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TESTIMONY ON DEPARTMENT OF BUSINESS REGULATION AND DEPARTMENT OF HEALTH REGULATIONS RELATED TO THE MEDICAL MARIJUANA PROGRAM
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The ACLU of Rhode Island appreciates the opportunity to testify on these proposed regulations in light of our organization's strong and long-standing interest in the state's medical marijuana program. Since the two documents that are the subject of this hearing are 99 pages long and, to our knowledge, were not necessarily drafted with input from the affected patient community, we trust that your Departments will review our comments below, and those offered by others, carefully and thoroughly. This APA public hearing process is designed to encourage such feedback, so we look forward to substantive revisions being made in response to this input.

As presently drafted, however, we fear some provisions of these rules would add substantial and unnecessary barriers to the continued success of the medical marijuana program. Without minimizing our other comments, as explicated below, we are particularly concerned about new requirements impinging on the practitioner-patient relationship (§§2.3 and 2.5 of the proposed DOH rules); the lack of adequate regulatory protections for patients seeking employment (§6.0 of the proposed DOH rules); unduly broad access to compassion center video recordings (§1.4(G) of the proposed DBR rules); a failure of the rules to pre-empt municipal attempts to undermine the statute's cultivator license provisions (§1.5(E) of the proposed DBR rules); and a totally arbitrary penalty process for plant tag violations (§1.7(B) of the proposed DBR rules). Our detailed comments on these and other provisions follow:

I. DEPARTMENT OF HEALTH REGULATIONS

1. Section §1.22 [Page 3] The proposed regulation defines "primary caregiver" to apply only to residents of Rhode Island. This is not a limitation contained in the statute, and we do not think it should be included in these regulations. Rhode Island is simply too small a state to impose such a restriction, as it needlessly limits the pool and availability of caregivers to patients who require one, particularly those who live near the Massachusetts and Connecticut borders.

2. Section §2.3 [Page 4]. An important revision to these regulations is that in requiring practitioners to provide a written certification specifying the qualifying patient's debilitating medical condition, the certification must include "a copy of the relevant patient medical records as specified in §1.31" of the regulations. In principle, we do not take issue with the requirement since the statute envisions a release of records for this purpose. However, the Department's implementation of the requirement raises a host of questions, none of which appear to be adequately answered by these regulations.

a. To start with, although §2.3 references providing "relevant" medical records "as specified in §1.31," the language of §1.31 – which is taken directly from the statute – provides no guidance as to exactly what the "relevant" records are.

As worded, §2.3 appears to require only those records "documenting" the medical condition, but that lends itself to more questions. Does sharing only the record containing the practitioner's confirmatory diagnosis satisfy this requirement, or must all of the supporting medical documentation for that conclusion (e.g., X-rays, MRIs, consultation reports, etc.) be submitted as well? Does it include records going back years if the patient's qualifying condition dates from long ago? The lack of specificity is troubling, but to the extent the DOH makes the record-giving requirement onerous, it could also discourage some practitioners from certifying

patients for the program in the first place, thus undermining a key component of the medical marijuana statute's goal: promoting patient access to the program.

b. In addition, the proposed regulations fail to provide other types of guidance on how this statutory mandate will be implemented. For example, which medical professionals at DOH will be responsible for examining these records and determining whether they do, in fact, document a condition that qualifies the person for participation in the program? How does a patient challenge a contrary determination made by DOH? What limits, if any, will be placed on that professional in requesting additional medical records from a practitioner? How will this new process ensure that the review will comport with the statutory time requirements for issuing a permit? How long will these medical records be kept by the DOH before they are destroyed?

These are important questions that need to be answered before the Department begins receiving sensitive medical records of participating patients. Along with practitioners and the public, patients (some of whom may have been participating in the program for a decade without needing to turn over sensitive medical records to the state), have a right to know how this new process will work. Those are precisely the sorts of issues that implementing regulations should be addressing and not leaving open to uncertainty.

3. Section §2.5(d) [Page 4] requires the practitioner to "document after examination, the patient's response to conventional medical therapies and explain the risks and benefits of the use of marijuana to the qualifying patient." This sentence is somewhat ambiguous and potentially misleading. It could be read to imply that medical marijuana should only be used as a last resort, and that practitioners must require their patients to try other treatments first in order to be able to examine their response to them. However, the medical marijuana statute clearly does not require first use of other treatments. Some patients decline "conventional" treatments due to the risks

and side effects, and none of them should have to suffer adverse side effects, or wait weeks or months engaged in other treatments, in order to qualify for the medical marijuana program. Since we assume that was not intended, we urge that this sentence be clarified.

4. Section §2.5(e) [Page 4] provides that the "practitioner must be committed to the continual assessment of the patient and the patient's response to the use of marijuana. This must be demonstrated through follow-up appointments, semi-annually at minimum, before the card is renewed." A semi-annual minimum follow-up requirement is not contained in the statute, and for good reason. It is not only unnecessary for many patients, but it puts a significant financial burden on them. This mandate is particularly difficult for those with mobility issues. While it might make sense for practitioners to require a follow-up appointment for those patients who are new to the program, it is unduly burdensome for patients who are established in the program. We urge that this requirement be removed, or else be limited to the first follow-up visit or, alternatively, to only those conditions that could reasonably be deemed temporary in nature.

The net effect of §§2.3 and 2.5 is to make it more difficult for patients and practitioners to participate in the medical marijuana program. This would be a troubling outcome in and of itself, but it is doubly so in light of some evidence suggesting that access to medical marijuana has a positive effect on reducing deaths from opioid overdoses.

We therefore urge, in accordance with our suggestions, that the statutory "medical records" requirement be implemented in a responsible and transparent manner that does not undermine the medical marijuana statute or intimidate existing and new qualifying patients and their practitioners from applying for or renewing their participation in this important program.

5. Section §7.1 [Page 12] states that patient applications and supporting information "are confidential" and protected under HIPAA. We would urge that this language be strengthened to

note that the medical marijuana statute itself and separate state laws provide independent confidentiality protections for this information beyond HIPAA.

6. Finally, ambiguities in the current medical marijuana law have led the ACLU to file two lawsuits over the statute's meaning. We urge the Department to formally resolve those ambiguities through these regulations.

a. Section §6.0 [Page 11] addresses medical marijuana use protections for patients, caregivers and medical professionals. Not included in the list is the statutory ban on employers refusing to employ an individual "solely for his or her status as a cardholder." R.I.G.L. 21-28.6-4(c). We urge that this provision be included and also clarified as explained below.

In the past few years, the ACLU has received a number of complaints from participants in the medical marijuana program who have had to take a drug test for a job. Not surprisingly, the test turns up positive for marijuana, and these employers have (initially) refused to hire the applicant based on the test results, notwithstanding the state law's protection. They have disingenuously claimed that they were not denying the applicant employment because of his "cardholder status," but rather because he failed a drug test. We have been mostly successful in persuading employers that such an interpretation of the law is improper, but we were recently forced to sue one employer who stuck to that strained interpretation of the statute. The Superior Court has denied a motion to dismiss the case, and the lawsuit remains pending.

In order to avoid any further disputes over the current language's clear attempt to protect medical marijuana patients from discrimination, we urge the Department to add clarifying language to address this issue. Possible language could be as follows:

"An employer may not refuse to hire, discharge, or otherwise discriminate against a person with respect to any terms, conditions or privileges of employment, or any other matter directly or indirectly related to employment because of their status as a cardholder, including because of a positive drug test for marijuana components or metabolites, unless the patient cardholder possessed or was impaired on the premises of the place of employment or during the hours of employment."

b. When the state's medical marijuana law was enacted ten years ago, the Department of Health acknowledged that registered nurse practitioners (RNPs) and practitioner assistants (PAs) could, like physicians themselves, certify that a patient had a debilitating medical condition that qualified him or her for participation in the medical marijuana program. They were able to make such certifications for patients with whom they had a bona fide practitioner-patient relationship and had completed a full assessment of their medical history. This is directly in keeping with the "global signature" law that the General Assembly had enacted in 2006. R.I. Gen. Laws §5-34-42. Unfortunately, in 2012, DOH summarily reversed course and directed that only certifications signed by practitioners would be accepted. The ACLU filed a lawsuit to challenge this action, and the matter ended up getting resolved informally without a court ruling.

In order to avoid any possible confusion or disputes in the future, we urge that the definition of practitioner be amended to make clear that, under the global signature law, PAs and RNPs, in line with their powers to prescribe medicine, similarly retain the authority to issue medical marijuana certifications.

II. DEPARTMENT OF BUSINESS REGULATION REGULATIONS

1. Section §1.3(A)(6) [Page 10] bars volunteers at compassion centers from being involved in any way "in the growth, cultivation, weighing, packaging or labeling, manufacturing, processing, dispensing or sale of medical marijuana." While we appreciate the intent behind this prohibition, the statute itself does not appear to make any distinction between employees and volunteers in terms of responsibilities, and at the very least, clearly envisions volunteers being able to *dispense* marijuana. See R.I.G.L. §21-28-6.12(g)(2). This section should be amended to authorize compassion center volunteers to, at a minimum, dispense medicine.

2. Section §1.4(G)(4)(g) [Page 17] requires all compassion center video surveillance recordings to be made available to DBR upon request, and states that the recordings will be confidential "except for authorized release in accordance with applicable law." In light of the important confidentiality issues raised by these recordings, we request two amendments. First, in order to avoid fishing expeditions, DBR should at least be required to document the basis for making such requests. Second, we would urge the language be changed to say "except for release when *required* by applicable law." There is a significant difference between sharing this confidential information when the agency *can* and when it *must*. We believe it should be limited to the latter.

3. Section §1.4 (J)(5)(a) [Page 27] requires patients to be provided a fact sheet explaining "limitations on the right to use medical marijuana." We believe the fact sheet should include information advising patients of their rights under the law to be protected from discrimination as well.

4. Section §1.5(E)(3)(b) [Page 35]. The medical marijuana statute gives DBR regulatory powers regarding "where cultivators are allowed to grow," while also requiring cultivators to abide by all "local ordinances, including zoning ordinances." R.I.G.L. §28-21.6-16(i). While this clearly envisions complementary authority between the state and municipalities in regulating cultivator licenses, some municipalities have begun considering the use of zoning ordinances to effectively *ban* such licenses in their communities. These efforts directly undermine, and effectively nullify, the statutory language explicitly providing for cultivator relationships and for DBR authority over growing locations. We therefore urge that this section of the regulations be amended to specify, pursuant to DBR's authority, that local ordinances cannot be adopted that

have the effect of banning cultivation. We believe similar language should also be added to Section §1.8(F)(7)(b) [Page 64].

5. Section §1.7(B)(10) [Page 45]. The statute establishes a minimum $25 fine per plant for any person found to have marijuana plants without a required identifier tag. In exercising the discretion given it by the statute to set a maximum fine, DBR proposes to allow the fine to range anywhere from $25 to $5,000 per plant. While the ACLU generally supports the notion of discretion when it comes to imposing penalties, the discretion must, as a matter of due process and basic fairness, be reasonable. This provision is anything but. One person should not have to arbitrarily face a penalty that is 200 times harsher than that imposed on another person for the very same violation of the law. We urge an amendment to this provision to impose a maximum penalty of $100 per plant or some similar and more reasonable figure than what is proposed.

6. Section §1.9(M) [Page 77]. In accordance with the statute, this section authorizes DBR to revoke plant tags for a variety of reasons. A tag holder is then given ten business days to destroy marijuana plants that are in violation of the law. However, the regulations provide no standards for appealing a DBR revocation decision or, more importantly, for staying the required destruction requirement pending an appeal. These issues should be addressed in this section of the regulations.

7. Section §1.9(O)(4) [Page 78]. This section gives law enforcement access to the state tracking system or "other data sharing mechanisms" when the tracking system is not available, "in accordance with applicable law." It is unclear to us what the "applicable law" is that authorizes access to other unnamed data sharing mechanisms. This section further fails to contain any restrictions regarding the confidentiality of data so obtained, as appears elsewhere in the regulations. We urge that this section be amended to address these concerns.

We appreciate your agencies' consideration of these comments and hope they will be taken into account in further considering and revising these regulations. If our suggestions are not adopted, we request that, pursuant to R.I.G.L. §42-35-2.6(1), you provide us with a statement of your reasons for not accepting the arguments we have made. Thank you for considering our views.

Submitted by: Steven Brown, Executive Director
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