AmericansFor SafeAccess
Advancing Legal Medical Marijuana Therapeutics and Research

Written Testimony to the Council of the District of Columbia Committee on Health

Hearing Date: March 7, 2014
Written Testimony Submitted: March 11, 2014

Introduction and Background

Americans for Safe Access (ASA) would like to thank Committee Chair Yvette Alexander and the Committee on Health for this opportunity to comment on the District's Medical Marijuana Program (MMP).

ASA is the nation's largest membership-based medical marijuana advocacy organization. Along with other medical marijuana advocates, ASA worked to overturn the Barr Amendment, which allowed the District to move forward with Initiative-59 (1998). ASA was actively involved with organizing patients and lobbying during Council's work in 2010 on B18-06222 to amend Initiative-59. ASA held patient lobby days, organized press events, prepared patients to testify before the council, and turned out patients for hearings. Since that time, ASA has held monthly patient meetings and several town hall forums to promote the program. Additionally ASA hosted a CME program in Washington, D.C. in February 2013 for physicians, and continues to lobby and provide commentary on advancing medical marijuana therapy at the federal, state and local level.

The opening of dispensaries in June 2013 and the registering of 174 patients (as of March 7, 2014) on its face shows some level of success for the MMP; however, in spite of this milestone, at most only 1.2% of the nearly 15,000 people in the District live with HIV-positive status are not enrolled in the program more than three years into implementation.[1] While DOH officials deserve credit for getting the program up and running to some degree of functionality, the unfortunate reality is that the department has yet to meet several of its statutory and regulatory obligations.

DOH also deserves a measure of credit for addressing long-standing deficiencies in the program, such as finally creating a Spanish language application, shortening the application process, and seating the Advisory Committee's two subcommittees. However, these areas are the low-hanging fruit, DOH needs to: 1) include more patients by replacing the overly restrictive qualifying conditions list with one that empowers physicians to best treat individual patients; 2) promote the program to all District physicians and fulfill its physician education requirement; and 3) remove needless bureaucratic hurdles that actually harm patients before the program can be successful.

[1] HIV/AIDS Policy Fact Sheet, The Henry J. Kaiser Family Foundation, July 2012, available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8335.pdf (last accessed March 11, 2014).

Headquarters
1300 Clay Street, Suite 600, Oakland CA 94612
PHONE: 510.251.1856

National Office
1806 Vernon St. NW, Suite 100, Washington DC 20009
PHONE: 202.857.4272 **FAX:** 202.857.4273

General Information
WEB: www.AmericansForSafeAccess.org
TOLL FREE: 1.888.939.4367

Moreover, patients are concerned that there may be an anti-medical marijuana bias within the two subcommittees. During the Intergovernmental Subcommittee meeting, the subcommittee tasked with monitoring best practices of other jurisdictions, the subcommittee stated that they only had contact information for other state's programs, and had done little in the way of researching or inquiring about their best practices. Worse still, physicians on the Scientific Subcommittee directly stated their skepticism about medical marijuana. Moreover, DOH has not yet unveiled the time table for when the public petition process to add new conditions will begin. In fact, DOH, public notice and participation at Advisory Committee meetings has left patients and advocates feeling disrespected. Public comments at the Scientific Subcommittee meeting on February 27, 2014 were limited to a mere 30 minutes, which meant that several members of the public were not allowed to speak or only given 30 seconds of time. On top of that, notice for the rescheduled meeting on Feb. 27th was not publicly listed on the DOH MMP page until the day before the meeting, which gave patients the impression that their input was considered trivial to the subcommittee. These facts gave patients little hope that swift and sensible reform to the program via the Advisory Committee subcommittees or DOH action will take place absent decisive instruction from the Council.

It's possible that some of DOH's problems come from understaffing the program. According the November 5, 2010 fiscal impact statement from Chief Financial Officer Natwar M. Gandhi to Vincent Gray, the program was to have two full time employees processing applications, and that by the end of Fiscal Year 2013, we would have 1,800 patients, with an additional 900 expected to enroll by the end of FY2014.[2] While the present enrolment of only 174 patients is due in part to the program starting more than 2 years behind the scheduled estimates of the fiscal impact statement, the end of the first year was estimated to enroll 800 patients. When this report was issued in 2010, patient advocates said the number was a low estimate. Instead, the program is on track to have fewer than 250 patients by the one year anniversary of the first enrolled District patient in June 2013.

With this background in mind, ASA offers the following comments on how to improve the MMP to work best for District patients who have been recommended medical marijuana therapy from their physician.

1. Improve the District's Qualifying Conditions Language via a Physician-Controlled Model

The District's MMP is by far the most restrictive in the country when looking at it from an eligible qualifying conditions perspective. Among the 20 states that currently have implementable medical marijuana laws, there are a total of 50 qualifying conditions (see attached chart, "State Qualifying Condition Chart Feb 2014"). The District only permits for four of the 50 conditions recognized in other states (for purposes of the chart, HIV and AIDS are considered a single condition).

Many states facilitate comprehensive access to medical marijuana by allowing their physicians to recommend medical marijuana for common conditions that have numerous causes. For example, 17 states allow physicians to recommend cannabis to treat severe or chronic pain, which can be brought about by conditions ranging from Arthritis and Fibromyalgia to Shingles and nerve

[2] Fiscal Impact Statement – "Marijuana for Medical Treatment Regulation Approval Resolution of 2010," Government of the District of Columbia, Office of the Chief Financial Officer, Nov. 5, 2010, available at http://www.dcpatients.org/Fiscal_Impact_Statement_11_5_2010.pdf (last accessed March 11, 2014).

damage, just to name a few. According to the Institute of Medicine, 116 million Americans (about 30 percent of the population) were living with chronic pain in 2011. According to the American Academy of Pain Medicine, 51% of people with chronic pain do not have control over their pain. By extrapolation, approximately 175,000 people are suffering from chronic pain in D.C. and 89,000 who do not have control over their pain. This is a considerable number of people who might benefit from cannabis compared to the current enrollment of 174 patients. Each one of these patients deserves the best treatment possible which must depend on their physician's evaluation and professional medical opinion. Cannabis may or may not be their best treatment option, but that decision is best made by the patient's physician, not well-meaning lawmakers or regulators who do not know the particular needs of an individual patient.

Adding New Qualifying Conditions without the Advisory Committee

Neither B18-0622 nor Title 22-C of the DCMR require the Advisory Committee to be formed in advance of adding new qualifying conditions. Title 22-C requires the following conditions to be met in order to add a new qualifying condition:

> *Any other condition, as determined by rulemaking, that is:*
>
> *(1) Chronic or long lasting;*
> *(2) Debilitating or interferes with the basic functions of life; and*
> *(3) A serious medical condition for which the use of medical marijuana is beneficial:*
> > *(A) That cannot be effectively treated by any ordinary medical or surgical measure; or*
> > *(B) For which there is scientific evidence that the use of medical marijuana is likely to be significantly less addictive than the ordinary medical treatment for that condition.*

This definition does not require the long and tedious public petition process must take place in order to add new qualifying conditions. In spite of the District having one of the strictest rules for adding new qualifying conditions, nearly any new qualifying condition can meet this 3-part requirement. According to Chapter 14 of Title 22-C, the Advisory Committee merely makes a recommendation to the Director of DOH on the addition of new conditions. A close reading of the statute and regulations leads ones to the conclusion that there is nothing that prevent the Director of DOH from adding new conditions prior to the formation or recommendation of the Advisory Committee.

The Best Solution: Physician-Controlled Qualifying Conditions Language

A solution that would remedy the need the for the Scientific Subcommittee to issue recommendations on new conditions would be for the Council to pass a bill that amends the qualifying conditions language in D.C. law to permit physicians to be in charge of which conditions can be legally treated with medical marijuana therapy. In fact, several members of the Scientific Subcommittee said this approach makes sense, and even Director of Health Dr. Joxel

Garcia said during the questioning of executive witnesses at the March 7, 2014 DOH oversight hearing that this was the preferred model. Such an approach allows any patient who could receive benefit from medical marijuana therapy to do so under the recommendation of their physician rather than being prohibited by an unnecessary bureaucratic hurdle that has already taken more than three years without yet being established. ASA recommends the following language from Massachusetts Department of Public Health, whose language was welcomed by the Massachusetts Medical Society.[3]

> *Debilitating Medical Condition means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, and multiple sclerosis (MS), when such diseases are debilitating, and other debilitating conditions as determined in writing by a qualifying patient's certifying physician.*[4]

2. Education program for doctors

One of the biggest problems facing patients right now in the inability to find a physician willing to write a recommendation for any of the current qualifying conditions. The reasons for this are not fully known, but one likely reason is that physicians and medical institutions in the District are either unaware or unfamiliar with the medical marijuana science or the MMP itself. As a result, District patients currently living with HIV, AIDS, cancer, glaucoma or severe muscle spasms are being denied the benefit of the program. With only 59 patients in the program as of October 21, 2013, no more than 0.4% (or 1 in 250) of the approximately 15,000 people living with HIV in the District are enrolled in the program.

Thankfully, the MMP regulations contain a provision that ought to address this issue, but DOH has yet to fulfill this regulatory requirement. Title 22-C of the DCMR contains the following rule requiring physician training to be provided by DOH.

> *805 TRAINING PROGRAM FOR RECOMMENDING PHYSICIANS*
> *805.1 The Department shall make available an educational program for physicians on the medical indications, uses, and side effects of medical marijuana and the District's medical marijuana program, and may charge a fee for the training program.*
>
> *805.2 The program shall be made available to physicians licensed to practice medicine or osteopathy in the District of Columbia who recommend or intend to recommend the use of medical marijuana to qualifying patients.*

---

[3] Massachusetts Medical Society Statement Regarding Approval of Regulations for Medical Marijuana by the Public Health Council, Richard Aghababian, M.D., President, Massachusetts Medical Society, May 8, 2013 available at http://www.massmed.org/News-and-Publications/MMS-News-Releases/Massachusetts-Medical-Society-Statement--Regarding-Approval-of-Regulations-for-Medical-Marijuana-by-the-Public-Health-Council/#.UngK5fnkvKd (last accessed Nov. 4, 2013).

[4] 105 CMR 725.004, "Debilitating Medical Condition."

> *805.3 If approved by the District of Columbia Board of Medicine, the program may be used to satisfy continuing education requirements for the practice of medicine for the number of credits approved by the board.*

According to DOH officials, the Department has met this obligation by notifying some D.C. physicians of a one-time CME training that ASA was provided for physicians in February 2013, as well as announcing the program at a meeting of the D.C. Board of Medicine.[5] ASA appreciates these efforts; however, by themselves they are not sufficient to meet the obligation created by the aforementioned rule.

Worse still, the physician FAQ available on DOH's MMP page has not been revised since April, 2012![6] How are physicians supposed to know how the program currently functions if the FAQ available to them does not contain information on how to participate in the program?

District patients and physicians would be well-served to have DOH develop the education program called for in Chapter 14 of Title 22-C. ASA recommends that DOH look to the CME created by the Massachusetts Medical Society as a basis for its own program.[7]

3. Bureaucratic Hurdles that Harm Patients

Physician Recommendation Form Procedure is a De Facto Physician Registry

The process by which doctors obtain recommendation forms is essentially a de facto physician registry. Instead of being able to download a form from the Internet, a District physician must fill out a form which contains a warning that may dissuade physicians from participating in the program that reads:

> *The United States Congress has determined that marijuana is a controlled substance and has placed marijuana in Schedule I of the Controlled Substance Act. Growing, distributing, and possessing marijuana in any capacity, other than as a part of a federally authorized research program, is a violation of federal laws. The District of Columbia's law authorizing the District's medical marijuana program will not excuse any person from any violation of the federal laws governing marijuana or authorize any registrant to violate federal laws.*

The only state with an official physician registry is New Jersey, which arguably has the least function medical marijuana program in the country along with the District. It has resulted in very few doctors willing to write recommendations, thereby negatively impacting patients. The

---

[5] While the D.C. Council has no statutory obligation to promote the program to physicians, it is noteworthy the Committee on Health Chairperson Alexander also encouraged the Board of Health to promote the MMP to physicians.

[6] "Medical Marijuana Program, Physician Frequently Asked Questions," available at http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/120430FAQPhysicians%20Final.pdf (last accessed March 11, 2014).

[7] Medical Marijuana CME, Massachusetts Medical Society, available at http://www.massmed.org/Continuing-Education-and-Events/Online-CME/Medical-Marijuana-CME/#.Unf-FPnkvKc (last accessed March 11, 2014).

District's combination of unnecessary paperwork that imposes fear-inducing warning has resulted in a similar chilling effect.

We urge the Department to remove this unnecessary barrier and allow physicians to download the actual recommendation forms and print them on tamper-resistant paper, as is common practice in many successful state medical marijuana programs.

Restrictions on Where Patients May Purchase Medicine

At present District patients are restricted on where they may purchases their medical marijuana. The current rules under Title 22-C of the DCMR requires that D.C. patient declare which dispensary they wish to purchase their medicine.

> *200.7 As part of the registration process, a qualifying patient shall designate the dispensary from which he or she will receive medical marijuana, and this designation shall appear on the qualifying patient's registration card and, if applicable, the caregiver's registration card.*
>
> *200.9 Within fourteen (14) calendar days of any change in the qualifying patient's name, address, caregiver, recommending physician, or designated dispensary, a qualifying patient who has been issued a registration identification card shall:*
>
> *(a) Submit a completed patient change of information form to the Department, and include as applicable:*
> *(1) Designation of a new dispensary;...*
> *...(d) Pay the required fee to receive a new registration identification card;*
>
> * * *
>
> *1300.1 The registration, renewal and replacement fees are as follows:*
>
> *(a) Initial registration fee for a qualifying patient $100.00;*
> *(b) Initial registration fee for a caregiver $100.00;*
> *(c) Renewal fee for a qualifying patient $100.00;*
> *(d) Renewal fee for a caregiver $100.00; and*
> *(e) Replacement card fee $90.00*

By requiring patients to designate a single dispensary location from where they can purchase medicine, patients will be placed at risk of hardships or barriers to treatment. Medically, patients may not be able to find the particular strain that works best for them at their dispensary on a regular basis. Moreover, some dispensaries are likely to have better selections of non-flower forms of medical marijuana than other dispensaries, but patients will have little ability to know what their other options are if they stuck with a single dispensary where they can shop. Financially, due to the artificially restricted market, patients are at risk of high prices due to the lack of market competition. The restriction also would be a major problem to patients registered to a dispensary that is forced to go out of business due to non-transferability of ownership, as they would have to wait - and pay - for DOH to issue them new registration identification cards.

ASA recommends that DOH strike all provisions pertaining to requiring patients to register with a single dispensary. If this provision must remain in place, DOH should take efforts to make sure that patients are approved and have the ability to shop at a newly designated dispensary on the same day as a transfer is request. The Department of Motor Vehicles is able to issue update driver licenses on the same day as information is updated to the the DMV, and the MMP should offer the same level of service. Additionally, if the single-dispensary requirement must remain in place, patients should not have to pay a fee for transferring their dispensary of choice.

Transferability Restrictions for Owners are Harmful to Patients, Could Cause Medicine Shortages

While it appears that Chapter 50 of Title 22-C of the DCMR 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.

The ability to transfer medical marijuana business interests in the District of Columbia is already tightly controlled by the existing regulations. We request that DOH revert to the previous rules on transferability prior to the rules issued on July 12, 2013 in Chapter 50, and to strike all of the changes to Chapter that were published on that date.

4. Areas for Additional Legislative Reform

The following are areas of the program that fall outside of DOH's ability to take action, and would require legislative action on the part of the Council. If the Council is going to address DOH's handling of the MMP through corrective legislation, we believe the following areas outside of DOH's direct purview should also be included with any legistive revision.

Adding Civil Discrimination Protections for Patients

At present, the District's MMP lacks explicit protections for several issues facing patients, including housing, education, employment, and organ transplants. Several states have included these protections without complications arising from federal funds received by landlords, educators, employers, or hospitals. Therefore, the D.C. Council should considering legislation to include these protections so that medical marijuana patients do not suffer discrimination simply for making use of the therapy recommended to them by their physicians. Additionally, parents who are medical marijuana patients should not be at increased risk for losing their children in custody proceedings merely for their patient status. Instead, medical marijuana patient-parents should be protected unless their conduct constitutes a clear and articulable danger to the welfare of the child.

ASA recommends that the D.C. Council consider the following discrimination protection language in the Delaware medical marijuana statute.

> ***§ 4905A. Discrimination prohibited.***
> *(a)(1) No school or landlord may refuse to enroll or lease to, or otherwise penalize, a person solely for his or her status as a registered qualifying patient or a registered designated caregiver, unless failing to do so would cause the school or landlord to lose a monetary or licensing-related benefit under federal law or regulations.*
> *(2) For the purposes of medical care, including organ transplants, a registered qualifying patient's authorized use of marijuana in accordance with this chapter shall be considered the equivalent of the authorized use of any other medication used at the direction of a physician, and shall not constitute the use of an illicit substance or otherwise disqualify a qualifying patient from needed medical care.*
> *(3) Unless a failure to do so would cause the employer to lose a monetary or licensing-related benefit under federal law or federal regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, if the discrimination is based upon either of the following:*
> *a. The person's status as a cardholder; or*
> *b. A registered qualifying patient's positive drug test for marijuana components or metabolites, unless the patient used, possessed, or was impaired by marijuana on the premises of the place of employment or during the hours of employment.*
> *(b) A person otherwise entitled to custody of or visitation or parenting time with a minor shall not be denied such a right, and there shall be no presumption of neglect or child endangerment, for conduct allowed under this chapter, unless the person's actions in relation to marijuana were such that they created an unreasonable danger to the safety of the minor as established by clear and convincing evidence.*
> *(c) No school, landlord, or employer may be penalized or denied any benefit under state law for enrolling, leasing to, or employing a cardholder.*[8]

[8] Del. Code 16 § 4905A (2013).

Sales Tax

Unlike sales of other medicines, pharmaceutical, or drugs in the District of Columbia, retail sales of medical marijuana subjugate D.C. patients to burdensome sales tax. Medical marijuana is often an expensive treatment option, and due to factors such as the limited ability to cultivate medicine and few patients being registered by DOH, retail prices for medical marijuana in the District at very close the street price for illicit marijuana. Moreover, with the physical ability to cultivate their own medicine and the caregivers of other patients do not have a legal right to cultivate medicine for themselves at the present time. While it is true that the District did include a provision to establish sliding scale prices for patients with great financial hardship, the cost of medicine remains burdensome to all but the most affluent of patients. In fact, insurance companies are not obligated, nor are they willing to reimburse qualifying patients for their medical marijuana expenses.

Because medical marijuana patients face financial burdens that those with other treatment options available are not subject to, DOH should consider adopting the following rule. If DOH is unable to promulgate a sales tax exemption, we would request that the Council consider the following for legislation.

> *Retail sales of medical marijuana shall qualify for the sales tax exemption afforded to "medicines, pharmaceuticals, and drugs" under Rule 9-449 of the DCMR.*

Increasing the Plant Limit at Cultivation Sites

D.C. presently has some of the most restrictive language on how many plants a cultivation center may grow at any given time. Councilmember Grosso has introduced B20-0678, the Medical Marijuana Plant Cultivation Amendment Act of 2014, which would wisely increase the plant limit from 95 to 500. We think this is a sensible improvement; however, we think that market forces are the best determinant for the number of plants that should be grown. Therefore, we believe that statutory caps on the number plants that can be grown should be removed.

Headquarters
1300 Clay Street, Suite 600, Oakland CA 94612
PHONE: 510.251.1856

National Office
1806 Vernon St. NW, Suite 100, Washington DC 20009
PHONE: 202.857.4272 **FAX:** 202.857.4273

General Information
WEB: www.AmericansForSafeAccess.org
TOLL FREE: 1.888.939.4367

Americans for Safe Access - State Qualifying Condition Chart Feb 2014

CONDITIONS	AK	AZ	CA	CO	CT	DC	DE	HI	IL	MA	ME	MI	MT	NH	NJ	NM	NV	OR	RI	VT	WA
Source: State Laws and Regulations, available at http://www.safeaccessnow.org/state_and_federal_law			*							*			X				X				
Admittance into hospice care		X	*				X		X	X		X		X	X	X					
ALS (Lou Gehrig's disease)		X	*				X		X	*		X		X					X		
Alzheimer's disease (including agitation of)			*						X	*											
Arnold-Chiari malformation and Syringomyelia			X							*						X					
Anorexia			X						X	*											
Arthritis	X	X	X	X	X		X		X	*			X	X			X	X	X	X	X
Cachexia or wasting syndrome or nausea	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Cancer			*						X	*											
Causalgia			*						X	*											
Chronic Inflammatory Demyelinating			*							*				X							
Chronic pancreatitis		X	*					X	X	X		X		X	X	X					
Crohn's Disease			*		X				X	*							X				
Damage to the nervous tissue of the spinal cord with intractable spasticity			*						X	*											
CRPS (Complex Regional Pain Syndromes Type II)			*				X			*											
Decompensated cirrhosis			*						X	*											
Dystonia			*						X	*											
Fibrous dysplasia	X	X	X	X	X	X		X	X	X	X	X	X	X	X		X	X	X		X
Glaucoma		X	*						X	X	X	X		X		X			X		
Hepatitis C	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HIV/AIDS			*						X	*											
Hydrocephalus			*						X	*											
Hydromyelia			*						X	*											
Interstitial Cystitis			*						X	*											
Lupus			X							*											
Migrane	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X
Multiple Sclerosis and Severe Muscle Spasms			*						X	*				X	X						
Muscular dystrophy			*						X	*	X										
Nail-patella syndrome			*						X	*											
Neurofibromatosis			*							*				X							
One or more injuries that significantly interferes with daily activities as documented by the patient's provid			X							*											
Other conditions as determined in writing by a qualifying patient's physician			*							*			X			X					
Painful peripheral neuropathy			*		X				X	X											
Parkinson's disease	X		X		X					*	X		X		X		X		X	X	X
Persistent muscle spasms, including spasms associated with Multiple Sclerosis			*						X	*											
Polyneuropathy			*		X		X			*	X					X		X			
Post-Traumatic Stress Disorder			*						X	*											
Reflex Sympathetic Dystrophy			*						X	*											
Residual limb pain			*						X	*											
RSD (Complex Regional Pain Syndromes Type I)	X	X	X	X	X		X	X		*		X	X	X	X		X	X		X	X
Seizures including those that are characteristic of epilepsy	X	X	*	X			X	X		*	X	X	X	X	X	X		X	X	X	X
Severe and/or chronic pain		X	X	X			X	X		*	X	X	X		X	X	X	X			
Severe nausea			*						X	*											
Sjogren's syndrome			*						X	*				X							
Spinal cord disease or injury, including but not limited to arachnoiditis			*						X	*											
Spinocerebellar Ataxia (SCA)			*						X	*											
Syringomyelia			*						X	*											
Tarlov cysts			*							*					X						
Terminal illness w/less than 12 months of life			*						X	*											
Tourette's			*						X	*				X							
Traumatic brain injury and post-concussion syndrome																					

**** California and Massachusetts authorize physicians to determine qualifying conditions in addition to the conditions explicitly stated in each state's law.***