SENATE MEMORIAL 105 TASK FORCE RECOMMENDATIONS

October 2018

Recommendations to Improve Affordability of and Accessibility to Medical Cannabis for All New Mexicans

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Senate Memorial 105 Task Force Recommendations

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Introduction

Access to medical cannabis is not equal for all New Mexicans. People who live in rural areas, those who live in any of New Mexico's Indian Pueblos, Nations and Tribes, as well people who live in federal housing, or receive primary care from federally funded programs, like Indian Health Service, the Veteran's Administration, federally qualified health care centers, etc., do not have an equal ability to access medical cannabis. People who are cash-poor are less able to access medical cannabis as a result of there being no ability to have the cost of medicine covered by the state or other 3rd party. These circumstances and other barriers prevent many New Mexicans who could benefit from medical cannabis from being able to access their rights under the 2007 Lynn and Erin Compassionate Use Act, New Mexico's medical cannabis law.

"Picuris Pueblo wants to find ways for members of the tribe, family members and others who live in Picuris to be able to access the state medical cannabis program. People who live in Picuris and in all of New Mexico's tribes are also New Mexicans. **All New Mexicans should have equal access to medical cannabis to alleviate pain and suffering caused by their debilitating medical conditions."**

Governor Craig Quanchello, Picuris Pueblo

Taos County

To address these inequities, the 2018 NM Legislature passed Senate Memorial 105 (SM 105), sponsored by Senator Gerald Ortiz y Pino (Bernalillo). SM 105 called for the Drug Policy Alliance (DPA) to convene a group to make recommendations to improve the medical cannabis program for New Mexicans addressing issues of affordability and accessibility. SM 105 also called for recommendations specific to the state entering into intergovernmental agreements with New Mexico Indian Nations, Pueblos, and Tribes to become medical cannabis producers.

In the spring of 2018 DPA began work to organize a task force and sought members from across the state to participate. Groups named in SM 105 were notified by email or USPS about the task force. These included the NM Department of Health, leaders of NM pueblos, nations and tribes, medical cannabis patients, and licensed medical cannabis producers. In addition to offices named in the memorial, the Department of Indian Affairs, Department of Veterans Services and the Office of African American Affairs were also notified about the task force and invited to participate.

In order to find interested medical cannabis stakeholders, DPA created an online survey that was shared via social media in April, 2018. Seventy people completed the survey and were considered for the task force. A ranking system was used to prioritize broad geographic representation, patient representation, balance racial / ethnic, gender and age diversity, and to include people with a range of related experience and expertise in law, medicine, hospice care, and disability rights. Twenty-five (25) stakeholders were selected and agreed to participate. The composition of the group included 14 medical cannabis patients, seven rural residents, eight

personal production license holders, three military veterans and three licensed medical cannabis business representatives. The full group met four times between June and September 2018. The Steering Committee comprised of DPA, the NM Office of the Attorney General, a representative from the Pueblo of Picuris, a clinician, and a patient advocate met weekly during to guide the process.

The recommendations included herein set forth a road map to improve New Mexico's medical cannabis program. If enacted these recommendations will result in increased participation in the medical cannabis program, and improved ability for New Mexicans to afford and access medical cannabis, regardless of their income or place of residence.

NOTE: The complex topic of intergovernmental agreements related to transportation of federally controlled substances between tribal and state jurisdictions is much larger than the issue of medical cannabis and deserves further exploration with legal experts and tribes. Though the task force did not make recommendations about *intergovernmental* agreements, there are recommendations to support improving access for individuals who are member of NM Indian Nations, Pueblos and Tribes, or who live on tribal land. There is also a recommendation specific to supporting tribes that are interested in establishing medical cannabis programs within their own boundaries and to support tribes that apply to become licensed medical cannabis producers that operate on state controlled land (not tribal land) for the state's medical cannabis program.

History of Medical Cannabis in New Mexico

New Mexico first established limited access to cannabis in 1978, when then Governor Jerry Apodaca signed the Controlled Substances Therapeutic Research Act. The law established the Lynn Pierson Therapeutic Research Program, which supported the use of medical cannabis for cancer patients undergoing chemotherapy or who suffered from Glaucoma until 1986 when state funding for the program was cut.[1]

In 2007 New Mexico made history when then Governor Richardson signed SB 523, The Lynn and Erin Compassionate Use Act. New Mexico became the first state to pass a medical cannabis law through the legislature. As the same time New Mexico became the first state to regulate the licensing and production of cannabis at the state level.

The Department of Health (DOH) established the patient registry and began issuing patient cards and personal cultivation licenses shortly after passage of the legislation. The patient population has grown every month since DOH began certifying patients. More than 58,000 medical cannabis patients are currently enrolled in the program and the department receives hundreds of applications for new and renewing patients every week.[2]

In 2009 DOH promulgated rules and began licensing medical cannabis producers. Program rules were updated in 2011 and in 2015. Today DOH licenses medical cannabis producers that grow and sell medical cannabis to patients, or wholesale to other producers. The department also licenses medical cannabis product manufacturers, delivery services, testing laboratories, and issues personal production licenses to individual patients.

The Department has only opened the application process for new medical cannabis producers three times, and only once in the last eight years. There are just 35 producers licensed to grow and sell cannabis in New Mexico, and the vast majority are located in the Bernalillo and Santa Fe counties. While the Department has authorized 80 dispensaries, many counties still have only one or two dispensaries. [3]

Funding to administer the medical cannabis program (MCP) is entirely generated through licensure fees paid by producers, manufacturers, and laboratories. Annual fees are deposited into the medical cannabis fund to support the administration of the medical cannabis program; unspent funds revert to the general fund[4]. This year the MCP generated more than $3 million dollars in annual fees. [5] Annual fees range from $35 for an individual Personal Production License, to $1,000 for Product Manufacturers, $2,200 for Testing Laboratories, and range from

[1] NMSA 26.2A.4
[2] Medical Cannabis Program presentation by Kenny Vigil to the SM 105 Task Force, 7/27/2018
[3] Ibid Vigil, Kenny - Medical Cannabis Program presentation
[4] NMSA 9-7-17.1 establishes the Medical Cannabis Fund in the NM treasury, created by passage of SB 240 (McSorley), 2012
[5] NM DOH Producer Re-licensure List 2018/2019 accessed online 7/1/2018

$30,000 and $90,000 for a Production License depending on the number of plants the producer intends to grow, from 150-450. In addition to the MCP administration being fully self-funded through licensing fees, medical cannabis sales generated more than $5 million dollars in gross receipts taxes in 2017. [6] In 2018 there are 35 licensed producers, 14 approved 3rd party manufacturers, three approved testing laboratories, and one approved courier.[7]

The program is budgeted for 28 full time staff who work in two separate divisions. The Patient Registry division, which processes all the new patient applications and renewals, has 19 staffed positions. A separate License and Compliance division was established in 2015 to oversee all medical cannabis business licensing and regulatory monitoring. This unit has eight staff including three compliance officers, an environmental scientist, a state investigator and a health and safety specialist. Both divisions are overseen by the Medical Cannabis Program Director, Kenny Vigil. [8]

Guiding Principles for the 2018 Medical Cannabis Task Force

The Steering Committee created value statements to direct the development of recommendations:

- Recommendations must be directly relate to medical cannabis affordability and/ or accessibility.
- Recommendations must be patient-centered and compassionate.
- Recommendations must aim to create equal access to medical cannabis regardless of income or place of residence.
- Recommendations must protect and/or enhance the rights of medical cannabis patients.

[6] Annual gross receipts tax (GRT) paid were estimate based on self-reported financial data from 2017 and 2018, including GRT that was submitted to DOH and provided by Medical Cannabis Program Licensing and Compliance division.
[7] Ibid Vigil, Kenny – Medical Cannabis Program presentation 7/27/18
[8] Ibid Vigil, Kenny – Medical Cannabis Program presentation 7/27/18

List of Medical Qualifying Conditions

58,782 Medical Cannabis Patients are currently enrolled in the program.[9]

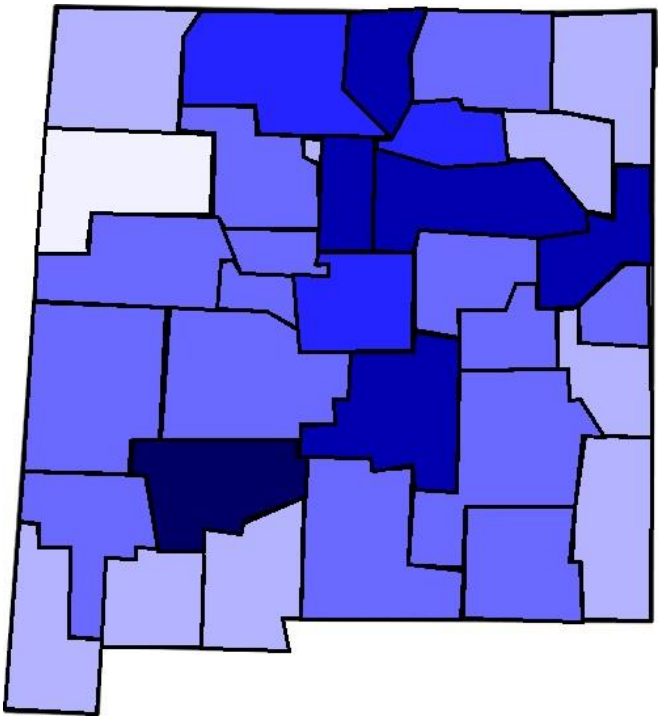
Medical Qualifying Conditions	Statutory or Departmental Approval	Number of Patients Certified with this Condition
Amyotrophic Lateral Sclerosis (ALS)	Approved by DOH	15
Cancer	Listed in Statute	3,407
Crohn's Disease	Approved by DOH	213
Damage to the nervous tissue of the spinal cord	Listed in Statute	132
Epilepsy/Seizure Disorders	Listed in Statute	734
Glaucoma	Listed in Statute	328
HCV infection and receiving antiviral treatment	Approved by DOH	56
HIV/AIDS	Listed in Statute	554
Hospice Care	Listed in Statute	149
Huntington's Disease	Approved by DOH	7
Inclusion Body Myositis	Approved by DOH	3
Inflammatory autoimmune-mediated arthritis	Approved by DOH	1,160
Intractable Nausea/Vomiting	Approved by DOH	372
Multiple Sclerosis	Listed in Statute	519
Obstructive Sleep Apnea	Approved by DOH	0
Painful Peripheral Neuropathy	Approved by DOH	1,470
Parkinson's Disease	Approved by DOH	306
Post-Traumatic Stress Disorder	Approved by DOH	29,504
Severe Anorexia/Cachexia	Approved by DOH	214
Severe Chronic Pain	Approved by DOH	19,402
Spasmodic Torticollis (Cervical Dystonia)	Approved by DOH	56
Ulcerative Colitis	Approved by DOH	129

Top 5 conditions that receive the most referrals are **bold.**

[9] NM DOH Patient Statistics Report 9/30/2018, accessed online 10/10/2018

New Mexico Medical Cannabis Patient Distribution by County

Map of rates of participation in the medical cannabis program



Rates of participation in the medical cannabis program vary by county. The county with the fewest medical cannabis patients per capita is McKinley County with about 3 patients / 1,000 people. The county with the greatest rate of participation is Sierra County with 29 patients / 1,000 people.[10]

Color Key	
	< 1%
	1.0 - 1.9%
	2.0 - 2.9%
	3.0 - 3.9%
	4.0- 4.9%
	> 5%

Total of Medical Cannabis Patients by County

County Name	Number of Patients
Bernalillo	20,011
Catron	113
Chaves	1,779
Cibola	788
Colfax	277
Curry	1,205
De Baca	54
Doña Ana	4,766
Eddy	1,600
Grant	1,007
Guadalupe	123
Harding	11
Hidalgo	81
Lea	1,354
Lincoln	938
Los Alamos	267
Luna	441
McKinley	593
Otero	1,812
Quay	408
Rio Arriba	1,509
Roosevelt	360
San Juan	1,383
San Miguel	1,315
Sandoval	4,253
Santa Fe	6,770
Sierra	716
Socorro	524
Taos	1,477
Torrance	493
Union	65
Valencia	2,091

NM DOH Patients Statistics Report, September 2018

[10] O'Donnell, Kelly "The Medical Cannabis Market in New Mexico," August, 2016

1. Lessen Cost Burdens

Problem: Many people who are medical cannabis patients live on fixed incomes, and many are unable to work due to debilitating, chronic or severe conditions. The cost of medical cannabis is not covered by traditional insurance or Medicaid. Patients report that they experience having to go without medicine they need because they cannot afford it.

Recommendation 1A: Remove requirement to pay gross receipts tax on medical cannabis. Make medical cannabis tax exempt like prescription drugs. This will immediately bring patients savings of about eight percent on medical cannabis.

Recommendation 1B: Add a provision in the Lynn and Erin Compassionate Use Act that directs the agency to create a discount program for patients who qualify for Medicaid, or whose income is 200% or less of federal poverty guidelines. Stipulate in statute that that producers must provide medical cannabis at a reduced rate for patients who are part of the program.

Discussion: The average cost of medical cannabis in New Mexico is still more than $10/gram plus gross receipts tax paid on the value of the goods. [11] Patients who don't have the ability to pay for medical cannabis have no support from the state, and while there is still conflict with federal law medical cannabis cannot be added to items covered by Medicaid.

Patients medical cannabis product needs and the products available vary greatly. In addition to, or in place of flowers, patients may need differing amounts of extracted concentrates, tinctures, salves, edible cannabis products etc. What is constant is that the burden of paying for medical cannabis products is born solely by the patient.

Medical cannabis can cost hundreds of dollars each month for the sickest patients who are least able to afford to pay for it. Limited licensed production of medical cannabis, rising demand from the growing patient population, and the high annual cost of medical cannabis licensure all contribute to the price patients pay at the register.

Example A: A patient who uses just one gram of medical cannabis flower per day would spend more than $700 per month for medical cannabis in New Mexico.

Example B: For pain patients, a popular manufactured 6 oz., 10-portion chocolate bar costs $30 and contains 200 mg of THC and 100 mg CBD. Each square is one "dose" that includes 20 mg THC and 10 mg CBD. The cost per dose is $3.00. A person who needs 4 doses per day would spend $360.00 plus GRT per month on medicine.

[11] The cost per gram estimate was generated from self-reported financial data from 2018 submitted to DOH and provided by the License and Compliance division of the Medical Cannabis Program.

2. Allow Multi-year Certifications

Problem: The Lynn and Erin Compassionate Use Act states that written certifications signed by a patient's practitioner may only be considered valid for one year, but many patients are permanently disabled, or use medical cannabis to manage symptoms for chronic conditions that will persist for the rest of their lives.

"I was diagnosed with end stage kidney failure. Cannabis helped me through two years of dialysis and one year of chemotherapy. I received my kidney transplant in 2012, and I still use medical cannabis. It helps decrease the severe side effects of the transplant anti-rejection medicine. Prescription drugs help me stay alive, and medical cannabis helps give me a better quality of life. **For patients, like me, who have permanent conditions it would be great to have multi-year certification for medical cannabis**."

Lisa Brooker, Medical Cannabis Patient

Eddy County

Recommendation 2: Eliminate statutory requirement for NM Department of Health to reissue medical cannabis cards annually. Allow medical providers discretion to issue a recommendation for medical cannabis use for up to 3 years in the case of chronic or terminal conditions, or permanent disabilities.

Discussion: Many of New Mexico's medical cannabis qualifying conditions are chronic or lifelong (see list of qualifying conditions page 8). Patients who have a permanent disability or a condition their provider believes will not change or resolve in one year should be able to certify their patients for multiple years.

Additionally, many patients receive medical care from federal health systems like the Veterans Administration (VA), Indian Health Services (HIS), or federally qualified health centers (FQHC). Providers working in these institutions, or others that receive federal funds are prohibited from certifying patients for state medical cannabis programs. This means that patients seen by providers at the VA, IHS, FQHCs and other many other institutions must pay out of pocket for a medical provider to certify them for medical cannabis.[12]

[12] See for example the medical cannabis law in Illinois, which permits card holders to register for three years at a time, and Michigan and New Jersey, which also allow multi-year patient registry cards.

3. Expand Medical Qualifying Conditions

Problem: New Mexico has a limited list of qualifying conditions. Medical cannabis could help many more New Mexicans who are suffering from serious and life-threatening debilitating medical conditions than currently have access to it.

Recommendation 3: Amend medical qualifying conditions listed in the Lynn and Erin Compassionate Use Act to add opioid use disorder and stipulate that, in addition to conditions listed, medical providers may to refer patients to the program for other serious medical conditions that they believe may be alleviated by medical cannabis.

Discussion: The Medical Advisory Board (MAB) created by the Lynn and Erin Compassionate Use Act calls for a group of nationally board certified physicians with specialties in medical oncology, neurology, infectious disease, psychiatry, family medicine and gynecology to be recommended by the NM Medical Society and appointed by the Secretary of Health to make recommendations on matters of adding qualifying conditions, ensuring an adequate supply of medicine, and issuing patient registry rules.

In the last eight years the MAB has recommended expanding the list of qualifying conditions to include opioid use disorders,[13] autism spectrum disorder,[14] neurodegenerative dementia- including

"As a physician, I have observed that medical cannabis is consistently beneficial for patients suffering from various medical conditions. Many of these diseases and conditions do not qualify in New Mexico for medical cannabis. There have been 700 medical conditions that have been studied and found to be effectively treated with cannabis. There are currently only 22 qualifying conditions allowed in New Mexico. It is frustrating for me and for my patients who need access to cannabis that do not qualify because of our limited list of qualifying diagnoses As a physician I am trained to diagnose and use my knowledge of the medicinal properties of medications including medical cannabis to alleviate the suffering of my patients. **I should be able to use my clinical knowledge and expertise to certify patients for medical cannabis use for any serious condition that I deem appropriate.**"

Celeste Madrid Taylor, M.D.

Doña Ana County

[13] People suffering from opioid use disorder (OUD) can access cannabis in New Jersey and Pennsylvania. The NM Medical Advisory Board for the medical cannabis program has recommended twice to add OUD as a qualifying condition for medical cannabis, but the Secretary of Health denied their recommendation. In 2016 NM Legislature passed HB 527 (Gentry) that included adding OUD by wide margins.(Votes: NM House 45: 16; NM Senate 28: 9)

[14] According to Mother's Advocating Medical Marijuana for Autism website: People can access medical cannabis to alleviate symptoms of autism in 11 states and D.C.: CA, DE, FL GA, LA, MA, MI, MN, OK, OR, PA, & Washington D.C.

Alzheimer's disease,[15,16] and others for inclusion, but the Secretary of the Health has repeatedly declined the MAB's recommendations.

Medical practitioners should be able to use their discretion to certify their patients for medical cannabis for any condition that the think it may relieve the symptoms and suffering from, just as they might recommend other types of treatment or medications. Medical cannabis has an excellent safety profile. There is no reason for its use to be restricted to particular list of conditions approved by law.[17]

4. Establish Civil Protections

Problem: New Mexico's medical cannabis law protects patients and caregivers from criminal liability, but does not provide civil protections for patients.

Recommendation 4A: Amend the Lynn and Erin Compassionate Use Act (LECUA) to remove the prohibition on possession of medical cannabis on school grounds for use by school staff and students who are patients on buses, in workplaces, and in other public spaces.

Recommendation 4B: Establish civil protections in the LECUA for medical cannabis patients related to employment, child custody, housing and schooling.

Recommendation 4C: Create a new statute enabling medical cannabis patients or their parent or guardian and schools to establish agreements allowing consumption or administration of nonsmokable forms of medical cannabis in class, on school grounds, at school-sanctioned events and field trips.

Discussion: Patients may face discrimination and consequences such as not being able to access education, losing custody of their children, having difficulty finding housing and/or jobs. There is a specific

> "The way the laws are now, my daughter and other children are being denied their right to an education, or being forced to go without access to medicine that they need. We tried many prescription drugs, but whole plant medical cannabis oil is what my daughter needs to be able to access in case she begins to have a seizure. Her medicine should be readily accessible to her student aide, or her teacher in case she needs it – just like epi-pens and inhalers. **We need to change the laws now so that we don't have to choose between our children's need for medical cannabis and their education**."
>
> Lindsay Sledge mother of a medical cannabis patient,
>
> Bernalillo County

[15] Dementia is a qualifying condition in 10 states. "Agitation in Alzheimer's Disease as a Qualifying Condition for Medical Marijuana in the U.S." Maust, Donovan et.al.

[16] Neurodegenerative dementia was recommended for approval by NM MAB in 2015, 2016 and 2017.

[17] See for example laws in California, Georgia, Massachusetts and Oklahoma that give the medical provider discretion to decide if cannabis would help their patient.

prohibition in statute preventing possession of cannabis on school grounds, on school buses, on public buses and in the workplace.

No one should have their job and ability to support themselves and their family taken away simply because they use a medication recommended by their doctor and authorized by the state of New Mexico. The New Mexico State Constitution affirms that children shall never be denied right and privilege of admission and attendance in the public schools, but this is exactly what is happening with students who are medical cannabis patients.

The needs of medical cannabis patients and the needs of employers and schools must be balanced, but people who use cannabis for medical reasons should not have to make a choice between their best medical treatment and their employment, their education or other civil rights.

New Jersey's medical cannabis law, modeled after New Mexico's law, passed by the NJ Legislature in 2012, includes this language provides protections for patients, stating that they "shall not be subject to any civil or administrative penalty, or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a professional licensing board, related to the medical use of cannabis authorized under this act."[18]

There has been movement in several states to establish access to medical cannabis for students. The best policy example is Colorado law that allows administration of medical cannabis by school personnel. New Jersey also permits access to cannabis at school with approval under legislation passed in 2018. Individual students in Illinois and California have been granted permissions through the courts. Legislation is likely to be proposed in both states in the coming year.

5. Support Patients in Rural Areas

Problem: People living in most of New Mexico still experience a lack of access to medicine and to providers willing to refer patients to the medical cannabis program. Few licensed producers or couriers service patients in vast sparsely populated areas of New Mexico. Rural patients who grow medicine outside and have only one harvest per year fear being criminalized for possession cannabis in excess of the maximum quantity[19,20] allowed by the department.

[18] See also examples civil protections for medical cannabis patient in laws in Delaware, Oklahoma.
[19] NMSA 7.34.3.7B, "adequate supply" is defined in statute, as an amount that is determined by the department to be sufficient to ensure an uninterrupted supply for a period of three months.
[20] NM DOH Rule 7.34.3.9A stipulates that the "maximum quantity" that a patient or caregiver are legally allowed to possess in any three-month period as 230 units, which is equivalent to about 8 ounces of cannabis flowers.

Recommendation 5A: Establish in statute that the agency must take reasonable steps to ensure access to medical cannabis for patients in rural communities.

Recommendation 5B: Change the definition of "adequate supply" in the statute to affirm that a patient may legally possess the entirety of the medicine grown in their personal garden, even if it exceeds the maximum possession limit.

Recommendation 5C: Support expansion of the Telehealth Act and the use of telemedicine in New Mexico to connect rural patients to medical providers for referrals to the medical cannabis program.

Discussion: People in rural areas have needs that were not anticipated when the Lynn and Erin Compassionate Use Act was written. As much as possible the legislature should work to ensure rural residents are served equally. The legislature can encourage the department to identify ways to help ensure safe access to medical cannabis in rural counties.

Patients in rural areas report that the same medicine is sold at higher prices than it is in Albuquerque, where competition among producers pushes prices down. Patients also report that the medicine available in rural communities is limited to very few products and is of lower quality. Delivery services exist but are also limited and patients must pay service charges.

Medical providers are increasingly referring to the program, and the Department of Health is actively seeking to present to medical professionals around the state about the program. In 2018 Health Educator, Jenna Burt, and Medical Director Leah Roberts presented more than 30 times to over 1,200 medical professionals.[21] But, even with this outreach, a need for education for patients, providers and medical cannabis industry professionals statewide was noted by Medical Cannabis Program Director Kenny Vigil in a presentation to the Task Force.

It would be prudent to harness New Mexico's health technology leadership to provide education training and support for medical providers and patients in rural areas, for medical cannabis. This would be especially for increasing rural residents' access to health care providers. The Medical Cannabis Advisory Board recommended increasing access of tele-medicine for medical cannabis certification in a report submitted to the Secretary in Nov. 2017.

A concerted effort must be made to recognize the needs of rural patients and support access to medical cannabis and medical cannabis program certification for patients in underserved areas of the state.

See also Recommendation 9 to Expand Licensing Structure.

[21] Ibid Vigil, Kenny – Medical Cannabis Program

6. Allow Donation of Medicine

Problem: Medical cannabis patients who cannot afford to purchase or who cannot grow medical cannabis have no legal options to receive donations of medical cannabis from other patients.

Recommendation 6: Establish in statute that transfer, sharing or gifting of medicine from one licensed patient or caregiver to another is permitted.

Discussion: The intent of New Mexico's medical cannabis law is to allow for the beneficial use of medical cannabis within a state regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments. Allowing gifting of medicine between patients supports this intent.[22] Currently there is no provision allowing cannabis to be shared between patients, so patients are still criminals. Sharing medical cannabis between patients should not be a crime.

"As an advocate for rural patients I often hear about people who need medical cannabis, but cannot afford to purchase it. I am also an approved caregiver for my wife who is a patient. As a personal production license holder I have learned to be a skilled grower and I would love to be able to help other patients in need by sharing medicine I've grown, but currently the law doesn't allow me to do that. **I hope the legislature will fix this by updating the medical cannabis law 2019 so that sharing medical cannabis between patients and caregivers is allowed**."

Heath Grider, New Mexico Cannabis Patients Advocacy Alliance

Roosevelt County

7. Allow Personal Cultivation at an Alternative Address

Problem: Medical cannabis patients who live on tribal lands or in federal housing run the risk of federal charges if they cultivate medicine at their residence, but current Department of Health rules require that a patient's garden be located at their residence.

Recommendation 7: Establish in statute that personal cultivation sites may be licensed at an "alternative address," a location other than a patient's residence, for example, a licensed collective cultivation site.

See also Recommendation 9A Collective Cultivation – which would require the department to create licensing that permits multiple patients and/or caregivers to grow medical cannabis together.

[22] See, for example, laws in Alaska, Colorado, Maine, Massachusetts, and Washington D.C. that permit gifting of cannabis between qualified patients.

Discussion: It is important for the Legislature to affirm a patient's ability to cultivate medical cannabis in a personal garden and there is no practical reason to require a personal garden by grown at the residence of the patient. For many patients growing medicine where they live may be impracticable or require them to violate federal law. See for example laws in California, Michigan, Oregon, Rhode Island, and Vermont.

There are New Mexicans in Picuris who need medical cannabis, but don't become qualified patients in the state program because they fear using, storing and growing their medicine at home on tribal land. The Pueblo of Picuris wants to support its members and others who live on tribal land to access medical cannabis without this fear.

8. Establish a Minimum Market Supply

Problem: Because there is no minimum threshold of supply of medicine in the New Mexico medical cannabis market, the administration has been able to limit the number of medical cannabis production licenses issued and cap the number of plants producers are allowed to grow. However medical cannabis patient enrollment has increased steadily every month since cards began being issued, and enrollment has tripled since the last time additional medical cannabis production licenses were issued.

Recommendation 8A: Direct the agency to take reasonable steps to ensure that, no less than, a minimum adequate supply of medical cannabis is available for purchase by patients.

Recommendation 8B: Establish a definition of "minimum market supply" to mean an amount of cannabis available in the marketplace, defined as, at minimum, the individual purchasing limit, defined by DOH rule, multiplied by the number of patients in the program.

Recommendation 8C: Require the agency conduct a semi-annual review of the supply of medicine and adjust licensing to meet demand.

Discussion: Only 35 producers have been licensed by the department and they are heavily concentrated in Albuquerque and Santa Fe. Even Las Cruces only has four licensed producers.

"Given the robust growth of medical cannabis patient enrollment in New Mexico over the last ten years and the fixed supply of medical cannabis product available, it is obvious that a serious shortage, or "inadequate supply" of medical cannabis product could be expected statewide. The Department of Health needs to address this shortage of medical cannabis production in the state. **The Department Health should fully implement their mandate of and ensure that the supply of medical cannabis available is enough to meet a basic minimum amount of product per medical cannabis patient**."

Laura Brown, M.D., M.P.H.--Medical Cannabis Advisory Board Chair

Santa Fe County

Production licensing has only occurred three times, and only once in the last eight years. Meanwhile, the patient population has grown to more than 58,000 patients.[23] The last time the department opened the medical cannabis producer application process was in 2015 when 12 new producers were given licenses.

In addition to limiting the number of producers, the number of plants a producer can grow are also limited. In 2018 the department licensed producers to grow 15,000 plants.[24] At the current level of patient enrollment this means that producers are cultivating less than 1/3 of a plant for each patient in the program.

This issue has been recognized as a problem for many years. In 2017 legislation sponsored by Senator McSorley and passed by the New Mexico Senate, Senate Bill 177, included a provision to tie the amount of plants licensed for cultivation to the patient population.

9. Expand Licensing Structure

Problem: Currently the Department charges some of the highest fees for medical cannabis licensing in the U.S. A producer pays an annual fee that is tied to a number of plants that they are allowed to grow. Producers are allowed to sell the medical cannabis to the public at locations approved by the NM Department of Health. They may also sell medicine to other licensed producers.[25]

Recommendation 9A: Add a provision to the Lynn and Erin Compassionate Use Act (LECUA) directing the department to expand licensing and create new types of licenses types. Licensing categories should include, but are not limited to 1) cultivation; 2) collective cultivation; 3) onsite medicine consumption and storage; and 4) retail.

Recommendation 9B: Stipulate in the LECUA that the department should develop reduced fees for licensing and prioritize licensing of businesses that locate operations in rural communities and /or that articulate a plan to serve rural and underserved patients.

> "I am a patient living in Ruidoso. There are few options for patients in my area to purchase medical cannabis. I would like to see more types of licenses I am also a personal production license holder and strong advocate for *collective cultivation* licensing that would allow patients to be licensed to grow medicine together. **It is really important for patients, especially those of us in rural areas where we aren't well served, to be able to support each other by being able to grow medicine together and share the harvest**."
>
> Josh Mccurdy, New Mexico Medical Cannabis Patients Advocacy Alliance,
>
> Lincoln County

[23] NM DOH Patients Statistics Report September 30,2018, accessed online 10/1/2018
[24] NM DOH Producer Re-licensure List 2018/2019 accessed online 7/1/2018
[25] See for example laws in Colorado, California, Massachusetts, Nevada, and Oklahoma.

Discussion: Medical cannabis licensing and production in New Mexico has not increased in relation to the growing patient population. As the need for cannabis increases across the state the number of licenses issued, and the licensing structure should be expanded to help address patient needs.

Medical cannabis patients, especially those in rural areas, would be better served by a licensing structure that allowed smaller operations and various types of licensing, including retail-only licenses for a lower fee.

Medical cannabis production in New Mexico is generally vertically integrated. Medical cannabis producers are licensed to grow a certain number of plants, from 150-450, capped by department rules. Licensed producers growers can wholesale to each other or sell directly to medical cannabis patients at their own distribution points. Department of Health approval for all dispensaries are required, but producers do not pay any fee to operate additional retail outlets. The department does not license stand-alone retail outlets, they must be operated by a licensed producer.

In 2015 the department began to issue licenses for delivery services, to manufacture products and for testing. The department should follow its own lead by expanding the license types they offer.

The department also needs to address challenges faced by patients that live on tribal land or in federal housing who need safe places to consume, store and grow their medicine by creating licenses for collective cultivation and onsite consumption and storage of medical cannabis.

10. Create a Patient and Caregiver Advisory Board and Support Position

Problem: Medical cannabis patients, caregivers and advocates do not have a formal way to have their voices heard by the department. Patients report that they encounter challenges navigating other state programs and agencies that they need support from the state to help navigate.

Recommendation 10A: Add a provision to the Lynn and Erin Compassionate Use Act that directs the agency to create a statewide Patients and Caregivers Advisory Board responsible for gathering input from the public and recommending from their own expertise changes or additions to the program, including consultation in promulgation of rules, and on matters concerning affordability and accessibility.

Recommendation 10B: Support the creation of a of *Patient Support Advocate* position (1 FTE) within the Medical Cannabis Program to help medical cannabis patients navigate

systems, to provide general education about the program to potential patients, and to support the work of the Patient and Caregiver Advisory Board.

Discussion: People who are directly affected by a policy should be formally recognized in law and be consulted during departmental rules making, and on a regular, ongoing basis. The proposed Patients and Caregivers Advisory Board could be modeled after the Medical Advisory Board that is included in the Lynn and Erin Compassionate Use Act.[26]

Patients have ongoing issues with discrimination and stigma and need a way to access case specific support when they come across ignorance of the Medical Cannabis Program. The department should support the needs of patients by creating a new staffing position that deals with the needs of individual patients.

11. Support Medical Cannabis Access in NM Indian Nations, Pueblos, & Tribes

Problem: NM Indian Nations, Pueblos and Tribes have members who could benefit from medical cannabis, but are not enrolling in the program. The Department of Health has not supported tribes seeking to support access for New Mexicans living on tribal land, or made an effort to collaborate with tribes related to medical cannabis production.

Recommendation 11: The state legislature should affirm support for New Mexico Pueblos, Nations and Tribes to enact medical cannabis programs within their territories. Additionally, interested pueblos, tribes, and nations should be encouraged to apply to become licensed producers for the state's program.

Discussion: This recommendation specifically relates to Tribes becoming licensed producers on state land. Recommendations related to the intergovernmental agreements that would be needed to allow cultivation, and sales on sovereign tribal land or transporting cannabis between state and tribal land are conversations that are larger than recommendations related to medical cannabis.

"Cannabis is still stigmatized, even for medical use, in Navajo culture, but for me cannabis is a healing plant. I would love to start conversations about establishing a medical cannabis program in the Navajo Nation. I'm working on this and other issues through Diné Introspective, a Navajo Nation non-profit organization that I helped found. We promote mental, physical, spiritual wellbeing working on issues in our local communities to support social and economic self-reliance and living a healthy lifestyle. **As a young leader in my community I am working to share the how medical cannabis has benefitted me and people I know to help dissolve the stigma**."

Anthony J. Lee, Diné Introspective

San Juan County

[26] See laws in Pennsylvania and West Virginia and Canada that include mechanisms for patient input.

Even though U.S. federal law and jurisdictional issues present challenges, there are creative ways to decrease the barriers to medical cannabis for New Mexicans who live on sovereign tribal land. Some of the challenges to accessing medical cannabis for individuals living in New Mexico Tribes, Pueblos or Nations in New Mexico are addressed in the following recommendations: Allowing patients cultivate medicine at an alternative address (Recommendation 7); Creating a collective cultivation licenses that would allow patients and caregivers to grow medicine together (Recommendation 9); Creating an onsite medicine consumption and storage licensing (Recommendation 9); and Allowing multi-year certifications (Recommendation 2).

Next Steps

- **In 2019 the NM State Legislature should make changes to the *Lynn and Erin Compassionate Use Act* to enact task force recommendations to improve access to and affordability of medical cannabis for all New Mexicans**

- **In 2019 the NM State Legislature should create legislation enabling students, including minors, to have medical cannabis accessible and administered on school ground and at school-sanctioned activities within guidelines of a written agreement signed by the school and the patient or their parent or guardian.**

- **Additional Exploration: Intergovernmental Agreements with New Mexico Indian Nations, Tribes and Pueblos to Participate as Licensed Producers in the State's Medical Cannabis Program:** Other states, like Nevada[27] and Washington[28] and tribes including Suquamish[29], Jamestown S'Kallam,[30] Yerrington Paiute,[31] and Ely Shoshone[32] provide examples of enabling legislation and compacts[33] that could be considered regarding commerce of cannabis grown on tribal land. But, New Mexico is different in at least one significant way. Washington and Nevada have both elected to have state jurisdiction of power over crimes committed by tribal members on tribal lands using the federal Public Law 280, New Mexico has not. Because of the increased risk of federal prosecution for New Mexico tribes and tribal members involved producing medical cannabis the discussion needs further consideration. Unfortunately, cannabis remains a schedule 1 narcotic at the federal level unique jurisdictional issue the question is more complex

[27] Nevada Senate Bill 375 Allowing Marijuana Agreements Between the NV Government and Tribes, 2017
[28] Washington Law Allowing Marijuana Compacts 2015 (pdf)
[29] Marijuana Compact Between the Suquamish Tribe and the State of Washington (pdf), 2015
[30] Jamestown S'Klallam Tribe Tribal Code Commercial Marijuana Activity (pdf), 2016
[31] Marijuana Compact Between the Yerington Paiute Tribe and the State of Nevada (pdf), 2017;
[32] Marijuana Compact Between the Ely Shoshone Tribe of Nevada and the State of Nevada (pdf), 2017

than it should be. More study and input from legislators, tribes, administrative officials and others is necessary to issue specific recommendations regarding the state entering into intergovernmental agreements with NM Indian Nations, Pueblos and Tribes.

Issues Beyond the Scope of SM 105

In addition to the recommendations listed above the task force noted four additional areas related to medical cannabis that should be investigated:

- Exploring Local Economic Development Act funding reimbursement to support serving rural and underserved areas of New Mexico;
- Establishing reciprocity for medical cannabis patients from other states;
- Regulating quality and consistency of medical cannabis;
- Studying potential impact of legalization of cannabis for adult use on medical cannabis patients.

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Senate Memorial 105

Sponsored by Senator Gerald Ortiz y Pino

Requesting the Drug Policy Alliance to convene a task force and make recommendations regarding medical cannabis affordability and accessibility, and recommendations specific to the state on entering into intergovernmental agreements with New Mexico Indian Nations, Tribes and Pueblos to participate as licensed producers in the state's medical cannabis program.

Whereas, the use of cannabis for medical purposes under a state-licensed system has been legal in New Mexico since the Lynn and Erin Compassionate Use Act was passed in 2007; and

Whereas, medical cannabis program participants are often on fixed incomes and may be unable to work because of their serious medical conditions; and

Whereas, the cost of medical cannabis is not covered by health insurance or medicaid; and

Whereas, many program participants report that the cost of medical cannabis is not affordable; and

Whereas, there are tribal members who are New Mexico residents who live on tribal land, are qualified to participate in the state medical cannabis program and are licensed by the department of health to cultivate their own medicine; and

Whereas, department of health regulations exclusively permit personal cultivation at a site that is at an individual's residence, which provision, as state law, does not extend to federal trust land; and

Whereas, the department of health does not permit qualified patients to collectively cultivate medical cannabis; and

Whereas, New Mexicans who are renters are required to provide written approval from their landlord or property owner in order to obtain a personal cultivation license, presenting concerns about personal health information privacy; and

Whereas, medical cannabis is not easy to access by members of tribes and other New Mexicans living on tribal land or in rural or frontier areas of New Mexico; and

Whereas, there are only thirty-five producers licensed by the state to grow and provide medical cannabis to qualified patients, and the department of health is not accepting applications for additional licenses; and

Whereas, medical cannabis program participation grows by hundreds of patients every month, and there are currently more than forty-seven thousand eight hundred forty qualified patients across the state; and

Whereas, there is a need for a safe space for all New Mexicans who are qualified patients to be able to use and grow their medicine where they are not under threat of prosecution; and

Whereas, many New Mexicans who would qualify for the medical cannabis program do not even apply to become program participants as a result of factors of affordability and accessibility and for fear of federal prosecution; and

Whereas, the department of health does not collect demographic information related to qualified patients who are military veterans or members of Indian nations, tribes or pueblos; and

Whereas, military veterans and members of Indian nations, tribes or pueblos receiving health care from the federal veterans health administration or the federal Indian health service may not be certified for the medical cannabis program by their primary health care providers; and

Whereas, agreements between the department of health and any sovereign Indian nation, tribe or pueblo located in New Mexico that elects to implement the provisions of the medical cannabis program would be beneficial;

Now therefore, be it resolved by the Senate of the state of New Mexico that the drug policy alliance be requested to convene a task force to make recommendations to improve medical cannabis affordability and accessibility for all New Mexicans, especially New Mexicans who are members of Indian nations, tribes or pueblos and reside on federal trust lands; and

Be it further resolved that the medical cannabis affordability and accessibility task force include recommendations specific to the state on entering into an intergovernmental agreement with any sovereign Indian nation, tribe or pueblo in New Mexico that elects to implement the provisions of the state's medical cannabis program; and

Be it further resolved that the drug policy alliance request the following individuals to join the task force:

A. the secretary of health or the secretary's designee;

B. liaisons from interested Indian nations, tribes and pueblos;

C. a medical cannabis patient advocate living in a rural area of the state;

D. a medical cannabis patient advocate who possesses a personal cultivation license;

E. a military veteran who is a medical cannabis patient;

F. a representative from the licensed nonprofit producers; and

G. anyone else with subject matter expertise as indicated by the drug policy alliance; and

Be it further resolved that the medical cannabis affordability and accessibility task force be requested to provide recommendations regarding guidelines for compliance with department of health rules or compliance with express provisions of an intergovernmental agreement to govern the rights and responsibilities of the department of health and an Indian nation, tribe or pueblo when that Indian nation, tribe or pueblo transports or sells medical cannabis outside of the boundaries of that Indian nation, tribe or pueblo; and

Be it further resolved that the medical cannabis affordability and accessibility task force be requested to report its recommendations to the interim legislative committee focused on Indian affairs and the legislative health and human services committee by November 1, 2018; and

Be it further resolved that copies of this memorial be transmitted to the secretary of health, the chair of the interim legislative committee focused on Indian affairs, the chair of the legislative health and human services committee and a representative of each New Mexico Indian nation, tribe and pueblo.