to submit written comments through the close of business today.

The Hearing Officer informed the public that this is a recorded proceeding.

The Hearing Officer explained that the hearing would proceed as follows:

- Dr. Zurlo would give a brief introduction regarding the proposed new rule.
- Mr. Woodward would then introduce and move for the admission of the hearing exhibits into the record.
- The Hearing Officer would then take public comments on each section of the rule from those wishing to offer comments. Each person would be allotted five minutes to speak.

The Hearing Officer also explained that the Department is not bound by the formal rules of evidence during these proceedings. However, the Hearing Officer may, in his discretion, exclude evidence that is incompetent, irrelevant, immaterial or unduly repetitious. The Hearing Office may take notice of judicially cognizable, technical or scientific facts within the Department's specialized knowledge.

Introductory Remarks of Dominick Zurlo

Dr. Zurlo expressed his appreciation for all the work and effort that has gone into the creation of these rules, and for everything that has happened in the last year. He noted that there had been over 75 public meetings between committees and board meetings in order to work through the different aspects of this rule, and also the previous rule and future rules that are in the making now. He specifically mentioned the Treatment Equity Fund.

He stated that this hearing is not for the Treatment Equity Fund. It is for the proposed rule for patients, certifying clinicians, practitioners, facilitators, healing centers, other approved locations and educational programs in Title 7, Chapter 35, Part 3.

He stated that 7.35.3.8 NMAC includes the patient enrollment application process, and this section defines what patients will need to do to be registered for the program. He further stated, as a note, that this is a *registration* process. The Department is not actually going to be approving the medical qualifications of the patient; it is simply to register the patient to ensure that they have met the requirements of the program.

7.35.3.8 NMAC establishes the requirements for the application for certifying clinician practitioners and facilitators. This section outlines the requirements for the different positions and what they will need to do to be certified.

He stated that 7.35.3.10 NMAC addresses the application process for certification as a certifying clinician, practitioner, or facilitator based on educational programs from other jurisdictions. This section outlines the different was that people what have been trained and educated in other jurisdictions such as Colorado, Oregon, Australia, and Canada in their approved programs and other programs that are deemed to match the requirements in New Mexico can obtain certification in New Mexico.

Section 7.35.3.11 addresses the process for the application for the healing centers where individuals will be able to receive treatment for psilocybin. It also includes the rule for other approved locations if there is not a healing center or a defined healing center in an area for other locations to be utilized for patients to be able to receive treatment.

Dr. Zurlo stated that 7.35.3.12 provides the application process for the psilocybin educational programs that develop in New Mexico. This section outlines what those requirements are, including what their requirements are for their instructors, also outlining what those programs will need to do in order to enroll students and the records that they need to maintain. It also provides the time periods that they will need to be approved, the requirements and prohibitions for certifying clinicians, practitioners, and facilitators.

7.35.3.13 goes through the requirements for the scopes of work for certifying clinicians and what is required to ensure that there is a clinician-patient relationship. It also addresses the requirements for telemedicine.

7.35.3.14 addresses possession, purchase or sale of medical psilocybin by practitioners, facilitators, healing center owners and employees, and chain of custody.

7.35.3.15 addresses psilocybin education programs, required reporting, and curricula approval. It also goes through what the educational programs will need to submit for their approval and certification, and what is required for reports of updates to their curriculum and their program.

7.35.3.16 addresses the requirements for third party evaluators of educational programs. This section outlines how educational programs will need to evaluate their curricula to determine the efficacy and the veracity of how their programs in the curricula are implemented.

Dr. Zurlo next addressed 7.35.3.17, educational programs, mentoring requirements, and record keeping. This section goes through the aspects of what the educational program requirements are to retain records and the options that need to offer with regard to mentoring. This would be after the educators and the providers have gone through their programs—additional mentoring that they provide to those providers.

7.35.3.18 contains the educational requirements for certifying clinicians, practitioners and facilitators. This section goes through the requirements of what training is necessary for the different levels of certification of provider, whether it is by the certifying clinician, practitioner, or facilitator, and goes through the different categories and topics that need to be present in the curriculum for the educational programs.

7.35.3.19 addresses practicum requirements for practitioners and facilitator. This section goes through the various requirements for individuals who wish to be certified as facilitators and practitioners, and goes through what hours they are required to have, what the restrictions are regarding that, and what the abilities are, including the minim number of practicum hours, the evaluation supervision hours, and what the standards should be.

7.35.3.20 sets forth the requirements for healing centers and other approved locations. Dr. Zurlo stated that this section goes through the requirements for healing centers to be approved, what they need to have in their facilities, the cautions and precautions that they need to take, and the ability for them to respond to emergencies that may occur.

7.35.3.21 addresses Department evaluation and assessment of psilocybin educational programs, healing center, and other approved locations. This Section allows the Department to conduct site visits to review materials that are submitted by these certified locations and to ensure that those locations are safe and are actually being safe for the patients and for those practitioners and facilitators who are conducting administration or therapying those areas.

7.35.3.22 addresses prohibitions and limitations for qualified patients. This Section goes over what patients and certificants are able and allowed to do under the law and under the Medical Psilocybin Act.

7.35.3.23 provides that a certificant or person who holds an ownership in a certificant shall not also hold an ownership for a permitee.

7.35.3.24 addresses complaints to the Department and the methodology for those submissions.

7.35.3.25 addresses informal administrative review of denied patient applications. This Section goes through the possibility if applications are denied for any reason, what the procedures are for administrative review of that application and for final determination.

7.35.3.26 addresses voluntary withdrawal from enrollment or relinquishment of certification. It allows for a certificant or patient to withdraw from the program at any time in writing.

7.35.3.27 addresses disciplinary actions and appeal processes for enrolled patients, patient applicants, certificants and applicants for certification. It focuses on the potential grounds for disciplinary action, how that individual could then request a hearing, and the timing and logistics for the hearing, as well as the procedure to ensure that that is done with due process for those individuals.

7.35.3.28 states that the provision of this rule are separate and severable.

Dr. Zurlo then turned to the proposed amendments to 7.35.2 NMAC.

He stated that 7.35.2 addresses different definitions that needed to be added to the new rule, and the new proposed rule refers back to section. It includes items such as what are adverse health events for reporting purposes, what a certificant is, a certifying clinician expiration date, etc., healing centers approved locations, and outlines what those definitions are.

He closed by saying that the amendment to 7.35.2.24 is some clarification with regard to the requirements for the transportation of psilocybin to expand that rule.

Introduction of the Exhibits by Chris Woodward

Mr. Woodward provided a summary of the proposed exhibits for the hearing, which had been previously submitted to the Hearing Officer. Mr. Woodward stated as follows:

He stated that the proposed exhibits were available on the DOH website, and also were available on the Sunshine Portal. He then identified the exhibits, as follows:

DOH Exhibit 1 is the proposed new rule 7.35.3 NMAC

DOH Exhibit 2 is the proposed amendment to 7.35.2 at Sections 7, 10, and 24. Section 7 is the definition section. Section 10 is the general producer requirements. Section 24 contains the requirements for transportation of psilocybin. The amendments are in red-line text, so you can see exactly what has been proposed to be changed.

DOH Exhibit 3 is the Notice of Public Hearing for this rulemaking process. It is the notice of hearing for the hearing being held on October 2, with a description of the proposed rule and how public comments can be submitted.

DOH Exhibit 4 is an affidavit of publication from the Albuquerque Journal, a newspaper of general circulation in the state of New Mexico, attesting consistent with the State Rules Act that the Notice of Hearing was published on August 25, 2026.

DOH Exhibit 5 is an affidavit of publication for the New Mexico Register, published by State Records and Archives. It is the official publication for all notices and rules in the state of New Mexico. and it attests that the notice of hearing was duly published in the New Mexico Register by State Records Center and Archives, in issue No. 16, Volume 37.

DOH Exhibit 6 is the August 24, 2026 letter from Secretary Gina DeBlassie appointing Craig Erickson as hearing officer in this rulemaking proceeding.

DOH Exhibit 7 is an affidavit from Jacob Clark attesting to the various things the Department of Health has done to comply with the notice requirements of the State Rules Act—the publication of the Notice, the posting of the Notice, and circulation of the Notice by email to various parties..

DOH Exhibit 8 contains all of the written public comments in this proceeding.

Mr. Woodward stated that any public comments that were submitted to the Department prior to the close of business on the day of hearing would be added to DOH Exhibit 8. He said that about 80 public comments had been received.

Mr. Woodward then moved for the admission of DOH Exhibits 1 through 8. The motion was granted at hearing, and the Exhibits became part of the record in this proceeding. Ultimately,

the written comments, including those submitted prior to 5:00 PM on the day of hearing, included DOH Exhibits 8.A through 8.XXX.

On November 9, 2026, Mr. Woodward submitted a written response to the written public comments on behalf of the Department. That document was made DOH Exhibit No. 9 and the Hearing Officer admitted it as part of the record in this proceeding.

Public Comments

The following are the comments that were offered by members of the public at hearing.

The Public Comment of Barak Wolff

Mr. Wolff stated that he is a founding board member of End-of-Life Options New Mexico ("EOLO"). EOLO is a nonprofit that was created in 2021 with a mission to provide statewide information and support about end-of-life options, including medical aid and dying. He stated that he had 25 years of work in public health. He worked in rural health, EMS and trauma systems, and as the direction of the Public Health Division. Since retirement, he has worked for 20 years as a senior analyst at the Senate Health and Public Affairs Committee during the legislative sessions. He stated that he has drafted many sets of regulations over the years, and helped implement the programs involved with some assistance from time to time. He noted "this auditorium is familiar territory."

Mr. Wolff stated that EOLO was involved in the development of the Medical Psilocybin Act ("MPA") to a limited extent, but was an early and strong advocate for its passage. He has been involved with Dr. Leeman's Advisory Subcommittee over the past many months and has been well impressed with the active engagement of clinicians and advocates working on behalf of those who will benefit from the program. The work of the Advisory Committee has been both professional and client-focused to create a program that will help ensure access to a safe and high-quality program.

He then stated that, as evidenced in the numerous public comments that we would hear on the day of hearing and in writing, there are several key areas where the proposed regulations fall short of expectations. He hopes this hearing process will lead to some significant changes.

The written comment from EOLO to the New Mexico Board of Directors which have been submitted with their specific concerns, outline and offer clear recommendations for changes in the areas of landlord notification/approval, including long-term care facilities, which is particularly important for people at the end of life. He also noted the issues of provider certification when these clients have a prognosis of less than nine months to live and are already deeply engaged in the medical care system, and the requirement of participation registration with the Department.

He stated that he is not going into detail, but these areas of the regulations have created some unnecessary and deleterious burdens on people at the end of life.

Mr. Wolff closed his remarks by stating that he appreciates the thought and dedicated work of DOH staff on this important new program, as well as the hundreds of people who have been actively working on crafting this new and innovative program with so much potential. His caution, based on years of experience, is that when you request and provide the opportunity for public participation, you really need to be responsive to the voices you are going to hear.

The Public Comment of Lance Chilton, MD

Dr. Chilton practiced pediatric medicine for 43 years in Albuquerque, Gallup, Taos, and Santa Fe. He retired a few years ago. He is also a board member of EOLO, because he believes all of us should have options at the end of our lives.

He stated that he is impressed that medical evidence suggest that psilocybin may be a good option for some end-of-life New Mexicans. It may help to relieve the anxiety and depression that people experience when they know they are dying.

He was pleased when the legislature passed the legislation that established this program.

He stated that psilocybin may be a partial answer to helping people at the end of their lives face daunting decisions and choices, as long as it isn't made unnecessarily difficult to access this medication . . . adding to the problems that people face at the end of their lives.

Dr. Chilton noted that, unlike cannabis, psilocybin usage affects only the person to whom it is administered. No vapor is given off, and no residue is left on nearby surfaces.

He encouraged the easing of some of the restrictions on psilocybin usage, at least for end-of-life patients thought to be within their last six months of life when they have already been determined to be eligible for hospice services.

The Public Comment of Chris Peskuski

Mr. Peskuski is a Marine Corps veteran living in Albuquerque and a peer facilitator in the UNMS psilocybin study for PTSD.

He stated that about 25,000 people have now received psychedelic care through state regulated programs with very few adverse events. The Hero Card Project has spent almost a decade helping veterans prepare for and integrate psychedelic experiences, many of them carrying PTSD, depression, and depression and addiction at once.

He stated that these systems work. Colorado built on what Oregon learned, and both rely on what every field of medicine already does. The provider who knows the patient screens them and refers out when something exceeds their scope. New Mexico goes further. Under New Mexico law, licensed clinicians deliver every treatment, and these rules put a licensed behavioral health provider in the room for every dose. That is more clinical oversight than Oregon or Colorado require.

However, he asserted, at the front door, these rules turn away from all of that and toward the medical cannabis program, a law written nearly 20 years ago. He argued that the laws have changed, times have changed, and the medicine is different. Under these rules, nobody gets in without a prescriber's signature, a recent in-person exam, and up to 30 days waiting on state approval.

He argued that that gate does not provide added safety, stating that clinical risk involves dynamic tracking and an ongoing relationship. A one-time appointment is a gateway, and at a gateway people disclose selectively.

Mr. Peskuski stated that he is asking for five changes:

- Remove the controlled substance number requirements so that licensed behavioral health providers with diagnostic authority can certify patients into the program.
- Bring physicians in with screening flags which have real medical risk.
- Strike the application process. The Department should receive patient information, not be the arbiters of approval.
- Allow individual sessions with one licensed practitioner, as Colorado does.
- Remove the landlord signature requirement for treatment at home.

Mr. Peskuski stated that he had to leave the country to get help and it worked. Many do not have the capacity to do that, and this program was created to they would not have to. He stated that dangling access just of reach is an insult to veterans and first responders who need it. It will leave them coping in unhealthy ways. They survived combat and the calls no one else would take; some won't survive this way.

The Public Comment of Crystal Romero

Ms. Romero is an Army National Guard veteran and a member of the UNM Group Psilocybin Assisted Therapy Research Team. She stated that she wanted to echo what her colleague Mr. Peskuski shared, but also wanted to ask us to think about what is at stake beyond the regulations themselves.

She stated that many of the people who come through these doors will arrive after years, sometimes decades, of trauma, moral injury, institutional betrayal, and treatments that have not given them the relief that they were searching for. They are not simply consumers purchasing a service. They are people placing themselves in an incredibly vulnerable position and trusting the system we can create to protect them. That is why the people sitting beside them matter.

Training matters, screening matters, preparation matters, and integration matters. And, most of all, accountability matters, but access matters too. If we build the safest program in the country, we make it inaccessible to veterans like herself, first responders, survivors, folks that live

in rural areas of New Mexico where she is from, and people without significant financial resources, then we truly have not created access.

Thus, she said, perhaps the question before us is not simply how do we regulate psilocybin; the bigger question is what kind of system would we want someone to love to walk into at the most vulnerable moment in their life? She stated that if we build from that question with safety, compassion, competency and accessibility at the center, New Mexico then has an opportunity not merely to follow what other states have done, but to lead.

The Public Comment of Dr. Mary Curry

Dr. Curry has been in New Mexico and has been around the Department of Health for a good portion of that time. She was involved in the early implementation of the HIV/AIDS program for the nine counties in northern New Mexico, which was designed and rolled out as an integrated model that entered through behavioral health. She was also involved in the implementation and sustainability of the substance abuse screening, expert screening, brief intervention and referral to treatment program in rural and frontier areas of New Mexico, also creating an integrated model where you could access behavioral services.

She has seen New Mexico embrace innovation and do things in a way that has brought national, federal recognition to it, and she thinks we have the opportunity to do that again.

She stated that she currently has a small software company in integrated behavioral health for child, youth and family behavioral services and she works as a private practice clinician. She specializes in the treatment of traumatic stress and has served many veterans and active-duty National Guard, primarily helicopter pilots.

She thinks that one of the things about psilocybin treatment that is truly mind blowing is that it has the potential to cure, and what we have now has the potential to treat chronic psychological and physiological illness.

She is interested in understanding what kind of data is going to be collected, and what kind of data story we are going to be telling here. She said she is here to talk about changing a model where a client/patient enters through screening efforts through a certified clinician. She notes that she paid on her "own dime" $8000 to become certified through the California Institute of Integral Studies. She said that either a person is in treatment with someone who is certified, or you have a collaborative role and understanding with other clinicians where they can be screened both for health issues and psychological issues. If there is a health issue, the client/patient can go to their doctor to be sure there is no concern about, for example, hypertension, or something like that. If they are screened out medically or with mental health screening, they are screened out but that is not a gateway point. Her main concern is that inequity to access is a really high potential and it's happening.

She also encourages access to microdosing.

The Public Comment of Kate O'Flaherty

Ms. O'Flaherty is a resident of Oregon and visiting friends in New Mexico. She has participated in the Oregon program, on almost every level—as a cultivator, licensed facilitator, and then as a facilitator trainer.

After reviewing the rules, she states that she appreciates the value put on safety and access to people who are in dire situations. However, she echoes what others have said regarding "a bit of over-regulation" which might lead to problems that Oregon is currently experiencing. The Oregon department is in a budgetary crisis and a lot of service centers are shutting down. A lot of facilitators are dropping out as well.

She encourages the Department to think about lower dosage and how there is much lower risk with low dosage. She thinks the rules should only really apply to larger doses in a high-risk situation.

She thinks requiring both a facilitator and a practitioner in all sessions is a little bit much. It will raise the cost for the patient and for the program. Some people don't require that much oversight unless they are in a high-risk situation. She also thinks the number of facilitators in group sessions could be reduced, especially dependent on dose.

She is a "huge" advocate of micro-dosing.

The Public Statement of Lita Fatemi, MD

Dr. Fatemi is a board-certified internal medicine physician and hospice physician. She is an associate professor at the UNM School of Medicine and the founder of Conscious Physicians Psychedelics Academy. As a child, she survived war in Iran and lived under terrorism. Psychedelics and deep personal work helped her heal. Thus, she has firsthand experience with what this medicine can do.

She offered the following recommendations:

- Allow certifying clinician visits by telehealth.
- Remove the reporting step after medical clearance.
- Fund educational scholarships.
- Remove the landlord clause.

The Public Statement of Ellen Schimmels, NP

Ms. Schimmels is a doctoral-prepared nurse practitioner and full clinical professor with 30 years of mental health experience, including 23 years of active duty in the US Army. She is also a

trained psychedelic facilitator and a therapist with the UNM Group Psilocybin Assisted Therapy Study. Further, she is a cancer survivor. She notes that we don't approach mental health care with the same coordinated, comprehensive model that we use for conditions such as cancer.

She appreciates the proposed rules recognizing education but encourages the Board to think more broadly about it as essential to a safe, affordable and sustainable system. She urges the creation of a centralized, statewide medical psilocybin education framework in its higher public education system.

The Public Comment of Dave Lande

Mr. Lande supports microdosing. He notes that less is more. He supports more access and more options. He thinks the rental clause is not fair.

The Public Comment of Larry Leeman, MD

Dr. Leeman is a professor at the UNM School of Medicine for certified family and addiction medicine. He is co-directing a research program for psychedelic assisted therapies, and a member of the Medical Psilocybin Advisory Board and the chair suicide and end-of-life committee. He indicated he was speaking for himself, not for any of those organizations.

He suggests that the community college system is the only system that could be affordable for training facilitators.

He also stated the rules really get involved in how many people need to be there, and we need to actually think about systems of care and what is needed to have access. We need to make the end of life as easy as possible. We should not have people running around to find certifying clinicians and different things for that group.

He recommends striking the landlord provision because it requires people to reveal their healthcare conditions to the landlord and creates legal problems.

Dr. Leeman also recommends being careful about having enough training. Oregon requires 130 hours; Colorado requires 150 hours. He stated we have about 75 hours. He thinks that's good; he supports it.

He stated that the end-of-life committee felt everybody should have 8 to 10 hours of end-of-life. Colorado has two to three hours and it is not enough. This program is looking at taking care of the sickest people.

He recommends seven hours of trauma training, four hours on screening, suicidality and crisis response and specific training and challenging experiences.

The Public Comment of Patricio Dominguez

Mr. Dominguez represents the Plant Medicine University, which he states is a program in process for this specific purpose. He said he would address the trap of out-of-state corporations. He urged reliance on in-state companies.

The Public Comment of DezBaa'

DezBaa' stated that she wanted to echo everything that has been said in the hearing, especially Dr. Fatemi and Dr. Leeman. She is the Chair of the Equity Access and Cultural Considerations Committee. She was speaking as a concerned citizen and an advocate on her own behalf.

She urged the Department to consider the confluence of expert knowledge, knowledge that has been passed down through generations, including indigenous people's healers, traditional medicine people and people who have worked with the people who were present at the hearing. She said that her people are asking to have the agency to change their own world within themselves, to be able to have that within their own homes, to be able to allow their elders to peacefully transition without the bureaucracy, and to be able heal within their own capacity.

That concluded the in-person offering of public comments.

The following comments are from individual who offered public comments on-line:

The Public Comment of Paul Walton

Mr. Watson is the executive director and founder of Firefighters for Plant Medicine, which engages in advocacy, education, cultural awareness for psychedelics and medical cannabis as well. He is also a first responder and firefighter with Bernalillo County. He has used the medicine himself and it changed his life. He indicated his support for the comments made by others.

He stated that the "barriers" in the proposed rule create a problem. For firefighters, the number one line of duty death is cancer. That's the end-of-life. First responders in general resort to a coping mechanism of alcohol addiction and abuse. The number one cause of death is suicide. PTSD, complex PTSD, moral injury, severe depression and ADHD result in a lot of people who are struggling daily to do daily functions. Inserting extra barriers through the rule can inhibit someone's ability to reach treatment; it causes unnecessary stress. Those stressors can deter someone from going through the process. He argues that removing some of these barriers and lightening up the guardrails can help first responders gain access.

He agrees that safety comes first. He recommends reducing some of the barriers a bit. The only people who should be seeing a medical physician for the application is someone who has a medical condition that raises red flags.

He supports microdosing as a viable solution for therapy.

The Public Comment of Jim Dodson

Mr. Dodson stated that he is a patient advocate and citizen researcher.

He tried to use an "immersive reader" recording to present his comment. The recording could not be heard, so he said he would read it. The statement relates successful experience with psychedelic therapy.

He urges permitting home settings for treatment.

He recommends amending the rules to permit patients the right to choose their own preferred modality.

The Public Comment of Brett Phelps

Mr. Phelps is a lawyer speaking on behalf of the Psychedelic Bar Association New Mexico Working Group.

He strongly recommended that the Department exempt a patient's own resident from the landlord permission requirement. This would require that a patient disclose their participation in a lawful state regulated system for the medical use of psilocybin to their landlord and obtain the landlord's affirmative written consent.

He notes that even a landlord who support a tenant's participation in the program may understandably refuse to sign a document expressing authorizing possession and administration of psilocybin on the landlord's property.

The requirement also creates serious privacy and discrimination concerns. A request for landlord approval necessarily reveals sensitive medical information, and may invite questions about a disability or medical condition. Federal and state housing and civil right law significantly restrict discrimination based on disability and regulate how housing providers may seek and use disability related information. This places landlords in an extraordinarily difficult position—approve conduct involving a federally prohibited substance, or deny permission to a tenant seeking medical treatment authorized by state law.

Mr. Phelps asserts that the proposed rule invites litigation against the landlord and plaintiffs may challenge the regulation itself and the State's role in creating or enforcing that requirement.

His organization recommends that the Department revise the rule to expressly exempt a qualified patient's own residence from any landlord approval requirement.

The Public Comment of Senator Jeff Steinborn

Senator Steinborn is a member of the New Mexico Legislature. He is the primary author of the New Mexico Medical Psilocybin Act.

The specific issues he wanted to address include the following:

- He is totally opposed to the landlord signoff for homebound patients. He argues it is inappropriate to subordinate the legal right to access this medicine to a landlord. It violates the right of medical privacy to receive care. If the landlord does not support it, it jeopardizes the ability to receive care. He notes that the State does not request permission from the federal government for having this program.

- He is concerned about the same requirement for landlords to have to give approval to a healing center. We don't require that for other medical offices in a building.

- He agrees that we should be adding specific training in adverse experiences as follows: 8 hours for end-of-life and palliative care considerations; 7 hours for trauma and trauma informed care; 4 hours for screening suicidality and crisis response and managing challenging experiences during and after psilocybin assisted therapy.

- He is concerned about the 30-day state approval for applications to request treatment. He noted that Dr. Zurlo had stated at the beginning of the hearing that it is not a question of whether or not the state is being put in a position to decide if someone can receive treatment or not. He said that would be a huge concern, but he is also concerned that the requirement is a potential duplication of other work requirement being promulgated on providers in this rule. He strongly encourages a review of the rule to streamline. Further, it should be done a lot sooner than 30 days; maybe a week or two later.

The Public Comment of Mary Crow

Ms. Crow is a resident of Silver City. She is a family nurse practitioner, and is enrolled in New Mexico's psilocybin certification program. Her biggest concerns are penalties regarding the fact hat psilocybin has not been decriminalized and she worries about how it would affect her clients how it affects services, and how it would personally affect her.

The Public Comment of Lisa Ginsburg

Ms. Ginsburg is the founder of the Chang Institute, the nation's first government accredited training program in Oregon, Colorado, and hopefully New Mexico. She expressed her gratitude for the program and expressed that she would be proud to bring her expertise in training to New Mexico.

The Public Comment of Denali Wilson

Ms. Wilson is the Director of Strategic Support for Healing Advocacy. She identified several provisions in the draft rules that she believes will limit patient access, complicate insurance coverage, and overall increase costs to the patient and the Department, as follows:

- The certifying clinician requirement goes beyond what was anticipated in the statute. They urge a model that preserves safety without a prescriber gateway; the MPA only requires that a patient have a qualifying condition which any licensed provider authorized to diagnose can confirm. They recommend the Department regulate specific contraindications such as medication interactions, uncontrolled hypertension, history of psychosis, and whatever is supported by evidence. Heightened clinical review and attestation should only be required when a risk factor is present and should be conducted by a clinician whose scope fits the particular risk.

- A medical encounter whose only purpose is program entry lack independent medical necessity—a requirement for billing insurance. This will invite claims, denials, and clawbacks and create a liability problem. If the Department chooses to keep this role, they want to see targeted recruitment, not just of medical doctors, nurse practitioners, and psychiatric nurse practitioners, but naturopathic doctors, and doctors of oriental medicine who can help fill the provider gap that the design is likely to create.

- She urges the Department to reconsider the supervisory relationship that is created in the rule between the practitioner and the facilitator. This structure can pull the facilitator under the medical malpractice laws, but the facilitators are not eligible as covered providers, leaving them personally liable for any claims that arise from medical harm. The design also invites payers to deny insurance claims as services delivered by someone not authorized to bill. They urge treating these roles as independent with coordination, instead of a supervisory model.

- Ms. Wilson argues that the landlord attestation requirement should not apply to patients in their own home or in long-term care. They endorse the EOLO proposed exemption.

- She recommends that minimum hours of training be established for suicide, allergy, suicidality, challenging experiences, depression, and PTSD.

The Public Comment of Ian Dunn

Mr. Dunn is a patient living with PTSD and is deeply concerned about the proposed rules, especially the landlord approval requirement. He said he wants to echo the comments of Denali Wilson, Senator Steinborn, and others.

He argued that if a healthcare team determines that a home is the appropriate setting for treatment, a patient should be able to consent to treatment in his home. Nowhere else in medicine

do we tell a competent adult who lawfully occupies a home that they must ask their landlord for permission to receive medical treatment. We do not ask landlords to determine whether a treatment is medically appropriate. We should be very cautious about creating a system in which access to healthcare depends upon disclosing private medical information to someone who has no role in the patient's care.

Mr. Dunn said he is appearing in the hearing as an advocate for Gen Z. He feels a particular responsibility to point out when a rule may affect his generation differently than generations designing it. He stated that his generation has grown up during a profound mental health crisis, but has shown a remarkable willingness to seek professional mental health services.

At the same time, young adults face a housing market in which home ownership is increasingly out of reach. Under the proposed role, and homeowner retains control over where they receive care; a renter has to approach his landlord, disclose enough information to explain why permission is being requested, and hope the landlord is understandable and approves psilocybin treatment. The renter may also have to tell the landlord that they have a serious mental health condition and explain why they are getting treatment, despite the fact that it is legal. After that effort, the landlord can just say no.

This rule will most effect young adults, people with limited income, rural New Mexicans, people with disabilities, people living on Social Security income, or anyone for whom home ownership is financially inaccessible.

The question should be does the patient lawfully reside there, does the patient consent, and has the location been determined to be clinically and operationally appropriate for treatment. If the answer to those questions is yes, Mr. Dunn said that he struggles to understand what legitimate patient safety purpose is served by giving a landlord veto power.

The Public Comment of Janis Phelps

Dr. Phelps is a clinical psychologist and the founder of the California Institute of Integral Studies certification program in psychedelic therapies and research.

She expressed her support of the program and seconded the suggestions of many others, both here and in the 80 letters that have been provided for the hearing.

She suggests reconsideration of the landlord approval process. She also suggests streamlining the access process and allowing relevant telehealth to occur. She recommends providing public education and reducing training costs. She supports instituting specific trainings as recommended by Dr. Leeman and others. She suggests asking Oregon and Colorado to share their training materials.

The Public Comment of Courtni Hale, Ph.D.

Dr. Hale has a Ph.D. in transpersonal psychology and is also a generational practitioner. Her research and experience over 25 years show that the setting, the preparation, and the

relationship matter profoundly, especially in work with complex PTSD, stress, anxiety, trauma, and recovery. Her concern is that the proposed framework may create too much control in some places and not enough meaningful standards in others, especially around culturally relevant materials. She stated that facilitators need to have direct experience with plant medicine. She also stated that people who live outside the capitalist economy don't have the money, but that does not mean they don't have the right or the cultural experience.

The Public Comment of Jennifer Johnson

Ms. Johnson is a hospice RN in Taos. She is helping build an end-of-life psychedelic care program for her hospice. She is also a trained psychedelic facilitator in private practice. She supports the program and really wants it to succeed.

However, as written, these rules will keep most of her dying patients and many rural New Mexicans from ever receiving care. She requests five changes:

- Delete the property owner statement. She is a landlord herself. Many landlords won't sign it, and hospice patients who rent will lose care in their own homes.

- Remove the certifying clinician requirement. The Act requires a clinician as a licensed provider with a Department permit and makes a qualifying diagnosis the threshold for entry. Nothing in the Act requires a controlled substance registration. She echoes the comments of many who opposed this requirement.

- Strike the patient application. Again, she echoed the comments of others.

- Let registered nurses be certified as practitioners, at least for end-of-life care. Hospice nurses already assess and monitor patients, manage symptoms and medication, coordinate with physicians, and support dying patients and their families through emotional and existential distress.

- Drop the requirement for a practitioner in the room at every session. Instead, require medical clearance from a qualified provider before treatment and let the certified facilitators work within their training and license. She urges writing an exemption for dying patients from the requirement of having two certified people at every bedside.

- She is worried about the cost of the program.

The Public Comment of Maria Fini, Ph.D.

Dr. Fini is an expert in brain stimulation but has decided to transition into psychedelic medicine.

She echoed the comments of other in opposition to the landlord approval clause. She also disagrees with the requirement that a healing center needs to get approval from its landlord.

She is also concerned about the cost that will be created by the group ratios for facilitators and practitioners. She gave an example of five people being paid to be there for eight people experiencing suicide, or, as another example, eight paid facilitators and practitioners for twelve patients.

The Public Comment of Sage Romanos

Ms. Romanos is a recognized member of the Cheyenne nation. She is also the founder of Healing Gardens Church, and said she was speaking on behalf of herself as a medicine woman, and for all other indigenous tribal members and medicine people. She urged that her training not be discredited.

The Public Comment of Robin Chavez

Ms. Chavez is the founder and CEO of Red Willow Hospice. She is also a graduate of Dr. Fatemi's Conscious Physician Psychedelic Academy—a nine-month facilitator training program.

Her primary concern is equity. As drafted, these rules would make access depend on whether a patient owns a home, a specially permitted clinician, and can afford to wait for treatment.

She opposes the landlord owner statement. She stated that most hospice patients receive care in their home, and many of them are renters. Requiring a landlord signature would put care out of reach for lower income families an older adults on fixed incomes. She requests that it not apply to end-of-life patients, patients receiving home care, or long-term care residents.

Alternatively, she suggests Colorado's model where patients simply demonstrates a right to reside there.

She also opposes the certifying clinician requirement and echoes the comments of many others in doing so.

Likewise, she opposes the patient application. She notes that no patient possesses psilocybin outside of a supervised session, so the application serves no clear purpose. Further, many patients do not have 30 days to wait.

She requests that the Department strike the requirement for both a practitioner and facilitator per session which raises costs and limits availability in rural areas. She also asks that registered nurses be recognized as qualified providers within their scope of practice and that a trusted support person be permitted alongside a single qualified provider.

The Public Comment of Amy Wong Hope

Ms. Hope is a licensed social worker and a licensed natural medicine clinical facilitator.

She asserted that the certifying clinician requirement who is acting as a medical prescriber is not increasing safety and echoes the comments of many others on this issue. She said it is a very big barrier to accessibility.

She is also concerned that the requirement could create a false sense of green light for a journeyer thinking that just because they have been certified by a clinician for psilocybin that they will say to a practitioner or facilitator, since I have been greenlit for this, why are you denying me bot as mental health professionals.

She noted that sometimes a contraindication shows up a month into the process and a single prescriber session was not enough to know the contraindication was there. She recommends that this requirement be removed.

She agrees with the concerns that indigenous teachers and traditional medicine holders have with the educational requirements.

She agrees with Dr. Fini's comments regarding ratios of providers to patients.

The Public Comment of Roberto Flores, M.D.

Dr. Flores is a psychiatrist in Sunland Park. He made the point that regulatory restrictions can also influence and ultimately dictate patient behavior. He said we can use the experience of medical cannabis, where access and qualifying conditions, purchasing options, and methods were overly restricted. He urged a more flexible framework that maintains appropriate clinical safeguards while giving qualified patients reasonable autonomy on how and where treatment can occur.

He believes that the regulation should not only seek to prevent diversion, but should also avoid creating restrictions that are unintentionally encouraging patients to leave the regulated system, which he believes many people that he treats might already be trying on their own.

Participants who were present for the hearing but did not make public comments include the following:

There were no further, on-line public comments, and no comments from telephonic participants.

The Hearing Officer then explained that he would be writing a report to the Cabinet Secretary, in which he would summarize the public comments offered at hearing as well as the written comments that had been submitted to the Department. He would then make a written recommendation to the Cabinet Secretary regarding the proposed new rule.

The Hearing Officer thanked the participants for their public statements and adjourned the hearing.

Written Public Comments

The following is a summary of the written public comments[1] submitted in this rulemaking process:

The Written Public Comment of Ian Dunn

Mr. Dunn is the Chair of the Medical Psilocybin Advisory Board. He states that he strongly supports the regulatory framework proposed in 7.35.3 NMAC, but has serious concerns regarding the provision requiring a property owner's approval before a patient may receive services in their home. *See* DOH Exhibit 8.A. He argues that this requirement introduces an unjustified barrier to care, infringes on patient privacy, and misaligns with New Mexico housing law.

In support of his argument regarding New Mexico housing law, Mr. Dunn cites NMSA 1978, § 47-8-25 (the Uniform Owner-Resident Relations Act). He argues that this statute provides that a resident is required to occupy and use their leased premises as a dwelling in compliance with their rental agreement. He argues that receiving professional health or supportive care in one's home—whether delivered by nurses, aides, hospice workers, or licensed psilocybin facilitators—is an established facet of domestic life, and does not convert a residential dwelling into a commercial or nonresidential operation.

With respect to his other concerns about the requirement of obtaining property owner approval, he argues as follows:

- The requirement compromises patient privacy by forcing patients (including those with serious or terminal illnesses) to disclose confidential medical decisions to third-party landlords who have no clinical role of legal entitlement to that information.

- The requirement creates a disproportionate barrier to care by effectively granting veto power to landlords over lawful, medically appropriate care within a tenant's private residence, thereby disproportionately affecting vulnerable populations and individuals receiving hospice care.

- The requirement is an example of administrative overreach because it requires third-party property owners to authorize private healthcare delivery and sets an unprecedented standard that departs from how other home-based health services are regulated in the state.

Mr. Dunn recommends replacing the landlord-permission requirement with a standard requiring proof of lawful residence or lawful occupancy of the location.

The Written Public Comment of Patricia Singh, Ph.D. LPCC.

Dr. Singh is an independently licensed behavioral health clinician in New Mexico. She is a New Mexico Board-Approved Clinical Supervisor, and the owner and Executive Director of A

[1] All of the written public comments are located in DOH Exhibit No. 8.

New Awakening—an outpatient behavioral health organization serving individuals with substance use disorders, including individuals involved in New Mexico's criminal justice system. She is also a co-founder of Trip HoM, a psychedelic-care organization. She has completed psychedelic-assisted therapy training through the California Institute of Integral Studies. She holds Colorado Natural Medicine Facilitator and Handler credentials.

Dr. Singh first recommends that the Department clarify and preserve the transitional pathway for experienced practitioners. She supports rigorous education and competency standards for practitioners. *See* DOH Exhibit 8.B.

She notes that 7.35.3.10 NMAC provides a pathway for applicants who have completed qualifying educational programs in other jurisdictions and permits recognition of certain government-approved programs and programs in collaboration with institutions of higher education or government-approved psychedelic research studies. She also notes that 7.35.3.19(H) NMAC provides that applicants meeting specified requirements and who apply by December 31, 2027 may satisfy a reduced practicum requirement by demonstrating at least 40 hours of documented contact time rather than completing the full New Mexico practicum.

She requests that the Department provide clear guidance regarding:

- The documentation required to establish equivalency of education completed outside New Mexico;
- Whether documented preparation, administration/facilitation, integration, supervision, and practicum experience obtained through another regulated state program may be credited toward the transitional requirements.
- How established psychedelic-assisted therapy programs completed before New Mexico's education programs existed will be evaluated; and
- What forms of logs, supervision records, patient-contact documentation, or other records will be accepted to establish the required 40 hours of contact time.

Dr. Singh also requests clarification of an inconsistency in 7.35.3.10(D)(1) NMAC, which describes a reduced practicum pathway as requiring at least 40 hours of contact time with a minimum of two separate individual sessions and **two** separate group sessions involving preparation, administration, and integration. However, she states that 7.35.3.19(H) NMAC describes at least 40 hours with a minimum of two separate individual sessions and **one** group session involving preparation, administration, and integration.

Dr. Singh also seeks guidance regarding implementation for qualified patients involved in the criminal justice system. She encourages the Department to clarify that:

- Justice-system involvement does not in itself disqualify an otherwise qualified patient;
- A referral originating form a treatment court, probation department, diversion program, behavioral health provider, attorney, or other justice-system participant does not itself make participation involuntary;
- Participation in medical psilocybin treatment must remain voluntary and based upon independent clinical determination of eligibility and medical appropriateness;

- Declining medical psilocybin treatment should not itself result in an adverse consequence within a state or local treatment, diversion, probation, or community-supervision program; and
- The protections provided by the Medical Psilocybin Act apply consistently throughout program implementation.

Dr. Singh also urged the Department to protect substance use disorder confidentiality in justice-system referrals. She notes that the proposed educational requirements include training regarding 42 CFR Part 2. She states this is important because substance use disorder is a qualifying condition and because some patients may enter the program while participating in treatment court, diversion programs, probation, reentry services or other justice-related programs. Dr. Singh encouraged the Department to provide implementation guidance on exchanging information between Medical Psilocybin Program providers and justice-system referral sources. She stated that such guidance should distinguish between information that may lawfully and appropriately be disclosed pursuant to a valid authorization or other applicable legal authority and detailed clinical information that should remain protected. She urged that participation in a justice-related program should not by itself result in automatic disclosure of protected information.

Dr. Singh next stated that the Department should preserve integration with exiting behavioral health and healthcare systems; she argued that it should function within the broader continuum of care rather than as an isolated episode. She noted that many patients with substance use disorders already receive behavioral health services through Medicaid or other healthcare programs. She encouraged the Department to ensure that its final rules and subsequent guidance should not inadvertently require independently provided healthcare services to be financially bundled into the cost of psilocybin administration when those services are otherwise appropriately provided and reimbursed though existing healthcare systems.

Dr. Singh also recommended that the Department monitor the access impact of administration session staffing requirements. She notes that 7.35.3.20(H) NMAC generally requires at least one practitioner and one facilitator during an individual administration session and established staffing ratios for group administration sessions. She also notes that the proposed rule allows the Department to waive or decrease the staffing requirement when the specified ration presents a barrier for patients and safety concerns are otherwise alleviated. She supports maintaining appropriate safety standards, and also encouraged the Department to develop a transparent and clinically grounded process for obtaining such a waiver. She raises a concern about the requirement that two certified professionals for every individual could materially increase cost and reduce access, especially in rural areas, as well as for patients relying on the Treatment Equity Fund or philanthropic assistance.

Finally, Dr. Singh urges the Department to preserve meaningful access through "other approved locations." She supports allowing temporary certification of "other approved locations" when a patient cannot be transported to a healing center, when medical necessity support another location, to improve access in rural and frontier counties, or to enable treatment in a natural environment.

The Written Public Comment of Healing Advocacy Fund, Psychedelic Mental Health Access Alliance, and the Rudick Law Group

Healing Advocacy Fund Psychedelic Mental Health Access Alliance and the Rudick Law Group jointly submitted a written public comment. *See* DOH Exhibit 8.C. For ease of reference only, in this report these entities will be referred to collectively as "HAF."

HAF first argued that the draft rules contain significant design concerns that threaten to impact patient access and the long-term viability of the state program. They argue that certifying clinician design exceeds the statute and misunderstands safety in psychedelic-assisted therapy.

HAF states that the design choice requires any patient who seeks psilocybin care to be seen by a specially-permitted DOH prescribing clinician provider in an in-person encounter with limited exceptions for telehealth. HAF asserts that the DOH has stated in public meetings that the design track's the states medical cannabis program, and the regulations are almost identical to the regulations for "practitioners" in the Medical Cannabis Program, which require a prescribing clinician to assess a patient for the medical appropriateness of cannabis. HAF argues that no such requirement exists in the Medical Psilocybin Act ("MPA").

HAF notes that the MPA provides the following two definitions:

> "clinician" means an **approved health care provider** licensed in New Mexico who holds a permit from the department to provide medical services to qualified patients.
>
> "qualified patient" means a patient whose clinician has judge the patient to be a medically appropriate candidate for the use of medial psilocybin **based on being diagnosed with a qualifying condition.**

HAF argues that these definitions create the legal parameters for patient entry in the Medical Psilocybin Program ("the program"), and that all that is required under the statute is a qualifying condition that is confirmed by any licensed healthcare provider in New Mexico who has the authority to diagnose and treat such conditions. HAF argues that the certifying clinician design greatly exceeds the framework set forth in the statute.

HAF argues that the certifying clinician design delegates safety and health screening to a prescribing provider gateway mechanism, and, in doing so, the program assumes that risks will be primarily static—not changing over the course of treatment—and pharmacological. HAF argues this is far from true, and the most significant risk factors are psychological in nature and medical risks that require screening the day of administration. HAF argues that these are missed in a safety system that assumes prescription authority upon entry equals medical safety.

HAF states that in a safe psilocybin treatment model, safety screenings are ongoing and conducted by the team most closely relating to the patient throughout their preparation and assessed by clinicians whose subject matter scope of practice aligns with the particular risk. Where

expertise is not held by the primary care team expert referrals and consultations are made with clinicians who have appropriate expertise before treatment continues.

HAF recommends removal of the certifying clinician design. HAF also suggests that the Department should consider requiring same-day pregnancy and drug testing, which are commonly observed risks in psychedelic-assisted therapy and preventable by a simple urinalysis.

HAF notes that the Department has objected to the foregoing proposed revision on the grounds that it relies on patient attestation of health history rather than a medical exam. HAF argues that their recommended protocol is based on the objective assessment of the psilocybin's physiological risk profile, which is extremely low. They argue that any practitioner or facilitator can be trained to conduct the screening, without creating the barrier of the program's prescriber-gateway design.

If the Department is unwilling to consider an alternative design, HAF recommends strategic targeting of the limited provider base that will be able to fill this entry point role. In addition to targeting medical doctors, nurse practitioners, psychiatrist, and other traditional prescribing providers, HAF recommends additional provider types who have prescribing authority: naturopathic doctors, acupuncturists, and chiropractors.

HAF next asserts that the patient application process in the draft rules is unnecessary and should be stricken. HAF argues that this provision arises out of the requirement of a patient identification card in the Medical Cannabis Program. That provision was promulgated in the context of cannabis (at the time) being an illegal substance and there was a need to provide legal authorization to medical cannabis patients.

HAF argues that the medical psilocybin program operates much differently. Because it relies on supervised administration in approved locations only, no patient will legally possess psilocybin outside of a supervised episode. HAF asserts that there is no scenario in which a psilocybin therapy patient will need to prove their authorization to possess psilocybin, and consequently no need for patient identification cards.

HAF argues that this requirement has no legal or policy justification, and will put a tremendous administrative burden on the Department, add additional patient wait times, introduce additional potential for patient data to be accessed without consent, and further stigmatize psychedelic-assisted therapy patients. HAF argues that this provision should be stricken.

HAF next raised a concern that the draft regulations create a supervisory relationship between permit-holders, such as the supervision of facilitators by practitioners. HAF argues that supervisory roles carry liability for those who are supervised. Facilitators are not medical professionals, and not subject to the Medical Malpractice Act. This may inadvertently bring the facilitator's conduct within the supervising practitioner's malpractice exposure, while leaving the facilitator outside the coverage framework. This problem could undermine the program's ability to build the integrated clinical workforce it requires.

HAF argued that the foregoing issues carry long lead liability problems that may take years to surface but will ultimately bear on the program's long-term viability. HAF asserts that the most significant of these issues involve third-party payers.

HAF argues that the certifying clinician role creates a substantial risk of denials and clawbacks. HAF asserts that because this role exists solely to facilitate entry into the psilocybin therapy program, the clinical encounter creates a clearly defensible basis for independent medical necessity, and this is precisely the standard insurers apply when evaluating coverage.

HAF states that they recognize that HCA offered reassurances on this point during an Advisory Board meeting, but regulatory structures inevitably change over time and a clinical encounter that exists to authorize participation in a Schedule1 substance program, rather than to address an independent medical need will invite scrutiny over time and may provide grounds to deny claims or pursue clawbacks.

HAF argues that for these reasons, the Department should adopt the alternative patient flow proposed on page 3 of HAF's written comment. *See* DOH Exhibit 8.C. They assert that for patients who already have a diagnosis and an established care team, the sole function of the certifying clinician encounter is program entry. HAF argues that creating a mechanism for these individuals to proceed directly to care protects both patients and the program's long-term financial viability.

HAF also argues that services rendered by unlicensed or non-clinically credentialled individuals are generally not reimbursable by health insurance. HAF asserts that where a regulation creates a supervisory or assistive relationship between a clinician and a non-clinician, a payor may characterize services under the clinician's credential as having been delivered by someone not authorized to bill, exposing the practitioner to claim denial, clawbacks, or other more serious consequences, such as fraud.

For the foregoing reasons, HAF recommends that the Department treat the roles of practitioners and facilitators as legally and professionally independent in the regulatory framework, and also separately articulate the ways in which they may coordinate care.

HAF addressed additional issues which they assert impede access. First among these issues is HAF's position that landlord attestation for other approved locations should not apply to patients seeking care in their home or in residential living. HAF argues that the foregoing requirement, found in 7.35.3.11(A)(8) NMAC, should be clarified. HAF argues that the landlord attestation requirement, as written, applies to any property where an administration session occurs, including a patient's own home. For patients who rent their own residence, HAF asserts, the proposed rule would require the patient to obtain a signed statement from their landlord acknowledging their participation in the Medical Psilocybin Program and describing what they are authorized to do under their certification—before they can receive care in their own home.

HAF argues that the Department has acknowledged that this rule was borrowed from the Medical Cannabis Program. HAF argues that because cannabis is smoked or vaporized, creating a real effect on odor, ventilation, and property value, there is a practical interest in confirming a property owner knows that may occur on their property. HAF argues psilocybin creates no

lingering property effects of any kind, and, thus, the property-owner interest that justifies the cannabis provision is not present in medical psilocybin.

HAF also note that the Department has suggested that ongoing federal illegality justifies the required landlord's permission. HAF argues that New Mexico has already made the decision to depart from federal law, a calculated choice to put our state above misguided federal judgment.

HAF endorses the revision recommended by End-of-Life Options New Mexico, as follows:

> This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care residents.

HAF argues that the failure to make this revision is likely to expose the Department of liability under state law protections against discrimination. They assert that similar litigation in Oregon on behalf of home-bound patients has cost the Oregon Health Authority hundreds of thousands of dollars, and is ongoing.

Finally, HAF recommends that minimum hours should be assigned to certain didactic topics. HAF recommends that the following content areas should be added to bring the rules closer to educational and safety standards:

- Suicidality screening and crisis response – 5 hours
- Challenging experiences, including de-escalation – 4 hours
- Pharmacology, drug interactions, and clinical research – 5 hours
- Trauma and trauma-informed care – 7 hours
- End-of-life care – 5 hours.

The Written Public Comment of Multidisciplinary Association for Psychedelic Studies (MAPS)

Sia Henry submitted a written comment on behalf of MAPS. *See* DOH Exhibit 8.D. She is the Associate Director of Policy and Advocacy for MAPS.

Ms. Henry raised concerns about the proposed regulation. She asserted that while the medical nature of New Mexico's legal model is explicit in the statute, the proposed regulations go beyond the statute "over-medicalizing and over-complicating the provision of psychedelic care and prioritizing property owner rights over the right of patients."

In particular, she states that the design of the certifying clinician requirement exceeds what the statute requires. She states that the design would compel any patient seeking psilocybin-assisted therapy to first see a prescribing provider, in person (with narrow exceptions). She asserts that this requirement includes no exception for patients who already have a qualifying diagnosis. She notes that the statute specifically defines "qualified patient" as "a patient whose clinician has judged the patient to be a medically appropriate candidate for the use of medical psilocybin **based on being diagnosed with a qualifying condition.**" She notes that this language specifically ties patient entry to the qualifying medical condition alone. She also notes that the statute defines "an

approved health care provider licensed in New Mexico who holds a permit from the department to provide medical services to qualified patients."

Ms. Henry argues that the Department has "implemented" these two provision in an excessively conservative manner, a choice that will have long-term consequences for public trust in the program and for the efficacy of the care it delivers. She states that MAPS cautions against this approach. She suggests that Colorado's program offers a useful comparison. She states that its clinical facilitator track has operated with strong patient safety outcomes by matching health screening to each patient's individual needs and risks. She asserts that in Colorado, dually licensed facilitators work within their scope of practice to screen for health risks, consulting and referring out to more specialized practitioners when necessary. She argues that this model is both patient-centered and clinically appropriate—but proposed certifying clinician design is neither.

Ms. Henry next argues that the patient application structure mirrors the medical cannabis model, but it is unnecessary and unjustified in a supervised-use setting. She asserts that, as designed, a provider must submit patient health information to the DOH for review, approval, or denial within 30 days of submission. She argues that this process increases administrative burden on providers, which drives up costs, and burdens on patients, which can discourage them from seeking care. She argues that medical cannabis required a card system and application to protect patients from adverse law enforcement encounters. She argues that supervised, private psilocybin use presents no comparable justification.

Finally, Ms. Henry stated that MAPS is deeply concerned about the proposed requirement that patients who are renters and seeking care in their home obtain written landlord approval. She argued that no such requirement exists in Colorado, and implementing this requirement would likely make patients unable to access care in their own homes, unless they own the property. She argues that this provision exposes renters to stigma and discrimination, and forces the disclosure of private medical disclosure to landlords. MAPS requests that an exemption be drafted for patients who rent the home they live in.

The Written Public Comments of Anne Metz, Ph.D., LPCC

Dr. Metz is a licensed professional counselor in New Mexico. She is also a licensed Natural Medicine Facilitator in Colorado and director of an approved facilitator training program there. She has a background in risk assessment research and clinical facilitation experience under Colorado' regulated psilocybin program. *See* DOH Exhibit 8.E.

Dr. Metz argues that the certifying clinician model treats risk as a fixed, one-time determination, when clinical risk is dynamic that shifts with new information over time. She asserts that treating a certifying clinician's one-time, pre-treatment clearance as the safety mechanism for the whole course of care builds the same error into the program that risk-assessment research has spent decades correcting in other fields.

Dr. Metz argues that the practitioner who is actually with the patient is in the better position to identify and response to risk as it develops. That person can then refer out for medical consultation where a specific factor falls outside their own scope of practice. The requirement that

every patient clear a separate certifying clinician encounter before treatment can begin, regardless of whether a risk factor is present, does not make the program safer, and substitutes a single checkpoint for the ongoing clinical judgment that actually manages risk. Further, she asserts, it adds cost and delay for patients who have no risk factors, and in rural counties where a certifying clinician may not be available, may foreclose access to care entirely.

Dr. Metz next argues that the patient application places the greatest burden on the patients lease able to carry it. She argues that this requirement falls hardest on the rural, elderly, disable, and low-income patients this program is meant to serve—people who may lack reliable internet access, transportation to submit paperwork in person, or the time to navigate an additional bureaucratic process on top of a serious psychiatric condition. She argues that since psilocybin is administered only in supervised sessions, and patients never possess it outside that setting, the application does not serve a possession-authorization purpose like medical cannabis, and should be removed.

Dr. Metz argues that the facilitator ratio is unworkable given New Mexico's behavioral health workforce shortage, which she asserts is one of the worst in the country. She notes that Oregon requires no more than a single facilitator for individual sessions, and has a lower ratio only for high-dose group administration. Colorado sets no comparable ration requirement for individual sessions at all. She argues that the proposed requirement in New Mexico raises the cost of an individual session, and, in rural counties may make it functionally impossible to staff a session at all. She urges the Department to reconsider this provision with New Mexico's actual provider distribution in mind.

Dr. Metz next argues that proposed landlord permission requirement introduces friction into the patient's home that no other form of home-based clinical care requires. She argues that this provision introduces a requirement that has no counterpart anywhere else in New Mexico's behavioral health system, and risks delaying or blocking care for exactly the patients lease able to travel to a healing center. She urges revising the provision so that it does not apply to end-of-life patients, other patients receiving in-home care, or long-term care facility residents.

Dr. Metz concludes that the provisions she has addressed, taken together, raise the cost, staffing burdens, and administrative overhead of participating in the program—well above what Oregon and Colorado require. She asserts that the likely outcome is that clinicians will decline to take regulated-access patients and instead limit their practice to FDA-approved synthetic psychedelics, thereby bypassing the state program entirely. She states this will lead to the majority of New Mexicans who seek treatment through the regulated program without a clinician willing to see them.

Dr. Metz submitted a second comment on October 2, 2026. *See* DOH Exhibit 8.KKK. She expressed her disenchantment with this rule promulgation process in some detail, essentially arguing that the proposed rule does not follow the spirit of SB 219.

The Written Public Comment of Catherine Warnock, MA, LPCC, NCC

Ms. Warnock is a licensed professional counselor and experienced psilocybin-assisted therapy practitioner and educator. She submitted two written comments. In her first comment, she raised concerns about the training and practicum requirements in and their potential impact on affordability and workforce development. *See* DOH Exhibit 8.G.

She asserts that the proposed rule requires substantial didactic and simulated-patient education followed by a 100-hour practicum for facilitators and a 120-hour practicum for facilitators. The rule also requires specific experiences involving individual and group administration, preparation and integration, multiple patients, and different qualifying conditions. She argues that these requirements create costs on both sides of the training equation.

She asserts that student must be able to afford extensive education and supervised practicum hours. At the same time, education programs must develop the personnel, patient population, approved location, supervision group experiences, and administrative infrastructure necessary to provide these hours.

Ms. Warnock argues that this framework creates a significant startup challenge for New Mexico.

She argues that small educational programs may not have the capital or infrastructure to provide this level of practicum initially. She asserts that large universities, healthcare systems and national training organizations are better positioned to absorb these costs. She is concerned that financial capacity, rather than educational quality and demonstrated competency, will determine which organizations are able to train New Mexico's workforce. She is also concerned that the workforce needed to make the program operation depends upon a practicum infrastructure that may not fully exist until the program is already operational.

She notes that the cost will affect patients as well.

Ms. Warnock makes the following recommendations:

- A phased practicum requiring during the initial implementation years.
- Competency-based pathways that recognize demonstrated skills and prior relevant experience.
- Greater flexibility in how clinical experiences are obtained.
- State-supported scholarships or workforce-development funding for NM residents.
- Grants or startup assistance for small NM educational programs.
- Periodic review of the training requirements based on actual workforce capacity, training costs, and other patient access after implementation.

In her second written comment, she asks the Department to reconsider three provisions before adoption of the final rule. *See* DOH Exhibit 8.OO.

First, Ms. Warnock urges the Department to replace universal certifying-clinician in 7.35.3.8 NMAC and 7.35.3.9(D) NMAC with risk-based medical review. She strongly supports appropriate medical screening, but does not believe every patient should automatically be required to undergo a separate medical gatekeeping process regardless of their individual profile.

Instead, she argues that the rules should identify the specific medical histories, contraindications, medications, and other risk factors that require additional clinical review. When one of those factors is identified during standardized screening, the patient could then be referred to a clinician whose scope of practice is appropriate to that particular concern. The clinician could then attest that the relevant risk was evaluated and that the anticipated benefits of treatment outweigh the risks.

She argues that this would create a risk-based model rather than a universal medical-clearance model. She argues that universal certification creates an additional clinical encounter whose primary purpose is gaining entry to the program. She suggests that for patients without an established clinician, this means locating another provider, scheduling another appointment, paying another fee (which insurance may not cover), obtaining an in-person exam, and transferring records before treatment can even begin. For uninsured and underinsured New Mexicans, these requirements may be prohibitive, and in rural New Mexico access to a clinician may be difficult.

Ms. Warnock also recommends that the patient application process and state approval process found in 7.35.3.8 NMAC should be eliminated. She argues that this process delays care, increases administrative burdens for patients and for the Department, creates an additional repository of sensitive patient information, and requires patients to register with the government before receiving treatment, which may reinforce stigma around both psychedelic treatment and the conditions for which patients are seeking care.

The third proposed rule that Ms. Warnock addresses is the requirement of a property-owner statement found in 7.35.3.11(B)(9) NMAC. She recommends deletion of this proposed rule. She argues that this requirement creates a significant and unnecessary barrier to receiving treatment at a patient's residence.

She further argues that the landlord interest that may justify a similar requirement in the cannabis program is not present in this setting. Psilocybin is administered under regulated conditions. The property is not being used to manufacture, cultivate, or store a controlled substance on an ongoing basis.

Ms. Warnock argues that a property owner may have little incentive to sign an acknowledgment and may also have considerable perceived reason not to. She adds that a landlord who does not understand psilocybin treatment may be concerned about liability, or simply may not want to get involved.

Ms. Warnock notes that the result is that home-based treatment becomes available to homeowners, but not renters—an inequitable distinction not based on safety, medical risk or practitioner competency but on property ownership. This could also particularly affect low-income

patients, people with disabilities, rural residents, older adults, and others for whom receiving treatment at home is the most accessible option.

Ms. Warnock states that if the Department believes that property-owner interests require protection, it should consider a less restrictive alternative that does not give third parties effective veto authority over a patient's healthcare.

Ms. Warnock argues that the foregoing provisions illustrate a larger concern. She asserts that each of the requirements adds another cost, delay, and potential barrier. She notes that the Equity and Access fund is valuable, but equity should be built into the regulatory structure itself. She states: "Subsidizing an unnecessarily expensive system is not the same as designing an affordable one." *Id.*

She encourages the Department to evaluate each proposed requirement by asking:

> What specific risk does this requirement address? Is it necessary for ever patient? Is there a less burdensome way to achieve the same safety objective? And what will this requirement ultimately cost the patient?

The Written Public Comment of Chris Peskuski

Mr. Peskuski is a Marine Corps veteran and a resident of Albuquerque. *See* DOH Exhibit 8.N. He also addresses the provisions in the proposed rules related to the certifying clinician design, the patient application, and the property-owner statement. His comments echo the comments made by many others in this rule promulgation process.

He recommends removal of the certifying clinician design and instead regulating around the specific contraindications that warrant clinical review. He proposes an approach where a risk is identified and requires a clinician's attestation whose scope of practice fits the risk, allowing the patient's own treating physician to serve that role.

He recommends deleting the controlled substance number requirement in 7.35.3.9(D)92) NMAC so that any New Mexico provider licensed to diagnose the qualifying condition may certify.

Mr. Peskuski argues that the certifying clinician design misunderstands where the risk is. He states that the most significant risks are psychological, or medical risks that must be screened the day of administration, such as intoxication. He argues that the in-person exam at the time of certification my quickly be go stale, and a patient could be dosed on the strength of an exam that may be up to two and one half years old.

He also argues that full disclosure by a patient "is not the default" in a gateway process where someone is trying to clear a gate with a stranger. He asserts that disclosure is more complete in the context of a relationship with a provider who is in the room.

He also argues that the credential is the "wrong proxy." The certifying clinician completes eight hours of psilocybin training; practitioners and facilitators complete at least 70 didactic hours in a variety of contexts. *See* DOH Exhibit 8.N at page 3.

Mr. Peskuski asserts that the design exceeds the Act. He states that the Act defines a clinician as a New Mexico licensed health care provider who has been permitted by the Department to provide medical services. A qualified patient is defined as one whose clinician has judgment them to be a medically appropriate candidate based on a diagnosis of a qualifying condition. He argues that 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 1 for this use. Instead, the proposed rule requires a controlled substance registration from a clinician who provides none of the medical services the Act describes.

He argues that few prescribers will accept this role. For two years, a patient may work with a certified team who is not chosen by the prescriber, supervised by it, and may not be seen by the prescriber again. Further, many malpractice carriers exclude federal illegal activity. He argues that there is liability without authority. He also argues that the entry encounter is likely to not be covered by insurance as lacking independent medical authority.

Mr. Peskuski recommends that the Department strike the patient application process. At a minimum, he argues, the Department should make enrollment effective when the clinician's certification is filed. The Department could retain authority to audit, investigate, and act on problems after the fact.

He also argues as follows:

- The Act does not call for a patient application process, and does not require an approval gate.

- The cannabis rationale for applications does not carry over to this context.

- The information sought by the application already reaches the Department; practitioners and facilitators report dates of service, administration, product identification, dosage, integration and adverse events. Healing centers and other approved locations keep patient list and daily logs in the Department's system, and report adverse events within two days.

- The approval process lengthens the wait for care and there is no expedited path for example for end-of-life patients.

- The process creates a store of sensitive data that the program does not need, creating a database that could be breached or reached by illegal process.

- It further stigmatizes the patient.

- It creates an administration burden for the Department.

Mr. Peskuski next recommends that the Department should delete 7.35.3.11(B)(9) NMAC, and add the following sentence: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

In support of this recommendation he states:

- Other approved locations exist for 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.

- The landlord interests that justify restrictions on cannabis do not exist in this context.

- The provision inverts the default. Property owners can already restrict conduct on their property. The written landlord sign-off is required in advance; an owner who does not respond effectively blocks care.

- The statement itself is a disclosure of serious medical conditions.

- Patients who file in federal subsidized housing, which landlords operate under federal law, are at risk

- Long-term care facilities will not sign; they depend on Medicare and Medicade certification.

The Written Public Comment of Julian Joy

Julian Joy is a co-founder of MycoVita, a software-enable telehealth and patient-access company preparing to serve New Mexico patients under the Medical Psilocybin Act. *See* DOH Exhibit 8.O.

Mr. Joy first addresses telemedicine certification under 7.35.3.13(A)(2) NMAC and 7.35.3.8(B)(8) NMAC. His organization request that the three telemedicine branches—in-person examination by the certifying clinician within six months, telemedicine evaluation with review of diagnosis records from a clinician who examined the patient in person with six months, or telemedicine evaluation with a formal consultation with that clinician—be adopted as published.

He next addresses controlled-substance number in 7.35.3.9(D)(2)NMAC and 7.35.3.9(B)(3) NMAC, and the amended definition in 7.35.2.7. He requests that the Department state the purpose that controlled-substance registration serves since a certifying clinician never prescribes or dispenses psilocybin. He also requests that the Department consider accepting either a controlled-substance registration or a Drug Enforcement Administration registration so that qualified diagnosing clinicians who do not maintain a state CS registration are not excluded from the initial clinician pool.

With respect to the designate electronic system (Sections 7.35.3.8, 9, 13(C) and 20 NMAC), he asks the Department to publish—before the clinician application window opens—a technical description of the electronic system, submission formats, whether a certifying clinician may authorize a HIPAA business associate to prepare and upload submissions that the clinician review and sings, and whether machine-to-machine submission will be supported.

Mr. Joy asserts, with respect to the application window and timing in 7.35.3.9 NMAC, that the rule fixes the renewal time and a 30-day decision clock but not the initial window. He asks that the Department publish the date, or the interval after adoption, on which certifying-clinician, practitioner, ,facilitator, healing-center, and education-program applications will be accept for each category, and to publish the New Mexico educational module and certifying-clinician module (see 7.35.319(A) and(B) NMAC) or the list of approved providers.

He asks the Department to state whether preparation and integration sessions may be delivered by telehealth in an "approved setting" or whether only administration sessions must occur in a health center or other approved location.

He states that they support the fee-disclosure requirement in 7.35.3.11(A)(19) NMAC, and ask the Department to add an express prohibition on compensated patient referrals and fee splitting within the program rules, reaching non-clinician participants who are outside the Medical Psilocybin Act so that all participants can operate under one standard.

He requests the Department to state retention periods for enrollment, certification, session and consent records rather than requiring a plan without a period; to state the minimum patient age of the consent architecture for minors, and to publish equity-fund income thresholds, documentation standards and the disbursement path.

Finally, he requests that the Department state whether any application, certification, renewal or enrollment fee will be charged, so that providers can price services and disclose fees to patients accurately.

The Written Public Comments of Danielle Leonard

Ms. Leonard is a licensed mental health clinician. *See* DOH Exhibit 8.P. She comments on the certifying clinician provisions in 7.35.3.8 NMAC and 7.35.3.9(D) NMAC. She urges the Department to place entry decisions with the clinicians best trained to diagnose mental health conditions, rather than defaulting to prescribers.

She submitted two written comments, DOH Exhibit 8.P and DOH Exhibit 8.V.

In her first comment, Ms. Leonard argues that the rule confuses prescribing authority with diagnostic competency. She argues that the certifying clinician design comes from the medical statute, which required every patient to see a DOH-permitted clinician with a controlled-substance registration before entering the program. She asserts that the Medical Psilocybin Act does not have this requirement; it only requires a qualifying condition confirmed by a licensed provider with authority to diagnose and treat specific conditions such as treatment-resistant depression, PTSD,

and substance use disorders. She argues that the certifying judgment should rest with clinicians trained to assess those conditions, who have the training that fosters diagnostic reliability.

She further argues that entry decisions call for clinical judgment. She suggests that whether a person has a qualifying condition, and whether they are ready to begin treatment, are two separate questions that depend on their full clinical picture. These judgments belong to a clinician who can decide if they are ready, not a one-time prescriber who may have no ongoing relationship with the patient, who may have limited training. She asserts that this adds a step without adding that judgment.

She also argues that this extra gateway adds burden without adding safety, like many commenters in this promulgation process.

Ms. Leonard requests that the department:

1) Remove the certifying clinician requirement and follow the Act by allowing any licensed New Mexico provider with authority to diagnose and treat a qualifying condition to confirm it.

2) Recognize that diagnosing clinician's judgment governs whether a qualifying condition is present, when a client is ready, and how much preparation is beneficial.

3) Allow that clinician to consult with an appropriate medical provider when medical or medication questions fall outside of their scope, as mental health clinicians are trained to do and routinely do for clients on medication.

In her second written comment, Ms. Leonard addressed her support of licensed therapists as practitioners, citing 7.35.3.9(E) NMAC and 7.35.3.18(C) NMAC. She is glad that the rule places the clients who benefit from this program with licensed therapists, who are trained to recognize risk, respond to crises, and plan care over time, and who are also accountable to a licensing board and a code of ethics. She also wants to honor the facilitators and elders whose knowledge, care and courage helped make this program possible.

She also indicated her support for the rule on practicum standards, 7.35.3.19 NMAC, and the rule related to post-graduation mentoring, 7.35.3.17(A) NMAC.

The Written Public Comments of Gina Devani, Andrea Ensign, Brooke Kaemmingh, Candace Johnson, Brandon Johnson, Soma Franks, Alana Pratt, Deru Youmans, Madeline Bauman, Rae (Sherry) Yingling, Alicia Ramos, Mitchell Tappen, Gabe Charalambides, Janine Sagert, Gregory Evans, Frances Vega, Kate Clark, Beth Ann Kelly, Anne Vaillant, Karla Peskuski, Cynthia Gamel, Chris Riley, Michael Kaplan, Trina Zahller, Celeste Yacoboni, Jessica Riley, Ed Tajchman, Jeremy Renda, Pearish Smith, Io Berg, Joy Stearns, Andrew Stuart, Whitney Joiner, Katherine Bird, Jennifer Johnson, John Meade, and JoEllen Schlimmels

The foregoing written comments closely resemble each other in terms of the substance of their comments and recommendations regarding the proposed rules. In many cases, the substance

of the comments is a word-for-word reflection of most of the comments. The key recommendations therein fall into three categories, as follows.

The commentators first address the property-owner statement requirement found in the proposed 7.35.3.11(B)(9) NMAC. They recommend adding the following language to that provision: "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents."

The commentators argue that the landlord interest that justifies the cannabis provision—smoking on the property—is not present in a supervised psilocybin session administered by a licensed facilitator. They further argue that federal illegality alone does not justify it because New Mexico has already chosen to depart from federal law. They argue that giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the Department exposed under state protections against discrimination.

The second provision the commentators address is the proposed certifying clinician design, found in 7.35.3.8 NMAC and 7.35.3.9(D) NMAC. They urge the Department to remove the certifying clinician design and, in its place, regulate around the specific contraindications, medical histories, and medications that warrant clinical review. They state: "Where a risk factor is identified, require an attestation from a clinician who scope of practice fits that risk that screening was conducted and benefits outweigh risks."

The commentators argue that the design exceeds the Act and misunderstands where the risk is. They assert that 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. Consequently, they argue that a one-time "prescriber" gateway misses the risks, and creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

Finally, the commentators address the proposed patient application requirement found in 7.35.3.8 NMAC. They urge the Department to strike that process. They assert that it has no legal or policy justification in a supervised-use program and adds administrative burdens for the Department. Further, they assert that it lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

The commentators in this group are identified as follows:

Ms. Devani is a New Mexico resident living in Santa Fe. *See* DOH Exhibit 8.F.

Ms. Ensign is a clinician in Albuquerque. *See* DOH Exhibit 8.H. She is a clinical provider, PNHNP, and concerned about the property-owner statement and the patient application.

Ms. Kaemingk is a renter and hospice RN, MSN, in Santa Fe. *See* DOH Exhibit 8.I. She works in end-of-life with people and patients who will be affected by the proposed rules.

Ms. Johnson is a resident of Santa Fe. *See* DOH Exhibit 8.J.

Mr. Johnson is a resident of Santa Fe and also a renter. *See* DOH Exhibit 8.K.

Ms. Franks is a resident of Santa Fe and is pursuing a master's degree in counseling. *See* DOH Exhibit 8.L.

Ms. Pratt is a resident of Santa Fe. *See* DOH Exhibit 8.M.

Mr. Youmans is a resident of Silver City. *See* DOH Exhibit 8.Q.

Ms. Bauman, PLMSW, is a resident of Santa Fe, a renter, and a licensed Master of Social Work. *See* DOH Exhibit 8.R.

Ms. Yingling, MA, LPCC is a clinician from Sandia Park. *See* DOH Exhibit 8.S.

Alicia Ramos, MS, EMDR Therapist, and Owner of Embodied Sol Therapy 7 Coaching PLLC is a resident of Roswell. *See* DOH Exhibit 8.T.

Mr. Tappen is a resident of Albuquerque, a renter, and someone hoping to receive care. *See* DOH Exhibit 8.W.

Mr. Charalambides, is the founder and CEO Odyssey, which works with non-profit organizations to provide access to care for veterans and first responders. *See* Exhibit 8.BB.

Dr. Sagert has a Ph.D. in Culture and Mental Health and is an advocate for the responsible use of psychedelics for both clinical and spiritual purposes. *See* DOH Exhibit 8.CC.

Mr. Evans is a resident of Santa Fe and also a renter. *See* DOH Exhibit 8.DD.

Ms. Vega is a resident of Arroyo Seco, who describes herself as a cancer survivor who may need to get psilocybin treatment easily. *See* DOH 8.FF.

Ms. Clark is a resident of Arroyo Seco, and a healthcare worker who also works in hospice and palliative care. *See* DOH Exhibit 8.HH.

Ms. Kelly is a resident of Taos, a caregiver, and a hospice care worker. *See* DOH Exhibit 8.II.

Anne Valliant is a resident of Ranchos de Taos and a clinician and psychiatric provider. *See* DOH Exhibit 8.JJ.

Karla Peskuski, RN BSN, is a resident of Bosque Farms. She is also the mother of a veteran who has received care from a program similar to this one, and it changed his life after the military. *See* DOH Exhibit 8.LL.

Cynthia Gamel is a clinical counseling practicum student from Santa Fe. *See* DOH Exhibit 8.QQ.

Chris Riley is a former firefighter and paramedic from Rio Rancho. *See* DOH Exhibit 8.RR.

Michael Kaplan, MD is a resident and clinician in Santa Fe who has been profoundly benefited through legal psilocybin-assisted therapy. *See* DOH Exhibit 8.SS.

Trina Zahller, LCSW, is a clinician in Albuquerque. *See* DOH Exhibit 8.TT.

Celeste Yacoboni is a Santa Fe resident, as well as an ordained minister and licensed massage therapist who works will people who hold trauma in their bodies. *See* DOH Exhibit VV.

Jessica Riley is a resident of Rio Rancho, a renter, a clinician and a hospice or palliative care worker. *See* DOH Exhibit 8.WW.

Ed Tajchman is a Santa Fe resident. *See* DOH Exhibit 8.XX.

Jeremy Renda is a resident of Santa Fe. *See* DOH Exhibit 8.ZZ.

Pearish Smith is a clinician in Arizona. *See* DOH Exhibit 8.DDD.

Io Berg is a clinician and landlord in Albuquerque. *See* DOH Exhibit 8.EEE.

Joy Stearns has professional certifications in grief, loss, and trauma. *See* DOH Exhibit 8.HHH.

Andrew Stuart is a Taos resident. *See* DOH Exhibit 8.LLL.

Whitney Joiner is a clinician in Taos. *See* DOH Exhibit 8.NNN.

Katherine Bird is a resident of Espanola and a renter. *See* DOH Exhibit 8.OOO.

Jennifer Johnson is a hospice RN in Taos. *See* DOH Exhibit 8. PPP.

John Meade is a resident of Santa Fe. *See* DOH Exhibit 8.RRR.

JoEllen Schlimmels is an educator and practitioner. *See* DOH Exhibit 8.VVV.

The Written Public Comment of Maya Albert

Ms. Albert is the CEO of The Synthesis Institute, a psychedelic practitioner training organization which has more than 600 alumni in Colorado. *See* DOH Exhibit 8.U. She offered comments on two provisions of the proposed rule.

First, she addressed the in-person didactic requirement, which she states requires at least one third of which must be delivered in person. She asserts that the knowledge-based portion of the training transfers well to live, synchronous virtual instruction and the embodied competencies the Department is concerned with are built in supervised practice with real clients, for which the rule requires 100 and 120 practicum hours.

She requests that the Department allow the didactic model to be delivered fully through live virtual instruction, or, in the alternative, to allow in-person practicum hours to satisfy the in-person component. Given New Mexico's largely rural population and provider shortage, she asserts that her proposal would address those issues.

Second, Ms. Albert addressed reciprocity for supervised practicums. She asserts that the rule provides a reduced practicum through two waiver provisions, which she states appear to be in conflict. 7.35.310(D)(1) NMAC requires 40 hours of contact time with two individual sessions and two group sessions for applicants trained through programs in other jurisdictions. 7.35.3.19(H) NMAC requires 40 hours with two individual sessions and one group session for applicants who graduate from an approved program. An out-of-state applicant could reasonably qualify under either provision, according to Ms. Albert. She asks the Department to resolve the discrepancy by accepting any practicum completed through an approved or state-regulated program toward 40 hours, without specifying the number of individual or group sessions. She asserts that group formats are one valid modality among several and a fixed session count may create scheduling and cost barriers without a corresponding gain in safety.

Finally, she asks that this recognition continue beyond December 31, 2027 so that practicum hours completed and documented with another state's regulated program can count toward the New Mexico requirement on an ongoing basis.

The Written Comment of Firefighters for Plant Medicine (FFPM)

Paul Walton, the Executive Director of FFPM submitted a written comment on behalf of that organization. *See* DOH Exhibit 8.X. Mr. Walton outlines in detail why the rules for the Medical Psilocybin Program are needed for firefighters and first responders. He urges the state to be diligent in providing an avenue for patients to make reports about safety and ethical concerns, and monitoring programs due to the potential for causing harm when patients are in a vulnerable, non-ordinary state.

He addresses the substantial shortage of medical personnel, including drug prescribers, in particular. He argues that requiring each participant to get medical clearance through an in-person medical appointment is an undue barrier to treatment that can be safely and effectively avoided. He suggests that one less restrictive solution is to only require patients who are positive for any of the medical (history of cardiac issues, current use of SSRIs, etc.) to be required to see a prescriber. He argues that all other patients would need only see a license provider who can diagnose the four qualifying conditions of the program, screen for any disqualifying medical concerns, and then the Department would review the patient application to check again for medical concerns before approval.

Mr. Walton raised a concern about there being no exception to allow practicum students to train and practice with each other. FFPM strongly believes that practicing students should not be working with patients who suffer from severe depression and PTSD. He asserts that this has serious harm potential for patients, and is not worth the patient risk.

FFPM strongly encourages the Department to consider making an exception to the regulations or amend the bill to allow practicum students to train and learn with each other, instead of practicing for the first time with actual qualifying patients. He also suggests that this change in regulation would address the concern that the number of unique practicum patients currently required would be difficult for any trainee to obtain.

The Psychedelic Bar Association (PBA)

Jonathan Dennis and Brett Phelps, co-coordinators of the PBA New Mexico Working Group, submitted a written comment on behalf of the PBA. *See* DOH Exhibit Y. Their comment focuses on three issues: (1) access issues; (2) safety, liability, and risk management considerations; and (3) other recommendations.

The first access issue addressed by the PBA is the provider-to-patient ratio in 7.35.3.20(H)(5) NMAC, requires a minimum of one practitioner and one facilitator for individual patient sessions. PBA opposes this rule for the following reasons:

- The rule requires patients to pay for two certified individuals during the entire duration of an individual administration session. This is unnecessary to ensure patient and public safety in a majority of cases and increases the financial burden to care without benefit. PBA believes that a better approach is to require a single paid provider. PBA notes that Colorado and Oregon require only facilitator to be present and no known harms have occurred out of over 20,000 administration sessions in Oregon and 1500 in Colorado.

- PBA also opposes the proposed rule for group administration sessions. 7.35.3.20(H)(5) NMAC would require a minimum of one practitioner for every eight patients and a minimum of one facilitator or qualified student for every two patients. They argue that this draft rule is still out of proportion to the amounts needed to promote patient and public safety.

- PBA asserts that establishing mandatory minimum provider-to-patient ratios is problematic because it does not allow providers to make individualized assessments of patient and determine how much support is actually needed for particular patients. They argue that tort law and DOH regulations will establish a professional standard of care that does not permit providers to unreasonably defer from minimum ratios when assistance is needed than required by the regulatory minimums. In other words, "providers will not be able to evade liability when they make or approve of decision in which the minimum ratios are unreasonable relied upon, regardless of where DOH sets them." DOH Exhibit 8.Y at 2.

- PBA further argues that minimum ratios will create in some providers a cognitive bias known as an "anchoring effect" in which those providers show less diligence or

thoroughness in evaluating the relevant safety consideration and instead deter to the regulatory minimums. To prevent this, PBA argues that the Department should adopt rules that encourage provider vigilance in ensuring supervision is safe in proportion to the particular risks of the particular patient groups.

- PBA asserts that mandatory ratios do not give providers the flexibility to offer or receive services where the cost of safeguard is proportionate to the safety needs of a particular group, and would create paywalls that prevent and deter people from taking psilocybin within the program.

- PBA states that if the Department wishes to adopt minimum ratios, it should consider the examples of Oregon and Colorado. Both states have imposed ratios that consider a patient's dose as a proxy for the minimum amount of support that may be required in a group administration, and PBA provides detailed information regarding those ratios. *See* DOH Exhibit Y at 3 – 4.

PBA next addresses the certifying clinician design. PBA argues that this design will unreasonably limit patient access. They argue that an in-person prescribing physician exam is not an accessible design, especially in a state with a large rural population and a long-standing provider shortage. They fear this will create a service gap that will act as an incentive for profit-motivated license holders to dominate the space and charge unreasonable rates. They provide statistics to argue that there is a narrow pool of potential person who could serve as certifying clinicians under the proposed requirements of the rule, which requires certifying clinicians to have a NM controlled substance number. They also assert that frictions between state and federal law create a risk for holders of federal DEA registrations that in many cases are prerequisites for practice in the state among the already limited pool of persons with a NM controlled substances number. They argue that this could lead to the exclusion of more accessible low-risk healthcare pathways and funnel the state's gatekeeping into a high restricted, self-selective, exclusive subset of risk-tolerant adverse healthcare settings.

PBA also offers comments on the patient application process in 7.35.3.8 NMAC. They assert that the proposed rule would require a certifying clinician to submit an application to DOH for prior approval to treat a patient. They note that 7.35.3.25 NMAC would allow DOH to deny or suspend patient eligibility, but there is no reference in the rule to the criteria by which DOH would assess the application. Without such criteria, PBA state that they cannot comment on the appropriateness of the Department's role in assessing patient eligibility. Further, they do not accept that it is DOH's role or responsibility to make individual eligibility decisions.

PBA next comments on the list of reasons meriting "other approved locations" for administration in 7.35.3.11(B) NMAC. They recommend either adding a catch all provision (such as "or any other reason the Department justifies approval") or to fully anticipate or enumerate reasons for other approved locations that may otherwise be excluded (such as affordability).

PBA argues that the landlord permission requirement in the regulations for "other approved locations" should include an explicit exemption for patients seeking care in their own homes. They argue that the Act makes the medical use of psilocybin legal, and federal illegality does not justify

the landlord permission requirement. They argue that landlords are unlikely to give permission, and such an attestation would amount to proof in a legally binding document of aiding and abetting the possession or distribution of a Schedule 1 substance. It may also lead to landlord exploitation by extracting unfair terms or high rent from tenants lawfully seeking are in their home.

PBA also argues that the landlord permission requirement would violate patient privacy, HIPAA, and/or state and federal housing and civil rights law. They argue that the Department should not prioritize the property rights of landlords over patient privacy issues and should protect against discrimination.

PBA next addresses safety, liability and risk management considerations. The first of these arises out of the patient enrollment and application requirements of 7.35.3.8(A)(7)(c) and (B)(8)(b) NMAC, which require clinicians and patients discuss the risks and benefits of medical psilocybin usage, as asserted by PBA, in a vague way that is likely to be interpreted in different ways by clinicians. PBA recommends the creation of a non-exhaustive list of particular risks that must be disclosed in order to obtain a patient's informed consent. They also recommend that the DOH standardize the disclosures and their conversations to aid in the uniform administration of medical psilocybin and subsequent date collection regarding program outcomes.

The PBA also recommends that the required education for certifying clinicians, practitioners, and facilitators should require specific training on differentiating between difficult experiences, or "bad trips," and medical emergencies. This recommendation arose out of an experience in which a woman died at a festival after psychedelic harm-reduction providers failed to identify a medical emergency and not merely a "bad trip." A jury found the medical screener and the harm-reduction training provider liable for the woman's death.

PBA then addresses the evaluation of training programs. The proposed rule requires training programs to obtain a third-party evaluation report conducted by a qualified third-party evaluation team. The third-party evaluators are described in 7.35.3.16 NMAC and must be a team of at least three individuals who, taken together, must have expertise in psilocybin therapy, medical and research, and educational curriculum. PBA argues that allowing training programs to assemble their own panels to approve their curriculum is problematic and presents potential lack of rigor and integrity in the review. They recommend that the Department cross-reference HED rules regarding what compliance is necessary to provide clarity for training programs.

PBA next addresses issues of due process and burdens of proof. PBA first argues that when challenging an adverse determination concerning patient eligibility or a disciplinary action against a certificant, 7.35.3.27(L) NMAC puts the burden of proof on the applicant to show that the action made or proposed by the Department should be reversed or modified. PBA argues that this rule, as applied to certificants in particular, would likely expose the Department to legal challenges and civil liability.

PBA argues that certificants have a property interest in their certificate pursuant to Fourteenth Amendment law, and that property interest cannot be taken without due process. Thus, the burden of proof must be on the Department to remove professional privileges, not on the

certificant to maintain them. The PGA advises that the Department may be able to provide a temporary pause on a certficant's activity with a finding of public health or safety risk.

Finally, the PBA comments on 7.35.3.19(A)93) NMAC, which would require training "on the social, cultural and historical aspects of psilocybin use, including traditional use by Native American and other populations in New Mexico." PBA states that it is unaware of any evidence of traditional use of psilocybin by Native Americans. They applaud the effort and uplifting of indigenous of psilocybin, but assert that it can be harmful and offensive to misrepresent the traditional practices of Native people. PBA recommends revising the rule to require education about other traditional use of other psychedelics by Native peoples who have traditionally inhabited New Mexico, including peyote and the traditional use of psilocybin-containing mushrooms in present-day Mexico.

The Written Comment of Tracey Baca, DOM

Dr. Baca is a licensed Doctor of Oriental Medicine. *See* DOH Exhibit 8.Z. She comments in order to seek clarification regarding with an existing New Mexico license qualifies for a practitioner pathway.

She states that DOM scope of practice includes evaluation, diagnosis, management, and treatment of patients, including physical and mental conditions, counseling and education regarding physical, emotional and spiritual balance in lifestyle. She notes that the draft 7.35.3 rule describes the practitioner credential as a New Mexico professional license permitting the practice of "therapy, counseling, or behavioral services."

She thus requests that the Department specifically consider and clarify whether the existing scope of a NM DOM satisfies the practitioner licensing requirement under the proposed rule.

The Written Comment of Marcus Best

Mr. Best is a Taos County resident. *See* DOH Exhibit 8.AA. He submitted a written comment on the certifying clinician requirement and the patient approval process.

With respect to the certifying clinician requirement, he stated that the rules require an in-person evaluation with few telehealth exceptions, by a provider (an MD or NP) who holds a New Mexico controlled substance number, and that provider's role is limited to confirming a qualifying diagnosis. He asserted that that provider does not advise on medication tapering, on whether a patient is safe to dose, or on anything related to the treatment session itself.

He proposes that a better model would let the treating practitioner make the diagnostic certification, and would require medical clearance from a prescriber with a controlled substance number only when risk factors are present. If none are present, a diagnosis would be sufficient. He states that he understands that is consistent with what the legislation intended.

Mr. Best then addressed the patient application process, noting that after diagnosis, the patient and the certifying clinician must submit paperwork to the Department and wait for approval

before treatment can begin. He states that the reviewers have not met the patient and are not making a clinical judgment. He states that this step adds a delay of up to 30 days without added safety, and is most costly to people at the end of life and for people with treatment-resistant depression.

He urges the Department to revise both provisions.

The Written Comment of Scott Shannon, MD

Dr. Shannon is a psychiatrist and psychedelic researcher in Colorado. His states that his clinic has extensive experience with ketamine-assisted therapy and regulated psilocybin services. *See* DOH Exhibit 8.EE.

Dr. Shannon first addresses first the proposed requirement of an in-person certification from a clinician who has a controlled-substance number, which argues is unnecessarily restrictive, as follows:

- The statute defines a qualified patient in relation to a clinician's judgment that the person is medically appropriate based on a qualifying diagnosis, and does not make prescriptive authority the central clinical safeguard. From a medical/psychiatric point of view, this additional certification is not needed, adds cost to the system, and reduces access.

- He argues that the more important safety assessment occurs during preparation and immediately before administration, taking into consideration current medications, cardiovascular status, psychiatric history, changes in health and other risk factors. The practitioner who prepares the patient and is present for treatment is often in the best position to make this assessment.

- A better model would allow an appropriately licensed practitioner to document the qualifying diagnoses, and require consultation or medical clearance from a physician or other prescriber when defined risk factors are present.

- He encourages the Department to reconsider requiring a separate DOH approval before treatment can begin. This process adds little clinical information and creates delay, needlessly restricting volume and access to care.

- A notification or registration model would accomplish the Department's legitimate oversight and data-collection goals without imposing another clinical gate.

The Written Comment of End-of-Life Options New Mexico

Julia Bergen, the Executive Director of End-of-Life Options (EOLO), submitted a written comment on behalf of that organization. *See* DOH 8.GG. EOLO is a non-profit organization that provides information, education, and support for all end-of-life care options.

Ms. Bergen first addresses the landlord permission requirement in the location approval process. She notes that the landlord permission requirement as written would apply to a patient's

own home. She understands that this provision has its origins in the Medical Cannabis Program, and her comments echo those of other commentators who argue that the property-owner interest that justifies the provision in the cannabis program is not present in the context of psilocybin.

Again, like others, she argues against the forced disclosure of confidential, private medication and treatment to a patient' landlord, who has no clinical or regulatory role in their care. This is not necessary for patient safety, facilitator oversight, or program integrity, all of which are addressed elsewhere in the rule. For a patient who may already be navigating precarious housing, serious illness, and limited mobility, asking them to negotiate this disclosure with a landlord is a significant and unintended burden.

Residents of long-term care facilities have a related but separate concern. Residents of such facilities already allow physicians, nurses, and hospice staff to provide other forms of care without seeking treatment consent from the owner. Ms. Bergen argues that requiring a special permission specific to psilocybin and not other treatments singles out program participants for a disclosure and approval burden that does not appear to be tied to any actual safety or oversight need.

If the Department decides to retain the requirement, she urges it to add an exemption as follows: "This provision shall not apply to end-of-life patients or other seeking in-home care, or to long-term care facility residents."

Ms. Bergen also commented on the certifying clinician design. She noted that most end-of-life patients already have a well-established medical care team, and they are in the best position to assess the patient's medical prognosis and the appropriateness of psilocybin for that patient. However, these physicians are unlikely to be DOH certified. Requiring end-of-life patients to locate a DOH certified physician simply to confirm the imminence of their own death asked these patients to spend time and energy they do not have.

She argues that appropriate health and safety screening can be accomplished by permitted practitioners in accordance with their subject matter scope of their underlying healthcare license. Those who are overseeing patients with risks that exceed their scope of practice could consult with appropriate experts or refer patients for additional health screening.

EOLO believes this design should be reworked. However, if it continues, they request an exception for end-of-life patients, allowing those who have a prognosis of fewer than nine months to live to provide physician documentation of the prognosis to gain program entry.

Ms. Bergen next focuses on the patient application process, which she argues should be reconsidered. She states that for patients facing terminal or life-limiting disease, every added administrative step in treatment is time and energy they may not have. The process introduces delay into care. It may take time for the certifying clinician to assemble and submit the required documentation, and then the rule reserves 30 days for the Department to review the application. This could add additional months in just administrative time to the care, which could mean the difference between receiving relief or dying before care is available.

She echoes the comments of many in distinguishing the justification for an application in the Medical Cannabis Program and the medical psilocybin program.

EOLO recommends that the application process be removed.

The Written Comment of Sara Petrous

Ms. Petrous is a natural medicine facilitator in Colorado, an army veteran, and a former resident of New Mexico. *See* DOH Exhibit 8.KK. She states she has been significantly healed by the use of psilocybin therapy.

She uses the VA for all of her health insurance. She asserts that her breakthrough moments of healing would not be possible or very hard to achieve if she were to rely on the VA in New Mexico. The VA uses federal law and the new law in New Mexico would not be possible for the VA, or at least very rare with many hoops to jump through. She cannot afford private insurance and would not be able to pay for care herself. The price of getting approval for care will preclude people from even bothering to engage in the process.

The Written Comment of Cheves Fleming

Mr. Fleming has a diagnosis of cluster headaches and has had benefits from psilocybin. *See* DOH Exhibit 8.NN. He urges the Department to allow the licensed practitioner to do the diagnostic certification, and to allow the licensed practitioner to approve the patient without having to go through the DOH approval process. Accessibility for patients will be fast tracked with these changes.

The Written Comment of Amy Wong Hope, LCSW

Ms. Hope is a licensed clinical social worker, a licensed natural medical clinical facilitator, and founder of the Psychedelic Studies Certificate Program at the Southwestern College School of Counseling in Santa Fe. *See* DOH Exhibit 8.PP.

She recommends that certification for a qualifying condition may be provided by a licensed mental health professional whose scope of practice includes diagnosis and assessment of the designated conditions, rather than requiring certification by a medical prescriber. She argues that the proposed requirement creates an unnecessary barrier to patient access, medical providers may be reluctant to assume this role; and licensed mental health professionals already diagnose and assess mental health conditions within their professional scope of practice.

Ms. Hope also recommends that the rules clearly distinguish between (1) certification that the patient meets the statutory criteria for participation in the program; and (2) the subsequent assessment of whether that individual can safely and appropriately participate in a psilocybin administration session. Without this distinction, patients may interpret certification as a green light to proceed and facilitators may place inappropriate reliance on the certification when making their own safety determinations.

She recommends that New Mexico adopt an interdisciplinary approach when a patient's medical needs fall outside the scope of the evaluating mental health professional or facilitator, involving consultation with a qualified medical professional should be required when clinically indicated.

She further recommends that the Department establish clear screening and safety standards addressing conditions and histoires associated with increased risk during psilocybin administration

Ms. Hope recommends eliminating the patient application process and instead allow patient enrollment to occur through the certification process.

She also recommends deleting the property-owner requirement, or in the alternative, adding the following exemption: "This provision shall not apply to end-of-life patients receiving in-home care, or to residents of long-term care facilities."

She recommends that the rules explicitly include touch consent and explicit standards defining permissible and prohibited touch between a facilitator and patient during psilocybin services.

Ms. Hope submitted a second written comment on October 2, 2026. *See* DOH Exhibit 8.TTT. She provides an overview of the services she provides as a trainer, and the costs involved in that endeavor.

The Written Comment of Mary Curry, MD

Dr. Curry echoes in a very similar manner the arguments many others have made regarding the property-owner statement, the certifying clinician design, and the patient application process. *See* DOH Exhibit 8.UU.

In addition, she recommends an integrated mental health and substance abuse and medical model that is client/patient centered. The entry point of screening and diagnosis is a licensed mental health professional who has completed a certification to provide psilocybin treatment. She recommends using a screening tool that identifies the psychological and medical condition that are considered counterindications. If a medical condition is indicated, the client is responsible for meeting with their physician.

The Written Comment of Wendy Robbins

Ms. Robbins submitted a detailed economic analysis of her understanding of the costs involved in a medical psilocybin program. See DOH Exhibit 8.YY for the details. She concludes by requesting that the Department publish a complete economic analysis before adopting the rules, reduce unnecessary costs and create a workable pathway for microdosing.

The Written Comment of Heather Krause, MD

Dr. Krause is an emergency physician in rural northern New Mexico. *See* DOH Exhibit 8.AAA. She holds a certificate in Psychedelic Assisted Therapy from Memoru University in Colorado. She recommends establishing vertically integrated businesses, which would allow prescribing, growing, and administering by clinicians.

The Written Comment of Jim Dodson

Mr. Dodson suffered an accidental blow to his prefrontal cortex thirteen years ago which led to being fully and permanently disabled by MDD and PTSD. *See* DOH Exhibit 8.BBB. He describes in detail the miraculous results of psychedelic therapy in his life. He urges a system where this therapy can be prescribed just like any other protected drug and used as instructed, and home settings must be permitted.

Mr. Dodson submitted a second written comment on October 2, 2026. *See* DOH Exhibit 8.UUU. He described himself as a patient advocate and citizen researcher. He expressed a concern about rushing this rule promulgation process. He states that he understands that the Governor would like to see the first patients ready for treatment on January 1, 2027. He asserts that this is not a valid reason to rush this dynamic complex development phase that benefits only a select few corporate entities. He urges that board to apologize to the Governor for not meeting her request one full year ahead of the date specified in the statute.

The Written Comment of Henry Harbin, MD

Dr. Harbin is a psychiatrist with more than 50 years of experience in the behavioral health field. *See* DOH Exhibit 8.CCC.

Dr. Harbin supports the proposed regulations. He thinks the guidelines for certifying clinicians are appropriate and consistent with the types of medical screening that are required and implemented in the health care system.

He also supports the practitioner requirements in requiring documentation of current professional licensing to practice therapy, counseling, or behavioral services—e.g., PSY, LSW, LCSW. He believes the state should consider the cost of training requirements and consider whether they are consistent with training requirements for other types of specialized psychotherapies such a Dialectical Behavior Therapy, Trauma Focuses CBT, and EMDR. He notes that it is rate that other specialized psychotherapies are required to have additional training or certification before offering these interventions.

The Written Comment of Senator Martin Hickey, MD

Senator Martin Hickey is a senator in the New Mexico legislature and an MD. He was a lead co-sponsor of relevant legislation. *See* DOH Exhibit 8.FFF. He submitted a "Memo: Proposed NMAC 7.35.3 Provisions and Suggested Revisions" that was prepared for Legislative Counsel bill

drafting by Anne Metz, Ph.D., LPCC, which he appears to fully agree with. He provides additional commentary in red-line.

Dr. Metz recommended striking the controlled-substance-number requirement form 7.35.3.9(D)(2) NMAC. Senator Hickey appears to agree with that recommendation.

Senator Hickey states that he has been through a 5-day, two journey professional psilocybin retreat; he does not believe any of the state's regulators have had that experience. Consequently, they are limited in how the medicine works. Instead, he argues that they replace experience with medical cannabis regulations, which are totally different in criteria and benefit, and should be regulated as such.

He states that the competencies of psilocybin clinicians are to understand who would benefit from psilocybin, do the initial screening and earn patient trust, recommend the appropriate dosage, conduct journeys and follow-up integration. He states that education and certification must include 150 hours of specific training and experience in the therapeutic use of psilocybin. He states that a traditionally licensed health professional without this training offers no value.

Senator Hickey asserts that there is no call for a physical exam. Instead, the initial screening should include an inquiry about medical/mental conditions and medications that psilocybin would exacerbate or be contraindicated for. If found, then medical clearance should be required by a provider who has the documented competence for that.

He asserts that participation in the program should be self-generated with as few bureaucratic barriers as possible, and he states that he passed this concept in SB 273 for mental health parity.

Dr. Metz recommended that the Department drop the requirement of an in-person physical examination prior to certification with telemedicine only allowed if the clinician examined the patient within the prior six months, reviewed records confirming an in-person diagnosis within six months, or formally consulted with a clinician who conducted that in-person exam.

Senator Hickey agrees with Dr. Metz and agrees that if the certifying-clinician role is eliminated, the telehealth previous is unnecessary. However, if the separate certifying step by the certifying clinician is kept in some form, telehealth should be permitted on the same terms as the rest of New Mexico's telehealth policy, without a six-month in-person anchor requirement.

Senator Hickey agrees with Dr. Metz that the requirements for a patient application and 30-day departmental approval should be removed, and replaced with a registration/notification requirement. He argues that the state has no role in interfering with the patient provider relationship and this includes approval.

Senator Hickey agrees with Dr. Metz that instead of requiring a separate certifying clinician for every patient, the Department should require the treating practitioner to obtain consultation from a prescriber or relevant specialist only when specific, enumerated risk factors are present.

Finally, Senator Hickey agrees that the Department should add an exception to the landlord attestation for other approved locations stating that this requirement does not apply to a qualified patient's own primary residence to other patient's receiving in-home care, or to long-term care facility residents.

The Written Comment of Janice Gronvold

Ms. Gronvold is a New Mexico resident who works in the hospitality industry and has consulted to medical organizations and health resorts regarding holistic and integrated medical modalities as well as published work on non-pharmaceutical alternatives to treating depression, anxiety, substance addiction, less-than optimal mental status and cognitive decline. *See* DOH Exhibit 8.GGG.

She recommends the following:

- A patient who has already established mental health support with a professional should not have to locate a separate medical prescriber to conduct a certification evaluation; this is unnecessary and present challenges in finding medical prescribers who would participate.

- There should be an exemption for end-of-life patients and residents of long-term care facilities from the property-owner approval requirement.

She also urges the Department to not establish excessive licensing fees and a pattern where therapy is not financially accessible

The Written Comment of Katherine Hawke

Ms. Hawke is a New Mexico resident who has been closely involved with regulatory committee this year. She is also a clinician and a landlord. *See* DOH Exhibit 8.III.

Ms. Hawke first addresses the property-owner statement requirement. She states that she would be happy as a landlord to have her tenants receiving psilocybin in their homes. However, she would find it distressing to have to gin a document to give them permission—essentially saying that she is aware that federally illegal activities are happening on her property.

She states that from the renter's point of view, this requirement could block access. She supports exempting end-of-life patients and residents of long-term care facilities from the requirement.

She joins her colleagues in recommending the removal of the certifying clinician design. In its place, she recommends regulating the specific contraindications, medical histoires and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a qualified clinician.

She recommends striking the patient application.

The Written Comment of Larry Leenan, MD/MPH

Dr. Leenan is a Professor at the UNM School of Medicine, and a board-certified Family and Addiction Medicine Physician. He has extensive experience with several entities related to research and treatment in psychedelic assisted therapies. He is also member of the NM Medical Psilocybin Program Advisory Board, and Chair of the NM Medical Psilocybin Advisory Board Committee on End-of-Life Care. *See* DOH Exhibit 8.JJJ.

He advocates revising the property owner attestation for other approved locations by exempting a patient's own primary residence and residents of long-term care facilities.

Dr. Leeman also addressed the provisions related to educational requirement for certifying clinicians, practitioners, and facilitators. He recommended revising the proposed rule as to training as follows:

- End-of-life and palliative care considerations—8 hours
- Trauma and trauma-informed care—7 hours
- Screening, suicidality and crisis response—4 hours
- Management of challenging experiences during and after psilocybin assisted therapy—4 hours.

Dr. Leeman recommended removal of the patient application rule, and replacing it with a registration/notification requirement, noting that the DOH would retain full authority to audit, investigate, and take disciplinary action after the fact. He states that the DOH should not add a barrier that delays care and inappropriately interferes with the licensed practitioner/client relationship.

The Written Comment of Disability Rights New Mexico

Disability Rights New Mexico ("DRNM") submitted a written comment. *See* DOH Exhibit MMM. DRNM states that having a qualifying medical condition under the MPA, has a profound impact on those who have a disability; it has a profound impact on the individual and on their ability to access programs, services, and treatment, and on their ability to engage in activities of daily living. Further, they are often among the most stigmatized diagnoses, further limiting equal access to programs, services, and treatment.

DRNM asserts that the evaluation of the program's effectiveness must include an assessment of patient accessibility and the removal of unnecessary barriers to participation in the program. They argue that application process in the program would disproportionately exclude many of the patients the program aims to treat by requiring written landlord approval.

DRNM believes that it is commendable that the rules provide for those who are unable to be physically transported to a healing center, for reasons of medical necessity, for purposes of

improving patient access in rural and frontier counties, or to enable treatment to occur in a natural environment setting. However, they argue that that provision is undermined by the requirement of a written statement from the owner of rental property. This requirement disproportionately impacts would-be participants in the program who are most in need of the treatment to be delivered in the home-setting. They argue that landlord approval has nothing to do with whether or not an individual is unable to be physically transported to a healing center, nor does it serve any legitimate purpose to improving patient access in rural and frontier counties.

Indeed, as they assert, it is unclear what purpose this requirement serves.

They argue that the requirement for written landlord consent does not serve the interests of the program, or the interests of patients in the program. It appears to serve the interests of landlords about the interests of the patients. They state that, arguably, it is likely never in the interests of a landlord to confirm the use of a federally scheduled/illegal substance on their property. This exposure to liability will also certainly result in most, if not all landlords denying such requests.

Further, they argue, the requirement puts in the hands of landlords a treatment decision. In no other sphere does that occur; end-of-life hospice and in-home nursing care does not require landlord approval, even if those services require the administration of medication. Landlord approval is not required for other in-home therapies, such as occupational or physical therapy, or other therapies.

While the DOH has previously included a landlord consent requirement in the context of medical cannabis, DRNM argues that that program is distinctly different. They argue that medical cannabis is a drug program; medical psilocybin is a therapy program. Further, participants in the cannabis program obtain and dose themselves with cannabis in an unaccompanied purchase. That is not the case with medical psilocybin, which is dosed and administered by a qualified professional.

DRNM also asserts that disclosures to a landlord of a tenant's significant mental illness or other condition carry significant risk on the part of a tenant with a qualifying condition. Such patients may find that the requirement presents an unacceptable risk of personal and social discrimination, and may produce fear of retaliation by the landlord.

As to patients in rural and frontier counties, the requirement is likely to entrench the access problems it purports to address, because it will result in those patients being restricted to geographical areas in which an approved healing center is located, thereby creating service deserts and pockets of inaccessibility throughout the state.

Further, DRNM argues, patients who participate in federal housing assistance programs, who often are patients with disabilities and limited incomes, could face being excluded from the program because there is no recognized reasonable accommodation which would allow a Section 8 landlord to approve the use of a federally scheduled and illegal substance.

Thus, DRNM advocates removal of 7.35.3.11(B)(9) NMAC—the requirement of written consent from the landlord.

DRNM included and recommended that the Department review the following publication: Johannes Thrul and Albert Garcia-Romeu (2021) "Whitewashing psychedelics: racial equity in the emerging field of psychedelic-assisted mental health research and treatment." *See* Attachment to DOH Exhibit MMM.

The Written Comment of Andra Elizabeth

Ms. Elizabeth is an individual with a diagnosis of Complex PTSD, a survivor of an abusive childhood, and her condition has led her to attempt to end her life more than once. *See* DOH Exhibit 8.QQQ. She continued to struggle until she found psychedelic-assisted therapy.

She recommends the following:

- She opposes the landlord approval requirement.

- She opposes the patient enrollment and screening process, which would mean long drives for rural patients. The application process also requires to many steps for the people least able to manage them.

- She states that the "other approved locations" rule requires a lengthy application which expires after only 90 days. She suggests that certification should match the patient's enrollment period.

- She assert that the rules for healing centers amount to overregulation by requiring more than two dozen application items, strict group staffing ratios, two wilderness-certified staff for sites 15 or more minutes from emergency services, and two-day reported of "challenging psychological, emotional, or behavioral reactions," which are often an expected part of therapy, will raise costs and discourage centers from opening outside urban areas.

- With respect to the appeal process, she argues that requiring hearing requests by certified mail and in-person hearings in Santa Fe for anyone within 100 miles adds cost and travel for patients; she asserts that electronic submission and remote hearings should be the default.

The Written Comment of Mike Courtois

Mr. Courtois encourages the Department to consider some of the issues with the ketamine clinics in the state. *See* DOH Exhibit 8.SSS. His main concern is that there is not an integrated approach. With ketamine, people can go in for services and get approved by doctor, but there is no requirement to officer therapy afterwards. He feels the diagnosis should be provided by someone with less of a financial interest, and some kind of talk therapy should be more strongly encouraged with or as part of the program. He suggests there will then be more successful outcomes and less abuse of the system.

The Written Comment of Meredith Vaughn

Ms. Vaughn strongly encouraged the Department to consider aligning New Mexico's rules with the framework implemented by Colorado for psilocybin, rather than adopting the lengthy, complex procedures modeled after New Mexico's medical cannabis program. *See* DOH Exhibit 8.WWW. She asserts that Colorado allows the credentialed practitioner delivering the treatment to directly manage and take ownership of the process. She argues that this streamlines the procedural burden significantly while maintaining public health oversight. She also argues that replicating the highly administrative medical cannabis model in New Mexico would create unnecessary barriers to access and delay treatments that could be handled efficiently at the provider level.

The Written Comment of Maria Fini, Ph.D.

Dr. Fini asserts that there are three things that should be considered with this regulation: access, practicality, and affordability. She notes that many centers in Oregon are shutting down and low or even middle-income people are unable to afford psilocybin services there due to unnecessary and costly oversight. *See* DOH Exhibit 8.XXX.

She agrees with Denali Wilson that we should remove the state-level screening/approval process of patients prior to administration in 7.35.3.8(B) NMAC. She asserts that if psilocybin clinicians are properly trained, we should be able to rely on them to screen and determine eligibility for treatment, or add extra screening only when certain medical requirements are met. She further asserts that maintaining the state-level screening process will add unnecessary stress, time, and cost, as well as potentially being demoralizing.

She next argues that some of the regulations regarding the number of clinicians or facilitators in the room are unnecessarily cautious and will contribute to the failure of the program due to financial impracticality. She urges dropping the requirement that both a facilitator and practitioner be in the room for an individual session, arguing that it will make it too expensive. She further asserts that in many cases for people with PTSH it is more appropriate to start them with a small dose, making this requirement unnecessary. As an alternative, she suggests requiring a second person or practitioner at that time, or easily accessible by phone.

She states that 7.35.3.20(K) NMAC requires two people to have Wilderness medical or EMT training in rural settings. She believes one person could easily fill this requirement; two will make it too costly.

Dr. Fini asserts that some adjustments need to be made to 7.35.3.20(H)(5) NMAC, as follows: She believes that group administration has many benefits, one of which is it supports financial practicality. She is considering creating a healing center that would use the group model and invite participants for one-week retreats in which they would undergo two dosing sessions. She thinks three or four clinicians to one patient [sic] would be a good ratio, and allow for a cost staying under $5,000. She thinks that the ratios set forth in the rule would make these retreats prohibitively expensive.

She agrees with others that the landlord approval requirements for in-home use and in healing centers that rent property should be struck.

She asks whether in-person assessments under 7.35.3.8(B) NMAC are always necessary prior to dosing sessions. She argues that this will really impede access in rural and indigenous communities where transportation is inaccessible or very expensive. She suggests that medical screening like taking blood pressures can be provided by a different provider or in-person on the day of the session, rather than requiring a separate in-person session.

The Written Response of the Department

On November 9, 2026, the Department submitted a written response to the substantial public comments in this rulemaking proceeding. *See* DOH Exhibit 9. Given the substantial number of public comments at hearing and written comments provided for the record, the Department structured its response by topic, rather than by commenter. The following is a summary of the responses of the Department to the topics raised by the public.

The Department first addresses commenters' objections to the proposed patient-application framework. *See* DOH Exhibit 9 at 1. Several commenters argued against that framework, including the proposed 30-day Department review period, and argued that a registration process modeled on the Medical Cannabis Program is unnecessary for a supervised, private psilocybin program that issues no patient cards.

In response to that argument, the Department notes that the MPA, at Section 26-2D-9, requires the Department to adopt rules "for the collection of data from producers, clinicians, and qualified patients" to evaluate the efficacy of the medical use po psilocybin and to publish an annual assessment of the program. Thus, while that Section requires that data be reported in such a way that an individual qualified patient cannot be identified, that requirement refers to the Department's reporting of information concerning patients, not the collection of data.

The Department also explains that the enrollment process is not intended to be an involved process, and does not require the Department to render any clinical decisions regarding individual patients, or to collect detailed clinical records. It is instead a straightforward enrollment process that collects basic information about patients who will participate in the program.

Also, in response to the comments it has received, the Department proposed to reduce the 30-calendar-day maximum processing period for applications in section 8(C) to 10 days, and revise references to "applicant" to specify "patient." It will also include test to clarify that this is an enrollment process rather than a more involved application process.

The Department next addressed the objections of commenters to the clinician-centered model of the rule generally, as well as the specific requirement that a certifying clinician serve as the gateway to the program, and the requirement that a certifying clinician hold a New Mexico controlled-substance registration. The Department notes that some commenters proposed that the Department instead adopt a medical screening and referral model that requires providers to utilize a screening tool to refer patients to medical providers if that have contraindicated conditions.

The Department notes that the MPA at Section 26-2D-3(H) defines "qualified patient" as "a patient whose clinician has judged the patient to be a medically appropriate candidate for the use of medical psilocybin based on being diagnosed with a qualifying condition." Thus, the patient must be certified by a clinician in order to be enrolled in the program.

The Department states that it understands the concerns regarding access that were raised by commenters. In response, it proposes to remove references to the "certifying clinician" from the rule, and instead rely on practitioner screening and referral of patients who have contraindicated conditions or treatments. It also notes that a "practitioner" is defined in the proposed rule as a type of clinician certified by the Department, and practitioner certification therefore comports with he statutory requirement described above.

The Department further states that contraindicated conditions and treatments to be listed in the rule will include the following:

- Cardiovascular disease;
- Seizure disorder or history of seizure;
- Moderate or greater head trauma;
- Hypertension;
- History of stroke or cerebrovascular disease, including but not limited to aneurysms;
- Asthma/COPD;
- Diabetes;
- Psychosis or disease with a risk of psychosis (including bipolar disorder);
- Medication/drug-interaction contraindications (such as lithium, and drugs with serotonergic/psychotropic interactions);
- History of suicide attempt, thoughts of self-harm, or thoughts of harming others;
- Use of medical devices including but not limited to insulin pump, continuous glucose sensor feeding tubes, ostomies, central lines, supplemental oxygen, dialysis, tracheostomy, pacemaker, external defibrillators, pain pump, stimulators or other implantable devices; and
- Such additional contraindicated conditions or treatments as the Department may require.

The Department states that requirements concerning certifying clinicians at Section 7.35.3.18(B) NMAC will be deleted, along with continuing education requirements for certifying clinicians. It furthers states that the provider who certifies the patient will not be required to hold a controlled substances registration.

Further, the Department states that Section 8(B) will be revised to require that the practitioner attest as follows:

(1) That the practitioner has completed the required Department screening tool; and

(2) That the practitioner has referred the patient to a medical provider (with the appropriate scope of practice to evaluate potential medical risk) if either:

a. There are medical risks indicated through the screening tool review,
b. The patient has not seen a medical provider within the previous 12 months; or
c. The practitioner has otherwise chosen, within the practitioner's discretion, to make the referral.

The Department states that the practitioner will also be required to attest that the practitioner has determined, in their professional opinion and based on consultation with the medical provider (as applicable) that:

(1) The potential health benefits of the medical use of psilocybin likely outweigh the health risks for the patient, and

(2) There are no identified medical risks that cannot be adequately addressed during treatment; or to the extent that there are any identified medical risks, a written plan has been created to address those risks during treatment, which will be implemented by the treating practitioner.

The third area of objections addressed by the Department in its Response relates to the proposed requirement that there be an in-person examination by a certifying clinician burdens rural patients, raises costs, and is unnecessary, and the commenters requested that telehealth evaluations be permitted and end-of-life patients be accommodated. The Department also notes that related comments proposed that an initial screening with inquiry into medical and mental conditions and mediations replace a mandatory physical examination, with medical clearance required only where screening identifies an issue. Furthermore, commenters also stated a concern that patients who are seen by Veterans Administration healthcare providers would have greater obstacles meeting the certification requirements, since their providers, as federal employees, would be prohibited from certifying patients for the use of psilocybin, a Schedule I drug under federal law.

The Department responds to these concerns by stating that, as noted above, it intends to remove the "certifying clinician" provisions of the rule, including the in-person examination requirements of Section 13(A), in favor of allowing practitioners to certify patients based on the above-described medical screening process.

Further, the Department states that, rather than requiring a certifying clinician within the previous six months, it intends to incorporate a requirement within Section 8(B) that patients who have not been seen by a medical provider in the previous 12 months be referred to a medical provider before being certified to the program. This, the Department asserts, will effectively remove the requirement that every examination be in-person. It will also be more individual-specific and should be less burdensome for patients in the program, according to the Department.

The Department next addresses five issues arising out of the proposed rule related to treatment locations and settings. The Department first notes that it has received considerable public comment regarding the proposed requirements found in Sections 11(A) and (B), which would require that an attestation be obtained from a landlord or property owner as a precondition of approval of a healing center or an "other approved location." In response to the comments received by the Department, it intends to strike the landlord/property owner statement requirements and

replace them with a requirement that the applicant attest that they are the owner of the property or that they are aware of the legal risk concerning the property.

The Department states that it will offer educational material to patients regarding the potential consequences of psilocybin use, and will also include a requirement within Section 8 that the patient attest that they have been informed of the legal status of psilocybin and potential consequences of using it. The Department notes that psilocybin is classified as a Schedule I drug under federal law, and the possession of it is deemed illegal under federal law, which may in some circumstances result in forfeiture of property associated with its possession. The Department states that in adopting these provisions, the Department seeks to ensure that applicants for healing centers and other approved locations, and patients, are enabled to make informed decisions.

The Department also notes that comments regarding potential conflicts with Section 8 and individual living in federally assisted housing are effectively resolved by the removal of the landlord-approval requirement, described above.

The Department notes that one commenter observed that, because Section 7.35.3.11(B) lists specific reasons for certifying other locations, any reason not listed might be presumed to be excluded, and recommended a catch-all provision. The Department declined to modify this rule, stating that the existing language is broad enough to meet the anticipated needs for approval of other locations.

The Department further notes that a commenter objected that other approved locations, intended to improve rural and frontier access, require a lengthy application yet expire after only 90 days, and recommended matching the certification to the patient's enrollment period. The Department declined to modify this provision as well, stating that the certification of "other approved locations" is intended to allow temporary, not extended, use.

The Department next addressed a comment that treatment should be available at long-term care facilities. The Department stated that the proposed rules do not prohibit treatment at long-term care facilities; it would be left to such a facility to decide whether to apply to become an approved location.

The Department then responded to objections from commenters regarding staffing ratios as proposed in the draft regulations. They urged the Department to increase the ratio of patients to practitioners and facilitators during administration sessions. In response to those comments, the Department proposed to revise the staffing ratios in Section 20(H) as follows:

- For individual patient sessions, a minimum of one partitioner and one additional practitioner or facilitator will be present.

- For group sessions, the ratio will be one practitioner for every nine patients and at least one additional practitioner, facilitator, or qualified student for every three patients. For example, if there are three patients, there must be a minimum of two practitioners/facilitators; if there are six patients, there must be one practitioner and two additional practitioners/facilitators; if there are nine patients, there must be one practitioner

and three additional practitioners/facilitators; if there are ten patients, there must be four additional practitioners/facilitators.

The Department intends to revise the rule to clarify that, for purposes of being "present" during an administration session, the practitioner will only need to be in the building (within range to be called into the room in case of an emergency,) and not necessarily in the administration session itself. This is because the facilitators are not licensed medical professionals and are not necessarily qualified to address emergency medical/therapeutic episodes. The Department notes that these ratios are intended for safety reasons, and to ensure patients get the attention needed during their administration and journey.

The Department also responded to a comment asking whether a given practitioner license would be eligible for practitioner certification in the program. In order to clarify which practitioners may be certified, the Department proposes to add text to Section 9(E)(1) that specifies examples of licensed providers who hold professional licensure in New Mexico to practice therapy, counseling, or behavioral services, consisting of licensed therapists, licensed professional clinical counselors, licensed mental health counselors, licensed alcohol and drug abuse counselors, licensed independent social workers, licensed clinical social workers, licensed master social workers, licensed psychologists, psychiatrists, psychiatric nurse practitioners, and advanced practice registered nurses. In addition, this modification will include a catch-all provision that authorizes a person whose license does not fall within this list to submit a letter from their licensing body indicating that utilization of medial psilocybin is within their professional scope of practice.

The Department also responded to a concern that placing a non-licensed facilitator under a practitioner's supervision could extend the practitioner's malpractice exposure to the facilitator while leaving the facilitator outside of the corresponding coverage framework, and recommended treating the two roles as independent.

The Department noted that the "facilitator" designation is a creation of this rule, and it does not exist in the MPA. The only providers referenced in the statute are "clinicians." Consequently, the Department asserts that facilitators cannot lawfully operate with the program without clinician supervision, because their ability to function within the program effectively derives from clinicians.

The Department also notes that most facilitators in Oregon and Colorado carry liability policies for protection against malpractice, and there are insurance carriers willing to insure facilitators.

The Department next responded to a comment that the requirement in Section 20(K) that there be at least two individuals present during administration sessions who have wilderness first aid certification, wilderness first responder certification, or licensure as a New Mexico emergency medical technician, is too costly, and that one person would be sufficient. The Department disagrees, and notes that this is not an unusual safety precaution for experiences in wilderness areas, giving as an example a requirement that Scouting America requires any group participating in treks at the Philmon Scout Ranch to have two members who are trained in Wilderness First Aid.

The Department then turned to a number of comments relating to training and curriculum issues, as follows:

- Some commenters recommended that the practicum requirements be reduced. The Department stated that it declines to do so, and that the practicum hours were previously increased in response to earlier public input. It does not believe that further revisions would be beneficial.

- Some commenters requested that the training requirements expressly include training for suicidality, challenging experiences, trauma, end-of-life care, and pharmacology. The Department notes that most of these subjects are already included in the existing curriculum requirements, including pharmacology, trauma, clinical research, end-of-life care, and bad trips and medical emergencies. For additional clarity, the Department proposes to add the term "suicidality response" to 7.35.3.18(C)(1)(e) NMAC. The Department states that it delinces to prescribe fixed hours for individual topes, noting that topic length may change, and the rule should allow educational programs to make adjustment without requiring a rule change.

- The Department notes that commenters correctly identified a conflict between 7.35.3.10(D)(1) (40 hours, two individual and two group sessions) and 7.35.3.19(H)(4)(b) (40 hours and one group session.) This was a continuity/typographical error and the Department proposes to revise both sections to read "one group session." The Department notes that it intends to retain the requirement of experience across more than one modality, as experience in only one modality would not demonstrate the flexibility and expertise required through the primary certification process.

- The Department responded to a comment regarding an absence of evidence of traditional psilocybin use by indigenous people in New Mexico. The Department has adjusted that language to require training on the "historical aspects of psychedelic use, including traditional use by Native American and other populations in New Mexico."

- Some commenters recommended that the curriculum expressly address touch consent and that the Department define permissible and prohibited touch. The Department notes that somatic training is already included in the proposed regulation in Section 18(C)(1)(y), and informed consent is already a required training topic in Section 18(C)(10)(x). The Department declines to promulgate rules defining permissible touch, because this is a negotiated patient-provider boundary addressed through training, rather than a matter for specification in a DOH rule.

- The Department next responded to a commenter who questioned the rigor of allowing training programs to assemble their own evaluation panels and asked how the rule intersect with New Mexico Higher Education Department regulations. The Department states that it is not requiring educational programs to comply with HED regulations; it is requiring programs to undergo a formal evaluation of their curriculum and program.

- The Department responded to a comment that practicum students be permitted to train on one another rather than with qualifying patients. The Department stated that it cannot lawfully adopt this recommendation because psilocybin consumption by non-patients is illegal under New Mexico state law, and student therefore could not lawfully consume psilocybin in the course of training.

- The Department will correct faulty numbering of 7.35.3.12(A)(21-24) NMAC, which is a typographical error.

The Department next addressed comments that were raised concerning program affordability, citing supervision costs, training costs, treatment-room costs, testing costs, andan comparable prices in Oregon. Some comments proposed microdosing as a pathway to a lower-cost option. The Department states that it is unable to make a full determination regarding cost and affordability until more information is available on what providers will charge, and any present estimate would be speculative. It notes that it also lacks authority to restrict or set practitioner fees.

The Department also notes that it is proposing the revise the rule to permit students who have completed half of their practicum to be counted toward the provider-patient ratio, and is proposing to adjust the group staffing ratios, both of which should reduce costs below the figure cited by commenters. Further, the Department does not intend to charge fees for permits, certificates, or applications, which should help alleviate costs for permitted and certified persons and entities.

The Department appreciates the interest in microdosing, but believes that would be more of a clinical consideration for providers than a structural feature of the program. It notes that microdosing is not prohibited by the existing framework where the practitioner and patient agree to use low doses, so long as administration occurs in the approved setting required by statute; NMSA 1978, § 26-2D-7(A) requires the Department to establish treatment protocols that include "approved setting for administration of psilocybin to patients."

The Department then addressed a proposal from a commenter who urged that clinicians be permitted to grow the medicine they prescribe and to vertically integrate prescribing, cultivation, and administration, arguing that this would substantially reduce costs. The Department declined to adopt vertical integration in the cultivation and administration of psilocybin. It states that such a model would create the very conflicts of interest that it seeks to avoid, giving as an example that where a provider is also a producer, the provider would both sell and produce the product, creating an incentive to sell more product than the patient needs, raising prices to improve the producer's bottom line, or to bypass safety requirements such as product testing.

The Department also argues that there is no indication that a vertically integrated model would necessarily reduce costs, as the same production requirements would apply. Further, it could increase costs by multiplying production locations and thereby increasing statewide expenditures on electricity, water, travel for testing, and build-out, as well s the Department's regulatory oversight burden. The Department states that a defined set of production locations should yield lower overall statewide production and oversight costs.

The Department then responded to a commenter who requested that the Department specify in the rule that justice-system involvement does not disqualify an otherwise qualified patient, that participation must be voluntary (though a court or probation referral does not render it involuntary), and that declining treatment carries no adverse consequence. The commenter also sought guidance on 42 CFR Part 2, HIPPA, and state confidentiality requirements.

The Department responded by stating that NMSA 1978, § 26-2D-10 provides that a person serving probation or parole, or in custody or under supervision pending trial as part of a community supervision program, shall not be penalized for participating in the program. Consequently, since that protection exists in the statute, it need not be repeated in the rule. Further, the Department lacks authority over courts, probation departments, diversion programs, and community supervision programs, and it generally cannot dictate their requirements through rule.

The Department also responded to objections from commenters regarding the appeals process in Section 7.35.3.27. These comments assert that the process is inaccessible, requiring hearing requests by certified mail and in-person hearings in Santa Fe, and question the allocation of the burden of proof.

The Department responded by stating that it declines to modify the certified-mail and venue provisions. It states that Section 27(D) requires that a hearing request be sent by certified mail, and Section 27(E) provides that hearings are held in Santa Fe, except where the appellant lives more than 100 miles from Santa Fe. The parties may also agree that the hearing be conducted by telephone or web video. The Department asserts that these standards are not unduly onerous, and the rule leaves open the possibility of a web-based hearing in every case.

With respect to the issue raised regarding the burden of proof, the Department states that Section 27(L), as proposed, would place the burden on the appellant to establish by a preponderance of the evidence that the Department's decision should be reversed or modified. Having considered comments on this topic, the Department proposes to revise this Section to specify that the appellant bears the burden where the Department has denied an initial application, and the Department bears the burden when it has suspended or revoked an existing certificate. The Department notes that whereas an existing certificate may implicate due process interests of the holder, the same is not true of the denial of the initial application (citing *New Mexico State Racing Comm'n v. Yoakum*, 1991-NMCA-153, 113 N.M. 561.) The Department also notes that it is a familiar practice for licensing and certifying bodies to impose the burden of proof on an initial applicant.

The Department next responded to comments that Section 25(E) wrongly limits judicial review. Section 25(E) states that "[e]xcept as otherwise provided by law, there shall be no right to judicial review of a decision by the administrative review committee." The Department asserts that in essence, this Section states that the rule is not establishing a right to judicial review of such decisions, and that there is no right of review "except as otherwise provided by law." The Department asserts that it is not required to establish a right of judicial review of such decisions by rule.

Finally, the Department responds to a comment which requested that the rule include specific record-retention periods, and that it establish a minimum patient age or consent architecture for minors. As a result of this comment, the Department proposes to add to the rule a requirement that healing centers, practitioners, and facilitators retain treatment records for a minimum of five years, consistent with the retention period applicable to educational centers. However, with regard to a minimum patient age, the Department notes that the statute does not establish one, and it believes this is best left to the licensed provider to determine within their practice and within the patient-provider relationship.

Analysis and Recommendation

In conducting the analysis of the issues in this rule promulgation process, the Hearing Officer was guided by New Mexico case law which provides instruction in determining whether a rule adopted by an administrative agency will be upheld. This guidance can be found in *New Mexico Mining Association v. New Mexico Mining Commission,* 1996-NMCA-098, 122 N.M. 332 at ¶ 15, which states as follows:

> Rules adopted by an administrative agency will be upheld if they are in harmony with the agency's express statutory authority or spring from those powers that may be fairly implied therefrom. [Citations omitted.] Similarly, regulations adopted by an agency are presumed to be valid if they are shown to be reasonably consistent with the statutory purposes of the agency. [Citation omitted.]

See also Rio Grande Chapter of Sierra Club v. New Mexico Mining Comm'n, 2003-NMSC-005, 133 N.M. 97 at ¶25.

The Hearing Officer has reviewed the exhibits and the public comments at hearing regarding the proposed new rule 7.35.3 NMAC and the proposed amendments to 7.35.2 NMAC. Further, the Hearing Officer has reviewed the New Mexico Psilocybin Act, giving a particular focus to NMSA 1978, §26-2D-7(A) from the New Mexico Medical Psilocybin Act, which states as follows:

> A. The "medical use of psilocybin program" is created in the department. In developing the program, the department shall establish:
>
> (1) appropriate qualifying conditions for qualified patients;
>
> (2) necessary initial and ongoing training for producers and clinicians;
>
> (3) treatment protocols, including patient selection criteria, medical service standards, dosage standards and approved settings for administration of psilocybin to patients;
>
> (4) safety protocols for producing psilocybin from mushrooms, transporting, storing and handling psilocybin and treating patients;

(5) other best practices for producers and clinicians;

(6) requirements for data collection to evaluate the program and the use of best practices by producers and clinicians; and

(7) other requirements, restrictions and limitations promulgated by the department to ensure an efficacious program.

The provisions outlined in the foregoing statute give the Department broad authority to establish the Medical Psilocybin Program and to establish the rules that govern it. A great deal of effort went into developing these rules. There were over 75 public meetings between committees and the Medical Psilocybin Advisory Board prior to the rulemaking hearing. Extensive public comments were provided to the Department in this rule promulgation process. The written response of the Department to those comments indicates that this has been a thorough rulemaking process, and that the Department has given careful consideration to the development of the new rule, the input from the public regarding the new rule, and a willingness to amend the proposed rule even prior to its final adoption.

The New Rule 7.35.3 NMAC

The Hearing Officer notes that there were approximately 30 public comments made at hearing and 80 written comments submitted in this rulemaking process. Substantial work took place in this process by the Medical Psilocybin Advisory Board and its committees. The Hearing Officer carefully considered the comments from the public and has summarized the public comments from the hearing, as well as the written comments that were submitted in detail as indicated above. The Hearing Officer has also considered and summarized the Response of the Department to those comments, and finds that the proposals made therein are well-founded and incorporated by reference into this Analysis.

The November 9, 2026 written response to public comments that was submitted to the Department supports the conclusion that the Department made the effort to consider the recommendations of the public with care and careful attention, as well as a willingness to adopt the recommendations that were made by the public on major issues. The Hearing Officer adopts the November 9, 2026 response of the Department to public comment, and, consequently, incorporates it into this Analysis as one of the bases for the Recommendation made herein.

The provisions found in the new rule, and the additional proposals made by the Department in the November 9, 2026 written response of the Department, are consistent with the requirements of the foregoing statute. The Hearing Officer recommends that the Cabinet Secretary find that the proposed new rule, with amendments, is consistent with the authority granted to the agency in rulemaking and consistent with the statutory purposes of the agency set forth in the statute. The proposed new rule is in harmony with the agency's express statutory authority or spring from those powers that may be fairly implied therefrom. *See New Mexico Mining Association v. New Mexico Mining Commission,* 1996-NMCA-098, 122 N.M. 332 at ¶ 15.

The Amendments to Rule 7.35.2 NMAC

The Notice of Hearing, DOH Exhibit 3, states that the Department is proposing to amend portions of 7.25.2 NMAC. In particular, it is proposing to revise some of the definitions found in 7.35.2.7 NMAC, revise the general producer requirements in 7.35.2.10 NMAC, and revise the requirements related to the transportation of medical psilocybin in 7.35.24 NMAC.

The proposed revisions to the definitions in Section 7 are set out in the red-lined version of the rule found in DOH Exhibit 2.

The proposed revisions to Sections 10 and 24, which are very minor, can also be seen in red-line in DOH Exhibit 2.

There were no public comments, either in person at the hearing, or in written comments, specifically regarding the proposed amendments to 7.35.2 NMAC. Thus, there was no opposition to the amendments. It should be noted however, that with the Department's decision not to establish a model based on the use of a "certifying clinician," it appears appropriate to remove that definition from the proposed rule. *See* DOH Exhibit at 7.35.2.7(C)(5) NMAC.

The Hearing Officer, having reviewed the record in this proceeding in full, recommends that the Secretary find that the provisions of the proposed amendments to select definitions in 7.35.2.7 NMAC are in harmony with, and/or spring from the authority given to the Department under the relevant statutes. Likewise, the Hearing Officer recommends that the Secretary find that the provisions of the proposed amendments to 7.35.2.10 and 24 NMAC are in harmony with, and/or spring from the authority given to the Department under the relevant statutes.

Recommendations

Based upon the foregoing, the Hearing Officer recommends that the Secretary adopt the proposed new rule 7.35.3 NMAC ("Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs") by the Department, as set forth in DOH Exhibit 1 as revised by the written Response of the Department found in DOH Exhibit 9.

The Hearing Officer also recommend that the Secretary adopt the proposed amendments to 7.35.2.7, 10, and 24 NMAC, with the exception of the proposed definition of "certifying clinician" in 7.35.7(C)(5)

Original Signed By Craig T. Erickson — *November 13, 2026*

Craig T. Erickson
Hearing Officer

Date