EMERGING ISSUE: MEDICAL MARIJUANA
Recommendations from Interested Parties

Prepared for the Children, Families, Health, and Human Services Interim Committee
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BACKGROUND

The Children, Families, Health, and Human Services Interim Committee began reviewing Montana's Medical Marijuana Act in April 2010 because of the many issues that began emerging across the state in 2010. The Committee heard presentations from state agencies, schools, local government, law enforcement, and the medical marijuana industry in April. Members also took public comment on the matter.

Because of the wide range of issues raised at the April meeting, the Committee asked its staff to work with interested parties on potential changes to the law. The Committee specifically asked that the parties review issues related to the regulation of physicians, patients, and medical marijuana providers. Committee members hoped that the process would lead to consensus proposals for strengthening provisions of the law.

Since April, legislative staff has:

- held one meeting with representatives of the Department of Public Health and Human Services (DPHHS), Department of Justice, Department of Corrections, Department of Agriculture, Board of Medical Examiners, and Board of Pharmacy to discuss issues of concern and ideas for addressing those concerns;

- requested written proposals from those agencies; and

- held three meetings with a work group representing medical marijuana caregivers and patients, local government, law enforcement, and schools.

The Work Group Process

The work group reviewed each section of the Medical Marijuana Act (Act) and discussed a wide range of topics during its meetings. The sessions provided an opportunity for participants to share their perspectives about the Act, as well as their concerns about various portions of the law. For some participants, the concerns focused on areas of the law they believe are too vague or too lax. Others considered most provisions to be adequate and thought some should be expanded.

The work group considered potential changes proposed by the participants and some ideas suggested by state agency representatives. Although the Committee asked for consensus recommendations, it became apparent throughout the work group meetings that consensus would not be reached on many items — if consensus were to be defined as 100% agreement among members. As a result, the group agreed to forward to the Committee all recommendations that had any level of support among members. The group further agreed that each recommendation would indicate the level of support that the idea had garnered among members.

The work group's recommendations are detailed in this report. Some recommendations

contain *(in italics)* additional items for Committee consideration. These indicate the types of questions that staff believes would need to be answered to allow for drafting of legislation related to the particular recommendation.

The recommendations are grouped into categories depending on whether they affect:

- caregivers, the people authorized by law to grow and provide medical marijuana;
- patients and/or physicians;
- general provisions of the Act; or
- prohibitions on medical marijuana use.

In addition, the recommendations in each category are further categorized by whether they received the full support of the work group or support from a majority or minority of the members.

RECOMMENDATIONS AFFECTING CAREGIVERS

Recommendations Receiving Full Work Group Support

- **Create a state-level regulatory board to oversee activities by caregivers.** Before making this decision, participants reviewed a background paper that covered the general laws for Department of Labor and Industry regulatory boards, including the requirement that all board expenses be paid for through licensing fees. They also discussed the operation of boards with the executive directors of the Board of Pharmacy and Board of Medical Examiners.

  A board would issue or deny licenses, review complaints, and sanction caregivers who are violating administrative rules or statutes. Participants believed that a regulatory board also could set guidelines on a number of issues, including requirements for inspections, auditing of plant-to-patient ratios, fire and safety standards, and educational and ethical standards.

  Committee Considerations: Pursuing this option would require a number of further decisions by the Committee, such as the membership of the board, the types of regulatory activities that should be specified in law, and the types of items that could be left to rulemaking by the board. In addition, there would be a delay between the time a board is created in statute and the time it is actually operational. This raises the question of whether the Committee would want to establish temporary guidelines or fees until a board is set up. An overview of regulatory boards is provided in the briefing paper entitled "General Provisions of DOLI Boards."

  The Committee would also need to determine whether DPHHS would continue to operate the patient registry or whether the new board would handle patient

registrations and renewals, as well. The work group recommended that DPHHS maintain control of the patient registry.

- **Establish a tiered system of licensing and regulation for caregivers** based on the number of patients they serve. Participants agreed that caregivers providing medical marijuana to only one or two patients should pay lower licensing fees and be subject to a lower level of regulation than caregivers who provide medical marijuana to dozens of people. The group indicated that the specifics of the tiered structure could be established by the new regulatory board.

  Committee Considerations: The Committee may want to consider whether the Legislature or a board should determine the tiered structure and establish minimum regulatory standards for each tier of licensing.

- **Allow a parent whose minor child has received a registry card to contract with a caregiver** to grow the medical marijuana. The Act currently requires the parent to serve as the minor's caregiver. Some participants said parents are unable or unwilling to grow marijuana, and this change would clarify that they could obtain the marijuana from a registered caregiver. However, participants also said the law should continue to clearly state that the parent must remain responsible for obtaining the marijuana and controlling the minor's use of the marijuana.

- **Allow caregivers to sell marijuana to other caregivers** in order to meet the needs of their patients while also maintaining a "closed-loop" monitoring and tracking system. Participants discussed the difficulty of growing marijuana and the potential for a caregiver's crop to be decimated by bad growing conditions or pests. They also acknowledged that in these instances, many caregivers will sell their excess marijuana to another caregiver. The legality of these types of sales is questionable. Work group members agreed that the law should allow for these sales within a system that is able to document that the amount of marijuana being grown and sold is still tied to the number of patients for whom it's being provided.

  Committee Considerations: Pursuing this option would require decisions on how these sales would proceed, how they would be tracked, and how much marijuana could be sold among caregivers. The Committee may also want to consider whether such details should be decided by the Legislature in statute or established by administrative rules developed by a regulatory board, if a board is created.

- **Create a new category of persons who are allowed to handle marijuana** but are not caregivers or patients. Caregivers said it was important to recognize that some employees in larger operations primarily take care of the plants or deliver medical marijuana to patients. Currently, these employees all should be registered as caregivers in order to handle or cultivate the marijuana. The group agreed that the Committee may want to determine whether a different term should be created to describe the duties of this type of employee.

Committee Considerations: The Committee may want to clearly define the duties of these persons and consider when and how they could be considered to be undertaking activities covered by the Act. For example, would the protections of the law apply to them only while they are at the place of employment?

- **Clarify that caregivers may also be patients**. The law is currently being interpreted by all parties as allowing a caregiver to also be a patient. However, law enforcement and DPHHS are often asked questions about this issue. The work group recommended that the Act be amended as necessary to clearly state that caregivers may also be patients.

Recommendations Supported by a Majority of Members

- **Establish additional offenses that would prohibit a person from being registered as a caregiver.** The Act currently prevents a person who has committed a felony drug offense from being a caregiver. Law enforcement representatives raised a number of concerns about other types of offenders who currently may become caregivers, including people who are registered violent or sexual offenders and people who have embezzled money or been convicted of felony theft. The group generally agreed that the Committee should expand the list of offenses that prohibit registration as a caregiver.

  Committee Considerations: DPHHS and the Department of Justice studied the issue of background checks for direct-care workers during the 2007-2008 interim, as required by Senate Joint Resolution No. 7. A work group conducting the study reviewed all criminal offenses to determine which ones should permanently or temporarily disqualify a person from serving in a direct-care position. If the Committee decides to pursue this recommendation, it may want to use the briefing paper entitled "SJR 7 Study: Background Checks for Direct-Care Workers — Disqualifying Offenses" as a starting point for reviewing which offenses should be added to the Act.

- **Require a 50-state background check before registering a caregiver**. DPHHS currently conducts background checks to determine if a caregiver has been convicted of a felony drug offense in Montana. However, a caregiver may have a felony drug conviction elsewhere that would not be discovered during this review.

  The FBI will conduct national background checks for state governments for licensing purposes if the checks are expressly authorized by a state law that has been approved by the U.S. Attorney General. The statute must require fingerprinting of the applicant.

Committee Considerations: The Committee may want to consider which state agency would be most appropriate for conducting broader background checks, particularly if a regulatory board is established under the Department of Labor and Industry. In addition, the Committee may want to consider whether a state agency or law enforcement should obtain the fingerprints needed for the background check. The checks also will be more costly.

- **Establish educational and ethical requirements for caregivers.** Most participants agreed some educational and ethical standards should be developed for caregivers, possibly by a regulatory board, if one is created. Some participants, however, indicated that existing training sessions sponsored by caregiver organizations already cover these topics and additional requirements aren't necessary.

  Committee Considerations: Pursuing this option would require the Committee to determine whether standards should be set in statute or by administrative rule, either by DPHHS or a regulatory board. The Committee may also consider setting minimum or maximum standards that must be incorporated into rule. Without a specific standard, an agency or board would have the discretion to set standards at any level deemed appropriate through the rulemaking process.

RECOMMENDATIONS AFFECTING PATIENTS AND/OR PHYSICIANS

Recommendations Receiving Full Support

- **Review the time period for which a patient registry card is valid**. Cards are currently issued for 1 year and must be renewed annually to remain valid. Some participants suggested that cards should be issued for less than 1 year to ensure that physicians provide followup care and monitoring, just as they would with many prescription drugs. Others suggested that cards should be issued for longer periods of time for some conditions that are incurable, such as glaucoma. The Board of Medical Examiners suggested allowing cards to be valid for up to 1 year, rather than for a full year. This would give physicians the discretion to determine how long their written certification would be valid.

  Because of the varying views, the work group agreed to recommend that the Committee review this issue and consider making the cards valid for longer periods of time for some conditions and requiring followup care for some conditions within a period of months after the card is issued. Most participants said the 1-year registration period should be the standard, with the law allowing for some variations.

  Committee Considerations: If the Committee decides to allow varied registration periods, including a period of less than 1 year, staff would propose that additional information be obtained on the administrative impacts.

Recommendations Supported by a Majority of Members

- **Review issues related to the definition and/or diagnosis of chronic pain and physician standards** with more input from the medical community. A majority of participants expressed concern about the large number of patients who have obtained registry cards for chronic pain. They believed that the statistics indicate that the term needs to be better defined or the physician standards for diagnosing chronic pain need to be spelled out more clearly. However, most members believed the Committee needed to decide these issues with input from physicians.

Recommendations Supported by a Minority of Members

- **Review the use of mass screening clinics** to certify the use of medical marijuana and determine whether the issue should be addressed by a regulatory board or in statute. Only a minority of participants wanted to bring the issue of mass screening clinics to the Committee's attention. Some participants defended the use of these clinics on the grounds that only a small percentage of doctors in Montana will provide written certifications. They also contended that many doctors are contractually prohibited by their employers from providing written certifications. Some participants felt the issue had already been addressed in the Board of Medical Examiners position paper on physician certification for medical marijuana, and some felt the issue was best left to a regulatory board, if a board is created. The Montana Caregivers Network, which has held clinics around the state, also noted that the number of people registered for an upcoming clinic was less than 50.

  Medical marijuana registry statistics show that as of May 31, 307 doctors had provided written certifications for patients. A report by the Montana Office of Rural Health in August 2009 indicated that 2,139 physicians were practicing in Montana in August 2009. Based on those figures, certifying physicians represent about 14% of the physicians practicing in Montana. A staff check of selected hospitals in Billings, Helena, Missoula, and Kalispell indicated that none of the hospitals prevent the physicians they employ from providing written certifications.

RECOMMENDATIONS INVOLVING GENERAL PROVISIONS OF THE ACT

Recommendations Receiving Full Support

- **Review all definitions in 50-46-102, MCA,** to determine whether new definitions are needed and whether existing definitions should be clarified. The group considered a number of proposals that clearly would have resulted in split votes. Those ideas included more strictly defining "chronic pain," requiring that physicians be in good standing with the Board of Medical Examiners, more specifically indicating when a person becomes a "qualifying patient," expanding the list of debilitating medical conditions, and changing the definition of "usable marijuana." At the same time, participants generally agreed that the law may need to recognize other types of people in the medical marijuana industry, such as those who grow plants for a large number of patients and those who are employed by large growers.

Because of the division on specific definitions, the group agreed to recommend that the Committee review the definitions section of the Act and make changes that lawmakers believe will best address those issues. In addition, they agreed that definitions involving physicians and medical conditions should be discussed with members of the medical community.

Committee Considerations: If the Committee wants to add or clarify definitions, the briefing paper entitled "Proposed Changes to Definitions in the Medical Marijuana Act" identifies some of the key issues raised during review of the Act.

- **Revise the confidentiality provisions in various sections of the law** to allow additional sharing of information regarding medical marijuana among state and local government agencies. The law currently allows DPHHS to share registry information only with state and local law enforcement agencies. Participants noted that if additional state agencies become involved in enforcing laws related to medical marijuana, they would need access to the records maintained by the state. For example, the Department of Agriculture may need to know where caregiver operations are located in order to conduct inspections ensuring that the operations meet state nursery laws. If a licensing board is established in the Department of Labor and Industry, the board would need access to information. In addition, local governments that are issuing business licenses may need verification from the state that a person is a registered caregiver.

  Committee Considerations: Pursuing this recommendation would require the Committee to consider which state and local agencies may need access to the information in order to be able to conduct any activities allowed through additional changes to the Act or other state laws.

- **Review and amend the allowable amounts of medical marijuana**. The law currently allows patients and caregivers to possess 1 ounce of usable marijuana per patient. However, an edible product with marijuana may weigh more than 1 ounce, while 1 ounce of hashish is much more potent than 1 ounce of dried marijuana. The group did not have time to delve into specific recommendations on this topic but agreed that this issue should be reviewed and clarified.

- **Amend the reciprocity provisions for people who hold cards in other states** where medical marijuana is legal. Clarifications were considered necessary in two areas of the law. First, participants agreed Montana law should govern out-of-state patients, including the limits on the amount of marijuana they may possess while in Montana. In addition, they wanted to clarify that Montana caregivers may provide marijuana to an out-of-state patient who is temporarily in the state. They suggested that such sales be limited to a certain number of days and that out-of-state patients must obtain a Montana card after they have spent a certain period of time in the state.

Committee Considerations: The law is currently silent on how an out-of-state visitor covered by the reciprocity provisions would obtain medical marijuana in Montana, meaning that Montana caregivers who provide it now could be considered to be breaking the law. If the law is changed to allow Montana caregivers to provide marijuana to non-Montana cardholders, it does represent a change from the current patient-caregiver system established in Montana law. The Committee may want to consider how this change could be made to ensure that the "closed-loop" patient-caregiver system is maintained.

- **Establish a procedure for petitioning the state to add medical conditions** to the list of debilitating conditions for which the use of medical marijuana is allowed. The request would trigger a review process by the state. Some participants said that additional conditions, such as insomnia and Post-Traumatic Stress Disorder, should be added to the list of debilitating medical conditions. Others, however, said that they had insufficient medical or scientific knowledge to support that type of change. Although state law gives DPHHS the ability to add new conditions by rule, the agency has not done so because it believes those decisions are best made by the Legislature. The work group agreed that a fair compromise on this issue was to create a process by which the state must periodically consider new conditions and review the evidence that exists for treating them with medical marijuana.

  Committee Considerations: Pursuing this option would require additional decisions on issues such as how frequently the state must review requests for new conditions, the types of information the state must review when making a decision, and whether the state agency would have final decision-making authority or whether it would simply make recommendations to the Legislature every 2 years.

- **Require patients and caregivers to carry their registry cards** in the same way that drivers are required to carry driver's licenses. The law does not currently require this, making it difficult for law enforcement officers to determine whether a person is a valid cardholder when they make a stop involving marijuana on nights or weekends.

  Committee Considerations: The work group did not discuss what penalty, if any, should be imposed for failure to carry a registry card. The Committee will need to decide if a penalty should be imposed. If so, staff could research options for consideration.

- **Establish a penalty for intentionally falsifying information on an application for a registry card.** Under the Act, DPHHS may deny a registry application if the information in incomplete or inaccurate. However, the law does not contain a penalty if a person deliberately provides false information on the application.

  Committee Consideration: Pursuing this option would require additional direction on the type of penalty to be imposed. Staff could provide options for consideration.

Recommendations Supported by a Majority of Members

- **Clarify that medical marijuana must be grown in Montana.** The Act does not address how a caregiver or patient could begin growing marijuana legally under the law. However, with the high number of registered caregivers, most participants agreed that sources of marijuana are available within the state. Thus they believe only marijuana grown in Montana for medical use should be sold for medical use.

- **Clarify that professional licensing boards may discipline a licensee** for unprofessional conduct even if the conduct is related to medical marijuana. Currently, two subsections of 50-46-201, MCA, could be read as prohibiting a licensing board from taking any action against a licensee if a violation of the board's standards involved medical use of marijuana. Most participants agreed that these subsections should be amended to make it clear that licensees could be subject to discipline if the medical use constituted unprofessional conduct or if a person's unprofessional conduct involved an aspect of the Act.

- **Require that a medical condition be diagnosed and documented prior to a person's arrest on a marijuana-related charge** in order for the person to raise the defense allowed for in 50-46-206, MCA. The so-called "affirmative defense" established in this section of the Act allows a person to raise as a defense in court the fact that the person was in need of medical marijuana or was providing marijuana for a medical use, even if the person is not currently registered as a patient or caregiver. Law enforcement and prosecutors on the work group said the provisions in this section discourage prosecution of almost any marijuana offense because the language is so broad. They also said that people who want the full protection of the law should be willing to register as a patient or caregiver.

  Advocates of the current law said many people who have qualifying medical conditions are reluctant to register with the state because they don't want to be on a government list, especially if the federal government might obtain the list. They also said this section of the law was merely intended to allow people to raise as a defense the possibility that the marijuana they possessed or were selling was intended for medical purposes — whether the argument was likely to succeed or not.

  The majority of participants agreed, however, that a person who wants to raise the defense must have evidence of the medical condition before the arrest and may not simply go to a doctor after the arrest and seek to have a medical condition diagnosed at that time.

Recommendations with Split Support

- **Review 50-46-206(1)(b), MCA, to determine if it should be stricken or amended.** This subsection allows anyone arrested for selling marijuana to raise an affirmative defense by saying that the sale was for medical use. A person does not have to be a registered caregiver to use this defense. Participants were about evenly divided on whether this provision needed to be changed.

RECOMMENDATIONS INVOLVING PROHIBITIONS IN THE ACT

Recommendations Receiving Full Support

- **Amend the use of the term "school grounds"** to "property owned by a school district." School representatives requested this change because many districts own property — including housing and vehicles — that may not be located near a school and thus may not be considered "school grounds" under the Act's current language.

Recommendations Supported by a Majority of Members

- **Prohibit possession and any use of medical marijuana on school property and school buses**. The Act currently prohibits the smoking of marijuana on a school bus or school grounds. Schools are concerned that this still allows students and employees to use marijuana in other forms while on school grounds, setting up potential conflicts with federal law that could jeopardize federal school funds. Most participants agreed to recommend this change. However, some participants said medical marijuana should be treated in the same manner as prescription drugs, which often may be brought to school, kept in the main office or school nurse's office, and administered by a school nurse or staff member.

- **Give local governments the explicit authority to establish limits on the public use of marijuana.** The group discussed whether smoking of medical marijuana in public should be prohibited by statute. When it became clear that participants were divided on the issue, they agreed instead to recommend that local governments be given the authority in statute to establish limits on public use. Some local governments have self-governing powers, but many do not. Cities, towns, and counties without self-governing powers may undertake some activities only as authorized by law. The Act does not specifically authorize local governments to enact regulations related to medical marijuana. This recommendation was seen as a way to give local governments the ability to set policies on public use of marijuana that are in keeping with the sentiment of local residents.

Recommendations Supported by a Minority of Members

- **Prohibit patients from involuntarily exposing anyone else to their medical use of marijuana.** Participants discussed this idea as it related to the issue of smoking in public and as it related to the issue of children who may be exposed to an adult's medical use in their homes. A prohibition on involuntary exposure would generally require someone to file a complaint with police and provide evidence to support the claim. Most participants did not support this proposal, for varying reasons. They did, however, believe the Committee should obtain more information from DPHHS about how it handles complaints involving children who are in homes where marijuana is used for medical purposes.

IDEAS RAISED BUT NOT FULLY REVIEWED

Numerous ideas were raised during the Committee's April 27th panel presentations and public comment period on medical marijuana, as well as in the process of meeting with state agency representatives and the work group. The work group did not fully explore many of these ideas because time simply did not permit full, if any, discussion of them.

The ideas are listed here in case the Committee would like to incorporate any of them into potential legislation or obtain further information about them. The ideas are grouped into general categories to indicate whether they would affect caregivers, patients and/or physicians, general provisions of the law, or prohibitions in the law.

Ideas Affecting Caregivers

- Limit the number of patients that a caregiver may have
- Require caregivers to pay a fee for their registry cards
- Consider establishing fire, safety, and zoning regulations for caregiver operations
- Prohibit caregiver operations within 1,000 feet of schools
- Limit the number of storefront operations
- Establish residency requirements for caregivers
- Allow laboratory testing of medical marijuana
- Prohibit financial relationships between a physician and caregiver in connection with a physician's appointments with patients seeking written certification

Ideas Affecting Patients and/or Physicians

- Allow physicians to revoke a written certification, require that they notify DPHHS, and require that DPHHS revoke a patient's card
- Require certifying physicians to be Montana residents and have an established practice in Montana
- Establish penalties for violation of various patient provisions
- Prohibit or regulate use of telemedicine for physician certification
- Require more detailed information on applications to ensure that medical marijuana is a treatment of last resort
- Allow an expedited application process for certain medical conditions
- Require in-person meetings between the physician and patient and a physical exam or complete medical records exam
- Require physicians, not third parties, to keep records of patient visits

Ideas Involving General Provisions of the Act

- Allow revocation of a person's registry card for a drug offense involving marijuana
- Establish penalties for violation of caregiver provisions
- Establish a waiting period before a person whose card has been revoked may apply for a card again
- Require state-level health care programs that subsidize or provide reimbursement for prescription drugs to do the same for medical marijuana for eligible patients

Ideas Involving Prohibitions

- Amend the Clean Indoor Air Act to specify that medical marijuana is a prohibited smokable product
- Clarify that the workers' compensation program doesn't have to cover the costs of medical marijuana

Work Group Participants

A number of interested parties attended the work group meetings and offered comments as appropriate. The following individuals were the members who were originally invited and agreed to participate:

Industry

Rick Rosio, Montana Pain Management
Jason Chris, Montana Caregivers Network
Tom Daubert, Patients & Families United/Montana Cannabis
Chris Lindsey, attorney
Jim Gingery, Montana Medical Growers Association
Rebecca Gross, A Kinder Caregiver, Inc.

Law Enforcement/Local Government

Kris Hansen, Deputy Hill County Attorney
Jim Smith, Montana Sheriffs and Peace Officers Association/Montana County Attorneys Association
Pat Brinkman, Great Falls Police Department
Greg Sullivan, Bozeman City Attorney

Schools

Aaron Bouschor, Montana School Boards Association

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