

From: [Gregory Evans](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing
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To the New Mexico Department of Health:

I am a New Mexico resident in Santa Fe, and I am also a renter. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

It is deeply important to me that the program lands well, reaches people and delivers positive outcomes. Breaking the intended access and equity goals due to unjustified regulation will undo much of the hard work that the department has done to put this together. Below are solutions.

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

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

I ask the department to consider these solutions:

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

OR

b) Delete paragraph (B)(9) of 7.35.3.11. If the department wants documentation of a home setting, follow Colorado here: the patient documents their own legal right to occupy the residence, no owner signs anything, and the clinician brings only the session dose and removes anything unused the same day.

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. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. 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. A signed acknowledgment gives an owner nothing to gain and something to lose, so many will decline to sign, and care at home for anyone who does not own their home will end before they are able to receive treatment.

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

Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks.

The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time “prescriber” gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks.

3. The patient application, 7.35.3.8.

Strike the patient application process.

It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients.

Thank you for considering my comment.

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