

From: Americans for Safe Access
To: District of Columbia Department of Health
Date: April 26, 2013
Re: Proposed new and revised regulations to 22-C DCMR (Medical Marijuana)

SUMMARY:

Americans for Safe Access (ASA), the nation's largest membership-based organization working exclusively on the issue of medical marijuana, thanks the District Department of Health (DOH) for the opportunity to comment on the proposed regulatory changes to 22-C DCMR (Medical Marijuana). These regulations represent a sincere effort on the part of the District to fully implement the program that was first approved D.C. voters in 1998; however, there are a number of areas in which the regulations would run the serious risk of creating unintended consequences that would harm safe and legal access to D.C. Patients. ASA would like to offer the following problem/solution analysis in order for DOH to best serve the District's patient population.

PROBLEM/SOLUTION ANALYSIS:

1. The Advisory Committee lacks the patient voice and falls short of addressing a statutory requirement of B18-622.

1400.1 The Advisory Committee (“Committee”) shall consist of seven (7) members, which shall be appointed as follows: The Director of the Department of Consumer and Regulatory Affairs, the Chief of the Metropolitan Police Department, and the City Administrator shall each appoint one member, who shall be either himself or herself or a subordinate designee; the Director of the Department of Health shall appoint four (4) members, one of which shall be the Director himself or herself or a subordinate designee, and the other three (3) of which shall be residents of the District of Columbia that possess either medical or scientific expertise that the Director of the Department of Health deems would be useful to the Committee.

Problem: The purpose and duties of the Committee are fantastic and something the District's medical marijuana program could benefit greatly from. However, the composition of Committee may not be able to effectively address these duties, and may frustrate the purpose of the Committee. For instance, it lacks the presence of patients, so the specific issues facing patients may not be heard in first-hand fashion. Although there is a requirement for those with “medical or scientific expertise”, there is no specific requirement for physicians or nurses. A further deficiency in the composition of the Committee is that it lacks legal expertise in the field of medical marijuana.

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Solution: Several states and municipalities have created similar committees (sometimes referred to as “commissions” or “task forces”), but have opted to expressly include certain medical professionals. For example Connecticut, which along with the District of Columbia has one of the two most restrictive medical marijuana programs in country, has a Board of Physicians to vet petitions for new qualifying conditions consisting of “eight physicians or surgeons who are knowledgeable about the palliative use of marijuana...in one of the following specialties: Neurology, pain medicine, pain management, medical oncology, psychiatry, infectious disease, family medicine or gynecology.”¹ Other states moved to require a nurse and/or pharmacist. Additionally, a report prepared at the request of District of Columbia Attorney General Irvin Nathan by the Department of Public Policy at the University of California, Los Angeles recommended that:

“Patients, physicians, Department of Health officials, residents of the community surrounding dispensaries and cultivation centers, law enforcement, and other experts such as Americans for Safe Access who provided the required D.C. training programs for employees of cultivation centers and dispensaries should all be represented.”²

1401.1 The Advisory Committee shall convene at least twice (2) per year to:

(a) Accept and review petitions for the approval of additional qualifying medical conditions and qualifying medical treatments, and to recommend in favor or against approval to the Director;

(b) Monitor best practices in other states, monitor scientific research on the use of medical marijuana, monitor the effectiveness of the District’s medical marijuana program, and make recommendations to the Mayor, the Council, the Director, and when asked to consult by other agencies;

(c) Issue recommendations to the Director of the quantities of cannabis, not to exceed four (4) ounces per month, that are necessary to constitute an adequate supply for qualified patients and designated caregivers; and

(d) Issue a report to the Mayor and Council recommending whether the District should allow qualifying patients and caregivers to cultivate medical marijuana, how to implement and regulate cultivation of medical marijuana by qualifying patients and caregivers, and any other comments the Committee believes to be of importance.

1

. Conn. Gen. Stat. § 21a408(1).

2

. Collett, Stephen C., et al, Evaluation of the Medical Marijuana Program in Washington, D.C. Department of Public Policy at the University of California, Los Angeles, April 2013, at 42.

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Problem: A report on patient cultivation of medicine was a statutory requirement of B18-622, which was to be completed no later than “[n]o later than January 1, 2012.” Given the extremely limited number of dispensaries coupled with capped limit of 95-plants per cultivation location, shortages of medicine is one of the greatest concerns to the patient community. A report on wisdom and necessity of patient cultivation in the District is an important step in addressing concerns about shortages of medicine

Solution: Given that the statutory deadline for the patient cultivation report was due 16 months ago, this report is long overdue. A requirement that this report be completed within 120 days of the formation of the committee is the best way to ensure that the issues concerning patient cultivation in the District are analyzed and reported upon in a timely and complete nature.

1403.7 The Committee may provide for a public comment period. Public comment may be by written comment, verbal or both.

Problem: The lack of a required public comment period could mean that both the comprehensive voice of the full D.C. medical marijuana patient community as well as the voice of community members might not have a chance to be heard before the Committee.

Solution: Community input, both from patients and their neighbors in the District, is vital in creating a program that works for everyone living in the District, and as such the public comment period should not be an optional decision for the Committee. We request that the District strike the word “may”, and replace it with “shall”.

2. The sliding-scale program may present the District an unintended legal issue, and does not have a clear means by which eligible patients would be identified.

6300.1 A registered dispensary shall devote two percent (2%) of its annual gross revenue to the Department program established to provide medical marijuana on a sliding scale to qualifying patients determined eligible pursuant to § 1300.4 of this sub-chapter.

6300.6 Not later than April 15th of each calendar year, the Department shall review the sliding scale program. As part of its review and subject to the limitation of the total amount collection:

(a) The Department may reimburse dispensaries to offset the discounts provided to eligible patients; and

(b) May adjust the percentage required to be devoted by dispensaries and the required discount to qualifying patients.

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Problem: The sliding-scale program is something that ASA strongly supports, however, we have great concerns about the wisdom of collecting money into a fund to offset enable the sliding-scale program. The combination of 6300.1 with 6300.6(a) may mean that the District would essentially be purchasing marijuana as far as federal law would be concerned. Additionally, even if there is no legal problem with reimbursing dispensaries for sliding-scale discounts, the District would be burdened with managing a fund of money that based upon the UCLA report's projected gross revenue in the first year of the program, the fund would generate no more than \$36,000.³

Solution: The provision calling for the collection of 2% of gross sales should be eliminated, as it would be much for efficient for dispensaries to offer direct discounts to patients without a middleman agency maintaining a fund to offset costs.

6300.4 A qualifying patient who establishes pursuant to § 1300.4 of this subchapter that his or her income is equal to or less than two hundred percent (200%) of the federal poverty level, shall be entitled to purchase medical marijuana directly, or through a caregiver, on a sliding scale from a registered dispensary in the District of Columbia.

Problem: Allowing patients with financial hardship to have discounted access to medicine is one of the strongest components of the District's medical marijuana program. However, this provision fails to say how patients would be recognized by the dispensary as being eligible. Dispensaries will need a simple means to recognize which patients are eligible for discounted medicine, and the means by which patients demonstrate eligibility should respect the dignity and privacy of patients.

Solution: The District should indicate a patient's sliding-scale eligibility by either denoting it on the patient's registration ID card, or by allowing a card that indicates that the patient is receiving public health assistance, such as a proof of receiving Social Security's Supplemental Security Income, Social Security Disability Insurance, or a SNAP card.

6300.5 A registered dispensary shall sell medical marijuana to a qualifying patient, who is registered to purchase medical marijuana on a sliding scale, at a discount of not less than twenty (20%) of its regular retail price.

3. RESTRICTIONS ON TRANSFERRING OWNERSHIP MAY HARM PATIENT'S ABILITY TO ACQUIRE AND MAINTAIN AN ADEQUATE SUPPLY OF MEDICINE

3

. Id. At 19 (noting that based on a GOA report, it is estimated that the District program will generate no more than \$1.8 million in gross sales in the first year)

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Advancing Legal Medical Marijuana Therapeutics and Research

Chapter 50, REGISTRATION, LICENSING, AND ENFORCEMENT OF CULTIVATION CENTERS AND DISPENSARIES, of Title 22-C, MEDICAL MARIJUANA, is amended as follows:

Problem: While it appears that this provision is written with the laudable intent of preventing operators from flipping their business for a quick profit, we believe that the unintended outcome of all of the changes proposed to this entire chapter may mean that patients end up with fewer operators providing them with medicine. If the punitive measures authorized by Chapter 50 are taken against operators, it would result in either a dispensary or cultivation site shutting down. Given that D.C. is currently operating well below its statutory limit for dispensaries and cultivation locations (coupled the 95-plant limit per cultivation location), the availability of medicine in the D.C. medical marijuana program will instantly face serious stress of basic market forces. Removing any of these businesses purely for an attempted transfer of business interest could be devastating to the availability and price of medicine. The removal of dispensary would be even more harmful, as any patient registered to purchase medicine from a dispensary that is shut down will have to wait weeks before switching their dispensary location, and the additional patients flooding the still-open dispensaries would harm the availability of medicine to those patients already registered at those dispensaries.

Moreover, the highly restrictive natures of these proposed changes would make it impossible for dispensary or cultivation site operators to transfer their business interests, and it does not appear that there are any mechanisms to deal with very practical realities that all business face. For example, if one members of a dispensary ownership team passes away, who would obtain that deceased person's interest in the business? The same question applies to situations where a dispensary ownership team may need to remove a member of their ownership team for good cause. In fact, the inability to transfer any individual business interested may mean that one problem officer could cause the entire business to fail if they are unable to remove that person.

Solution: The ability to transfer medical marijuana business interests in the District of Columbia is already tightly controlled by the existing regulations. We request the District maintain its present regulations in Chapter 50, and to strike all of the proposed changes to this chapter.

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