



September 29, 2026

End-of-Life Considerations and Concerns in the Draft Licensing, Training and Education Rules for New Mexico's Medical Psilocybin Program

Dear Department of Health Staff, Rule-making Team, and Hearing Officer,

End of Life Options New Mexico (EOLONM), a statewide nonprofit organization that provides education, information and support for all end-of-life care options, including medical aid in dying, writes to provide public comment on the draft rules pertaining to Licensure, Training, and Education for New Mexico's Medical Psilocybin Program. Our comments focus on the unique needs of end-of-life patients and sections where the draft rules do not adequately account for these needs. We are grateful for the opportunity to provide feedback on these proposed rules and are committed to the program's success.

NMAC 7.35.3.11 APPLICATION PROCESS FOR HEALING CENTERS AND OTHER APPROVED LOCATIONS

EOLONM is concerned about the landlord permission requirement in the location approval process and requests a clarifying amendment.

The draft provision in question requires:

“Proof of ownership by the qualified patient or attending practitioner or facilitator of any property on which medical psilocybin administration sessions will be conducted, or a signed, written statement from the owner of such property acknowledging that the owner understands that persons will be participating in the medical psilocybin program on the premises, and what those persons are authorized to do within the terms of their certification.”

As written, this requirement applies to any property where an administration session occurs, including a patient's own home. For end-of-life patients and other patients who receive in-home care and who rent rather than own their residence, the provision seems to require them 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.

We understand from MPA Advisory Board/Department discussions that this provision has origins from an analogous requirement within the Medical Cannabis Program. Cannabis is typically smoked or vaporized, and a landlord has a real, practical interest in knowing whether that will occur on their property, given the potential effects on odor, ventilation, and property value. Medical psilocybin administration is a different activity. It occurs during a discrete, clinically supervised session administered by a licensed facilitator, involves no combustion or lingering property effects, and is already governed by the program's own supervision, screening, and safety requirements. The property-owner interest that justifies the cannabis provision simply is not present here in the same way.

What remains, for end-of-life and other patients seeking care in their rented home is the disclosure itself. The requirement effectively conditions a terminally ill or homebound person's access to an in-home medical psilocybin treatment on first disclosing their participation in a state medical program — and the general nature of a private medical condition — to their landlord, a third party with no clinical or regulatory role in their care. That is a forced disclosure of private health information to someone outside the treatment relationship, unsupported by any compelling public policy or private interest that this disclosure serves. It does not appear necessary for patient safety, for facilitator oversight, or for program integrity, all of which are already addressed elsewhere in the draft regulations through facilitator licensure, supervision requirements, and program registration. For a population that is often already navigating precarious housing, serious illness, and limited mobility, asking them to additionally negotiate this disclosure with a landlord is a significant and, we believe, unintended burden.

Residents of long-term care facilities raise a related but separate concern. Similarly, a patient, practitioner, or facilitator would not be the property owner. Facilities already allow physicians, nurses, and hospice staff to provide other forms of care in a resident's room without seeking treatment-by-treatment consent from ownership. Requiring a special permission specific to psilocybin, and not to comparable medical treatments, singles out participants in the program for a disclosure and approval burden that does not appear tied to any actual safety or oversight need.

Given that psilocybin ingestion does not have any property impact, we do not believe the property ownership provision is necessary in the context of medical psilocybin. However, if the Department wishes to retain the provision, we believe there needs to be an exemption to address the above concerns:

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

This language would preserve the underlying property-owner protection where it serves a real purpose, while relieving the state's most vulnerable patients of a disclosure obligation that does not appear to advance any safety or oversight goal. We would be glad to discuss this further, to provide any additional information the Department finds useful, or to work with staff on alternative phrasing that achieves the same result.

NMAC 7.35.3.13 REQUIREMENTS AND PROHIBITIONS FOR CERTIFYING CLINICIANS, PRACTITIONERS, AND FACILITATORS

The proposed "certifying clinician" program design introduces a unique access barrier for end-of-life patients. The design would require all program patients to see a DOH-certified provider to confirm their qualifying condition and conduct a health screening, with this exam required in person except in narrow circumstances. Most end-of-life patients already have a well-established medical care team — the physicians best positioned to assess the patient's medical prognosis and the medical appropriateness of psilocybin for that patient — but these physicians are unlikely to also be DOH-certified. Requiring an end-of-life patient to locate an additional, DOH-certified physician simply to confirm the imminence of their own death asks these patients to spend time and energy they do not have.

The safety motives presumed behind the "certifying clinician" design can be accomplished by other means that better account for the access needs of end-of-life and other program patients. Appropriate health and safety screening can be accomplished by permitted practitioners in accordance with the subject matter scope of practice of their underlying healthcare license. Practitioners overseeing patients with risks that exceed their subject matter scope of practice should consult with appropriate experts or refer patients out for additional health screening.

We believe the entry design should be reworked, but if the Department decides to continue with the "certifying clinician" design, we request an exception from this design for end-of-life patients, allowing patients with a prognosis of fewer than 9 months to live to provide physician documentation of the prognosis to gain program entry.

NMAC 7.35.3.8 PATIENT ENROLLMENT APPLICATION PROCESS

The proposed patient application process in the draft rules should be reconsidered. For patients facing terminal or life-limiting diagnoses, every added administrative step in the treatment process is time and energy they may not have. An application-and-approval process introduces delay into care that should be available as quickly as clinically appropriate. It may take some time for the certifying clinician to assemble and submit the required documentation for the application, and then the rules reserve 30 days for the department to review the application. This could add additional months in just administrative time to the care, which for end-of-life patients could mean the difference between receiving relief or dying before it is available. We respectfully request that the Department reconsider

the design.

The application design appears to be a feature borrowed from the Medical Cannabis program structure. The “patient identification card” model in the Cannabis program exists because authorized patients possess, outside of any supervised setting, what would otherwise be an illegal substance. The Lynn and Erin Compassionate Use Act built a patient application process specifically to manage that unsupervised possession risk, but the medical psilocybin program presents no such risk. Because it operates on a model of supervised administration at approved locations only, no patient will ever possess psilocybin outside of a supervised episode. There is no scenario requiring a patient to prove authorization to possess the substance, and therefore no justification for requiring an application or identification card before an end-of-life patient can access care.

For patients who may have weeks or months, not years, the application process will cause further delay between diagnosis and treatment, and for end-of-life patients, this concern is especially acute. We recommend the application process be removed.

We appreciate the opportunity to provide these comments and concerns. People near their end of life have unique challenges that access to medical psilocybin may be helpful with. However, they must be able to obtain this assistance in a manner that acknowledges and is responsive to their physical and emotional frailty. Thanks for your consideration of these recommendations and we look forward to continuing to work with the Department to create and implement this unique and important new program.

Sincerely,



Julia Bergen, Executive Director
End of Life Options New Mexico



Marisa Bartolotta
Compassion & Choices
Policy Counsel

