

2017 Legislative Objectives:
System Goals for the Medical Marijuana Program in
Montana



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Montana Cannabis Industry Association MTCIA

In November, the citizens of Montana voted for the second time in support of medical marijuana access for their fellow citizens. The initiative, I-182, sought to re-establish access and bring accountability and responsibility to the current program by requiring

- Licensing for providers
- Mandatory inspections
- Allowing for cannabis testing for potency and toxins

The initiative also added PTSD to the list of Montana’s qualifying conditions. The initiative aimed at the basics, creating a sound foundation for regulating medical marijuana in Montana.

Whereas prohibitions play a role in all regulatory systems, they are not the sole purpose of such systems. Regulatory systems, when effective, are shaped around system goals. During the 2017 legislative session, the MTCIA will propose legislation and assess proposed legislation based on whether the provisions meet the following goals of making the medical marijuana program in Montana:

Transparent
Contained

Safe
Functional

Transparency refers to the ability to know how much cannabis is being produced in the state program, where it is and in what form, as it moves from seed-to-sale. The initiative addressed transparency in requiring all those financially involved with a provider to be listed on the license. The initiative also addressed transparency in making annual inspections of all medical marijuana facilities mandatory. The MTCIA supports instituting a seed-to-sale tracking system to make each step of the cultivation and production process transparent to regulators.

Contained refers to keeping the Montana program in Montana. “Contained” includes not only assuring that the cannabis produced in Montana is distributed only in Montana to approved medical marijuana patients, but also means protecting the program from a “green rush” mentality. The initiative included a one-year residency requirement to be a provider in Montana. The MTCIA supports extending the requirement to five years (grandfathering in current providers). An extended residency requirement may also serve to further align Montana with federal guidelines for states with medical marijuana programs (to be discussed later). In short, **containment** refers both to containing Montana-cultivated medical marijuana in-state and it also means containing the economy of the program in-state, too.

Safe refers to the safety of patients first, assuring the cannabis they use for their debilitating condition is clear of toxins and tested for potency. Safety refers, too, to the safety of the program itself and those who work within it, meaning safe working conditions and safety from bad actors infiltrating the program which then in turn jeopardizes the entire program. The initiative allowed testing labs in Montana. The MTCIA supports making this testing mandatory once labs are licensed, standardized, and available in the state.

Functional means the creation of a system that works. Many news stories referred to the initiative as reversing “strict” provisions of the 2011 legislature. This was a mischaracterization of what the initiative and the 2011 law (SB 423) did. The 2011 law did not create a “strict” program. It created a dysfunctional, non-functional, barely regulated program. Montana can have serious regulations *and* a program that functions. Systemic obstacles to access don’t make a program “strict.” Provisions that defy the principles of agriculture are not “strict.” They make for a program that doesn’t work.

Transparent. Contained. Safe. Functional.

These are the basics of a responsible state medical marijuana program. Without systems goals, and mistaking cumbersomeness for regulation and making prohibitions, primarily, the bedrock of a system is bound to lead to a systems failure. Systems experts say that if one wants to see what a system is designed to achieve look at what it is achieving. The results may not be the goals of those who designed the system, but the system they designed leads to what the system is in actuality accomplishing.

Another consequence and sign of a failed systems model is that in order to achieve the stated goal of the system (provide medical cannabis for approved patients, in this case), those in the system must find a way around the rules, or manipulate the rules, or break them, in order to get done what the rules of the system are supposed to support and enable.

Thus, the MTCIA will assess legislative proposals through this lens of goals of a transparent, contained, safe, and functional system of access meant to work for patients, government, providers, and communities. The policy options we will forward will be in the service of these goals. The law passed by initiative in November laid a good foundation. Yet, we can do more.

Provisions to Support a Transparent, Contained, Safe, and Functional Medical Marijuana Program

Seed-to-Sale Tracking

System Goals: Transparent, Contained, Safe, Functional

A seed-to-sale tracking system would enable the regulatory agency (Department of Health and Human Services, DPHHS) to track the production, transportation, destruction and sales of medical marijuana in Montana. Currently, six states use a tracking system for the purposes of creating transparency and containment. At least four more are expected to come online. DPHHS would have several options for a seed-to-sale system and through an assessment and RFP process can determine what is most appropriate for Montana. Much of the available software can be adapted to the specifics of a given state's program.

Seed-to-sale tracking allows regulatory agencies to track every gram of legal cannabis throughout the production cycle from seed through harvest, from transport and testing lab to dispensary and to sale. Tracking systems prevent the illegal diversion of cannabis and create the ability to recall plant product deemed as unsafe or adulterated.

When a program is transparent, hearsay and hyperbole no longer hold sway when it comes to whether the cannabis grown for approved patients is finding its way into the black market or across state borders. States with a seed-to-sale tracking system for state-legal cannabis and derived products can identify the source plant and source provider. Seed-to-sale tracking both prevents diversion and catches it. With transparency, black market leaks become difficult, all unlawful activity concerning the production and distribution of medical marijuana becomes considerably more difficult to undertake without detection.

A seed-to-sale tracking system serves the four objectives outlined in this report. It makes for a transparent system. When a system is transparent, diversion is prevented or is discovered, which assures the program remains contained. Being able to track contaminated product helps protect patients and keep them safe. Tracking also enables providers to run a functional business, forcing documentation of the details and variables important for any provider of a commodity or service to know.

State Canopy Limit and Licensing Base on Production

System Goals: Contained, Safe, Functional

Currently, the volume of cannabis produced in the state is regulated by tying the number of plants a provider may cultivate to the number of patients the provider has, four mature plants per patient. However, plant counts are a poor metric for determining how much cannabis is being produced in the state. Other volume management provisions in the current law include a provider being limited to what s/he may have on-hand for patients to one ounce each. Again, this metric is out of step with the realities of agricultural practices.

Harvest yields fluctuate. Patient use fluctuates. Sometimes, following a harvest, a provider may find him or herself over allowable limits per patient, but will not be in perhaps a week, once patients come for their medical cannabis. Anyone familiar with agriculture can recognize that the basic principle of “silo-ing,” harvesting and distributing as needed, as a more logical model of cultivation and distribution. In addition, patients do come and go. By the time the paperwork is processed and a provider gets word of a patient having changed providers, that provider may have been over his or her allowable product-on-hand and plant limits unknowingly for weeks. (This lack of “agricultural logic” in regards to allowable product on-hand per patient in the statute is one of the primary concerns of providers aimed at acting within the state law. If the legislature rejects the canopy model offered below, it would make sense to address this issue in the statute in an alternative manner.)

Managing volume via plant count has been widely discredited. At its simplest, the model fails in that different sized plants will obviously produce varying quantities of product. Knowing the number of plants in the system fails to give an approximation of the amount of cannabis being produced in the system. The emerging model for volume management involves parameters around allowable “canopy” and licensing based on square footage of plant canopy utilized by a provider.

“Canopy” refers to the extent of the reach of the outer layer of an individual or group of cannabis plants. It refers to leaf area per unit ground area. Canopy space is the total amount of square footage in flowering rooms that are under the grow lights. Canopy limits put a lid on how much cannabis is produced within a state program which, like a tracking system, serves as a deterrent to overproduction which can lead to black market spill over and price manipulation.

Two studies have looked at how much canopy space is necessary to meet the needs of a population. Usage studies from 2013 in the Netherlands and 2016 in the U.S. found that medical marijuana users consumed 0.7 grams/day on average. The research in the Netherlands was conducted by Bedrocan. Bedrocan holds the government contract there to produce medical marijuana. BOTECH was contracted with by the Washington State Liquor and Cannabis Board (WSLCB) to conduct a study to find out how much cannabis needed to be produced in the state to meet demand. The BOTECH study also showed that indoor production allows for 4 – 6 harvests per year and the harvests produce approximately 40 grams per square foot. However, like other agricultural products, yields can vary due to controlled variables (cultivator choices), partial or complete crop failure, and random variation.

BOTEC's recommendation was to allow for double the canopy needed to meet demand. Given that ancillary space (facility space used for walkways and activities other than growing) may run half the size of the canopy space, 2/3 of a facility may be devoted to canopy. The BOTEC study suggested that unduly constraining available grow space invites a range of adaptations and choices that

- Drive up cost as a result of limited availability, i.e. scarcity leaves patients without, drives up prices, and serves as an incentive for patients to turn to the black market
 - Reduce quality, as crowded plants are more vulnerable to pests and disease
 - Restrict the variety of strains available to those with shorter growing cycles
- None of which serves patients.

A rational statewide canopy limit of that necessary to meet average patient use x2 limits statewide production without introducing negative impacts to patients and the program. A rational statewide canopy limit can protect patient access while also serving law enforcement, providers, and communities. Limits that are too restrictive, however, have the opposite effect.

Under the canopy model, the DPHHS would license providers based on how much of the state canopy a provider applies to utilize. In Washington, there are three tiers representing different ranges (square footage) of utilization. If a provider applies to utilize a given measure of canopy, and that provider's application justifies the tier applied for and is approved, the provider must cultivate that amount of space.

This rule prevents the licensing of space that is unused, which can generate intentional shortages that drive up prices for patients and block other providers from canopy access. The canopy model combined with a tracking system also eliminates the need for the problematic limits on product on hand per patient described above. It does this in two ways. 1) The amount of cannabis in the system is managed instead by the canopy limit. 2) Tracking makes overproduction monitored, rather than diverted.

In sum, a tracking system combined with a rational statewide canopy limit dis-incentivizes over-production and creates obstacles to criminal activity.

A canopy-based volume management model would alter the current licensing fee structure. Rather than licensing based on patient numbers, licensing would be based on which "tier" a provider seeks a license for, each tier represent different ranges of square footage. As with the model in the initiative, the cost of licensing should support the administration of the program.

Mandatory Testing

System Goals: Transparent, Safe

The new law passed in November allows for cannabis testing labs to return to Montana. Many providers will choose to test and label their products. The MTCIA supports taking this effort a step further and requiring mandatory testing of medical marijuana products.

This provision serves the goals of transparency (one knows the product's strength and that it is clear of pesticides) and, of course, the goal of safety.

Like the tracking system and the canopy model, we would propose mandatory testing go into effect a year after passing to give the regulating agency time to get the appropriate parameters and standards in place. The MTCIA fully supports mandatory testing as long as there were time to get the labs up and going, standardized, and licensed by the department. In other words, we support mandatory testing as long as vetted, licensed testing facilities are available.

Currently, under the initiative, patients may choose providers who provide tested and labeled products. This may, even before mandatory testing comes into effect, create market pressure for all providers to undertake this safety measure.

Availability is a critical criterion for making testing mandatory. Cannabis is an agricultural product with a shelf life. Test results need to be turned around quickly. Mandated testing and a shortage of testing labs have created a backup in the Oregon system. A model assuring access to testing labs in rural areas will be critical to assuring that those who live in such areas have access.

A decision the legislature may want to consider is whether testing labs should be private (and unassociated with any provider); the purview of state government; or a contracted single lab who can meet the criteria of standardization and statewide access. Regardless, standardization and availability are critical to making mandatory testing a functional component of a state program.

Concentrates

System Goals: Functional, Contained, Safe

The word “concentrate” in the cannabis pharmacopeia refers to any product which refines flowers into something more clean and potent. Concentrates were assumed an acceptable form of medical marijuana in Montana until 2012 when the Montana Supreme Court upheld a lower court ruling that hash oil was not considered marijuana under the state's medical marijuana law. As a derivative of the cannabis plant, it was generally believed that concentrates, including hash oil out of which other products (including edibles) might be made, fell under the definition in Montana state law which defines medical marijuana as “any mixture or preparation of marijuana.”

Concentrates can carry stigma due to the street names given to them in the past, not unlike the often un-therapeutic sounding names assigned cannabis strains. But the umbrella term “concentrate” generally indicates that a product is a concentrated form of cannabis and carries a higher potency. Concentrates are produced in several ways and the MTCIA, while supporting the patient option of a concentrate in Montana, also supports parameters determined by administrative rule for its safe production.

Reasons to include the availability of cannabis concentrates for approved medical marijuana patients:

- “Phoenix tears” or “Rick Simpson oil” are names for a concentrate often pursued by cancer patients, in particular. It is potent and is not known for being used recreationally. There is significant anecdotal evidence about this concentrate’s use getting excellent results with those diagnosed with cancer. This represents the most significant reason for its inclusion for allowable use. Patients utilizing Phoenix Tears are often some of the most desperate, and ill, of medical marijuana patients.
- Infused products frequently involve candies or baked goods. This method of intake does not work for diabetics. Concentrates provide an option.
- Likewise, alcohol-based tinctures are not always a good option for alcoholics.
- Concentrates involve quick results with small amounts of product.
- Concentrates utilized via vaporization or e-cigarette do not emit an odor.
- Concentrates work for those patients who would rather ingest small amounts (think a grain of rice) and not engage in consumptive activities such as inhalation or eating.
- Concentrates are fast acting and strong for those who suffer intolerable chronic pain.

Those who utilize concentrates for medical purposes may not wish to administer the medicine frequently.

Medical marijuana advocate and former critic of the use of concentrates, writer Rick Pfofmer, after writing an article critical of the use of concentrates faced a backlash from Crohn’s patients, quadriplegics, and Multiple Sclerosis (MS) sufferers who reached out to explain how the use of concentrates had been a godsend for them. In an article in Cannabis Now magazine he wrote that they reported that “By being able to intake a large amount of THC or CBD in a small dose they were able to find the relief that had eluded them through either smoking large amount of flowers or consuming edibles.”

Concentrates are a standard option in other state medical marijuana programs and for many patients, the right option. Allowing for concentrates in Montana helps protect Montana patients who feel this form of ingestion is the only one that provides the help and relief necessary. It keeps patients in-state for meeting their needs. Again, other states have crafted rules to make the provision and manufacture of concentrates safe. If they can do it, so can Montana.

Five-Year Residency Requirement

System Goals: Contained, Safe

Under the provisions put in place by the initiative last November, providers must have been a Montana resident for at least a year before being eligible for a license to provide medical marijuana. The MTCIA supports expanding this requirement for providers to five years.

Regulated systems are attractive to cannabis entrepreneurs as they represent a safe environment for providing medical marijuana. A five year residency requirement makes Montana less attractive to “green rush” motives and criminal enterprises. The MTCIA supports grandfathering in any provider who has served as a provider leading up to the passage of the new requirement as long as that provider has been a resident for at least a year.

Such a provision is also good for Montana economically as it keeps the resources generated from the medical marijuana program in Montana.

Other issues

DUI

In Montana, it is a crime to operate a motor vehicle with 5ng/ml or more THC in the blood. This prohibition applies to both medical marijuana patients and non-patients alike. The AAA Foundation for Traffic Safety concluded that laws such as Montana’s are “arbitrary and unsupported by science.” The Arizona state Court of Appeals recently ruled that medical marijuana users cannot be convicted of driving while under the influence of the drug absent proof that they were actually impaired.

“A new study from the National Highway Traffic Safety Administration finds that drivers who use marijuana are at a significantly lower risk for a crash than drivers who use alcohol. And after adjusting for age, gender, race and alcohol use, drivers who tested positive for marijuana were no more likely to crash than who had not used any drugs or alcohol prior to driving.” (U.S. Department of Transportation, National Highway Traffic Safety Administration, *Drug and Alcohol Crash Risk*, Compton and Berning, February 2015)

There is little evidence that THC levels in the body have clear correlation to impairment levels. Metabolites of THC (9-carboxy-THC) which register in blood and urine tests can be found in the blood of a medical marijuana patient two weeks after use. It can be detected in urine 21 days after use. Yet, the presence of the metabolite 9-carboxy-THC is not related to a patient experiencing psychoactive impacts of cannabis.

The soundest approach to criminalizing driving under the influence of marijuana is the approach taken for prescription medications, that is, effects-based. In other words, criminalization should

be based on whether the driver was actually impaired as opposed to whether or not there was THC or THC's metabolites present in the driver's blood or urine. Reported "surges" in traffic fatalities following a state's allowing of legal cannabis use have been widely de-bunked and/or exposed as sacrificing accuracy for sensationalism. For example, a widely cited NBC News story from 2014 is headlined: "Pot Fuels Surge in Drugged Driving Deaths." The article reports on "a study that found the number of car crash victims who had marijuana in their system increased threefold between 1999 and 2010, a period during which a dozen states legalized medical marijuana." What the article failed to mention was during that same period, the number of total fatal accidents fell by more than 30% (www-fars.nhtsa.dot.gov/Main/index.aspx). Thus, it would make just as much sense if not more to describe the statistics as indicating that legalized cannabis significantly reduces traffic fatalities.

The MTCIA is not forwarding an effort to address this unscientific provision. Hopefully in the future the Montana legislature will amend this provision in our statutes which can result in citizens unnecessarily facing serious consequences without having committed an actual offense. Impaired driving is a concern for all Montana citizens, medical marijuana patients and non-patients, alike. The MTCIA fully supports keeping Montana roads and highways safe. Laws that make people "feel" safer but do not actually create greater safety distracts from and creates obstacles to implementing policies that get the job done in real terms.

Wholesaling

In 2011, before SB 423 was sent to the House and replaced with the provisions that wiped out medical marijuana access in Montana, the Senate approved what was then called "caregiver-to-caregiver" exchanges. What this term refers to is wholesaling. In Colorado, cultivators are allowed to sell up to 30% of their production to another cultivator. (In Montana the term for cultivator would be "provider.") In Washington, wholesaling is a foundational component of their regulatory model.

Such transfers would be safe and trackable under the provisions discussed in this document and would serve to support an even flow of product to need. Allowing these transfers would provide for a more functional, rational system model. The MTCIA supports wholesaling and believes with the appropriate tracking system, wholesaling can be done safely and without diversion. However, we would not prioritize it over other system components discussed in this document.

Patient Concerns

The primary mission of the MTCIA is to build a quality system of access for patients. However, there are individual provisions in the statute that have a negative impact on Montanans with debilitating illnesses that aren't necessarily integrated into the regulatory system. One of these provisions is that individuals under the supervision of the Department of Corrections are not eligible to use medical marijuana for their conditions, regardless of the seriousness of the condition or the efficacy of cannabis for that condition.

A second issue is the prohibition on parents who have secured a medical marijuana referral for their minor child from using a state-approved provider to provide the medical cannabis for their

child. In other words, if parents find that medical marijuana is the medication that works for their child and if two physicians approve the child for use, the parent must cultivate and process the cannabis into a non-combustible form themselves. This places an undue burden on parents with a sick child.

Parents pursuing medical marijuana referrals for their minor child must complete a Physician Statement for Minors that is signed by two doctors. There are currently 5 minors on the medical marijuana registry.

Rural Communities

As with most issues of “access,” medical marijuana access in rural areas involves different considerations than access in the urban centers. In assessing regulatory proposals, lawmakers from the rural areas may want to consider whether the system creates access and jobs in their community or region, or whether it sends resources out and makes access more difficult. Should a cancer patient in Plentywood have to drive five hours to Billings every two weeks for their product, or pay the cost of the product plus delivery if that patient is unable to travel? (The law does not allow a person without a physician’s referral to pick up medical marijuana for a person who does have a referral.)

Regardless of one’s personal opinion about medical marijuana, there are variables that need to be taken into consideration when regulating for safe access and assuring access in our rural communities.

Dis-incentivizing the Black Market

Part of safe access is practical access. A regulated system can get black and grey market activity out of the legal program. However, black markets can and do continue to exist just as they do for pharmaceutical drugs and a vast number of legal and illegal commodities and services. Part of the goal of any successful medical marijuana program is to assure the illegal, less safe market isn’t a more reasonable point of access than the regulated program.

Unreasonable taxation can make legal access uncompetitive with black market access. Making it too difficult to open a dispensary or obtain a license can also result in black market access being the only available access. This may turn out to be true particularly in rural areas. Prohibitionists often enable the black market with policies that make legal access less practical than the black market, even for patients that qualify for physician referrals.

Though analogies between the alcohol black market of Prohibition (bootlegging and speakeasies) and the black market for marijuana may not be perfect, it is informative to look at the approach of Rear Admiral Luther E. Gregory who was appointed to Washington State’s new Liquor Control Board when federal Prohibition was lifted. Lawmakers wanted to tax alcohol heavily. However, as with marijuana, the black market was well-established.

First, instead of cracking down on bootleggers and speakeasy operators, Gregory gave them amnesty and issued licenses to anyone willing to play by the state’s rules. Second,

backed by the governor and his influence in the Senate, Gregory arranged for alcohol taxes to be set as low as any in the nation, which allowed those willing to follow the law to keep a significant amount of their profits, and it made room for legal operators to compete with bootleggers' prices...

Predictably, this caused some turmoil in a legislature anxiously awaiting an infusion of cash from liquor sales, but the governor backed Gregory. Faced with a low cost of entry and legal profits, bootleggers and speakeasies around the state mostly turned legitimate. Meanwhile, the few remaining stragglers were quickly put out of business, and drinkers flocked to a competitive legal market.

That might have been the end of it, but there was one more piece to Gregory's plan. After holding down taxes—and thus prices—for three years, Gregory abruptly raised taxes so much that they were among the highest in the nation. The price of booze went up, of course, but people kept buying legal liquor and beer. There was no alternative left. Gregory had broken the back of the black market.

(www.theatlantic.com/politics/archive/2016/05/legal-pot-and-the-black-market/481506/)

In sum, what Gregory did was undermine the black market's capacity to compete rather than the other way around. While the MTCIA does not necessarily promote this model of transition, it serves to demonstrate the need for strategic thinking and not putting horses before carts as Montana builds its statutory infrastructure for a transparent, contained, safe, and functional program. Aside from the philosophical and moral argument around taxing medical marijuana patients, there are practical concerns about overtaxing and incentivizing black market access.

Expansion, Attrition, and Consolidation of Providers

Some legislators are concerned about the number of providers becoming too consolidated and creating an industry "bosses" state model. Others are concerned about providers being too ubiquitous. In 2010, in an unregulated environment, the number of providers peaked at 4,448. In 2016, before the program was shut down by the full implementation of SB 423, there were 480 (June 2016). What will happen under the law put in place by the initiative and what might happen with the implementation of further regulatory provisions?

Under the new rules passed by initiative, a provider and any investor in a provider must have been a Montana resident for at least a year. During the 2017 legislative session, the MTCIA will forward legislation to extend this requirement to five years, grandfathering in any provider who was a provider before the extended requirement goes into effect. This provision serves as a protection against an influx of out-of-state cannabis interests attracted by the safety of a more regulated environment in Montana.

The provisions of I-182 allow for new providers who meet the statutory requirements to pursue a license to provide medical marijuana. However, under the structure of the Montana program since its inception in 2004, a provider must "be named" by a patient in order to have the ability to pursue a license. In other words, without patients identifying an individual as their provider,

that provider cannot get a license. Thus, a new provider would need to have enough interested patients to make it worth creating a cultivation and provision environment that meets the new and more formidable requirements.

For example, under the 2011 law, an individual with two patients choosing that individual for their provider could register as a provider and if approved, cultivate up to eight plants under unknown conditions. With the passage of I-182, DPHHS will be executing mandatory inspections and creating standards for cultivation sites. This represents the first time since the program's inception in 2004 that medical marijuana facilities will be regularly inspected by a regulatory agency. It is likely that there are those providers who while able to provide the service under looser regulations will be unable or lack the skills to provide under the adopted higher standards. Most likely, some will not be interested in the additional labor entailed in meeting professional standards. But mandatory inspections will drive up standards and serve as a natural inhibitor of provider number growth.

Whereas new providers may take the place of those leaving the program due to more exacting requirements, attracting patients might be challenging in a system where the adoption of a provider by a patient must precede the cultivation of cannabis. Thus, a patient would have to be willing to sign up with a provider and forgo access for three to four months while the provider gets a seed to point of sale. This would represent a sacrifice many patients will be unable or unwilling to make when there are other providers ready to serve immediately.

If provisions such as seed-to-sale tracking and canopy limits are adopted by the legislature, further attrition of current providers may occur as a result of lacking, or not being interested in pursuing, the needed skill set necessary to utilize the software.

Seed-to-sale software, it should be noted, does not create an undo economic barrier to entry. Many are affordable, the more expensive end costing providers in states such as Washington \$2000-\$2500 per year. But while not an economic burden, some providers may feel intimidated by the expanded skill set necessary to be part of a well-regulated system that involves product tracking. However, it is worth keeping in mind that many jobs, from cashiers to shipping businesses, require the understanding and use of tracking software.

Eliminating the Card System

Montana's program model since 2004 has included the patient card system. A patient receives a referral from a physician and then names who will be providing the patient's medical marijuana when sending in the paperwork to the state. The paperwork triggers the provider's ability to cultivate and provide for the patient. Unless the patient files paperwork changing providers, the patient may only purchase cannabis from the named provider on his or her paperwork. As a result, a patient has limited opportunity to sort the market.

Allowing patients to compare providers and "shop around" for a strain or formula that meets the patient's needs, if implemented, would lead to further consolidation of the market as superior providers are uncovered and sought out. In essence, the card system protects mediocracy as

patients don't have the opportunity, without frequent and burdensome paperwork, to discover the range of quality available.

Eliminating the card system would lead to provider attrition as the patient market would be more free to weigh in. Eliminating the cards would also make it easier for new providers to enter the program. Under the card-free model, providers would have to estimate the needed production to meet the needs of those who would choose that provider in an open system. With a tracking system and canopy limits, over-estimating one's quality and "popularity" among patients would result in economic loss and destruction of product for which there is no patient market.

In an open system, a tracking system can also be utilized at the patient level. Patients must "swipe" a card that indicates to the provider whether or not the sale can be made, that is, whether that patient has already purchased his or her limit.

A combination of regulations and patient choices (market pressure) naturally brings about consolidation. In the best of worlds, consolidation is a natural and slow process. Without the ability of patients to "sort the market" for quality, while always playing an important role, quality will not necessarily play the dominant role in consolidation.

The MTCIA will not be pursuing changes in the program to allow an open market. However, we must recognize its advantage to patients, quality, and competition.

So, why not pursue it now?

The MTCIA aims at a regulatory system that first assures professionalism and safety system-wide. In order to establish a safe, functioning, stable system, the MTCIA seeks to establish best practices such as tracking, canopy-based volume control, and testing to assure all providers in the system are undertaking their responsibilities safely and lawfully. Once the system is stabilized in a place of transparency, containment, and safety, the MTCIA believes the card system should likely be eliminated in the interest of patient choice and the highest available quality of medicine being available to Montanans with debilitating illnesses. Make the system meet safety standards across the board, first. Then we can have greater assurance that wherever the patient chooses to go as s/he sorts the market, a base level of safety is assured.

In addition, the initiative introduced several new regulations that both government and providers must now implement. The proposals in this document create another layer of regulation that also must be implemented. Layering in regulations that allow for systematic development of the program keeps it stable. There is an implicit order in building a system and the proper balance of stability and change are important with each step. Eliminating the card system will introduce significant new dynamics into the program and will likely be most successful acting in a stable, transparent, contained, and functional environment.

Further, as an open system would likely entail tracking patient purchases, the MTCIA believes it is only fair that providers, who deal with significantly higher volumes of product, should be regulated under a tracking system before subjecting patients to such regulatory mechanisms.

It should also be noted that without shifting to a canopy model or another alternative model to tying cultivation limits to a provider's patient numbers, the state cannot eliminate the card system.

Once there are standards met throughout the state and we know there is a base level of safety system-wide, and once we can account for each gram of cannabis produced in the program, and once the state has the tools to make the system accountable, there is no reason patients shouldn't have the right to sort the market.

The MTCIA is committed to a quality medical marijuana program and is opposed to artificial barriers of entry. Other than parameters aimed at containment of the program in-state, the MTCIA believes the ability to meet safety standards and provide a safe, quality medicine should drive the spectrum of choices available for medical marijuana patients.

Building Systems: Phasing in Complexity

Systems expert and theorist Kevin Kelly lays out in his seminal book, *Out of Control*, principles by which systems function and optimize. One of the principles is described as "grow by chunking." Kelly describes this principle as follows:

"The only way to make a complex system that works is to begin with a simple system that works. Attempts to instantly install highly complex organization – such as intelligence or a market economy – without growing it, inevitably lead to failure . . . Complexity is created, then, by assembling it incrementally from simple modules that can operate independently." (p.469)

Montana needs a medical marijuana program that works. Though the 2004 initiative may have provided fundamentals for a program, those fundamentals were never built upon and the system failed. The law then passed by the legislature in 2011 was not intended to allow for a functional program and in that goal it succeeded. That law, as enjoined by the court, allowed for a clumsy, non-transparent, barely regulated system of access for five years.

The initiative of 2016 laid a new foundation, significantly more developed and sophisticated than the 2004 law and aimed at functioning, unlike the 2011 law. But rather than wipe out the 2011 law and start from scratch, the crafters of the initiative chose to layer in provisions to establish responsibility, accountability, and functionality into the program. The aim was to have the minimum in place necessary for an accountable, responsible program should the legislature continue to choose not to deal realistically and effectively with regulating medical marijuana in Montana.

Despite some problematic holdovers from the 2011 law, the initiative's provisions can maintain the program. However, we do not wish to see the same mistakes made in 2017 that were made in 2011 and the years leading up to it. We do not wish to see production "explode" beyond meeting the needs of Montana's patients. We do not want communities unhappy with the program's profile. Nor do we want to see legislative efforts to sabotage the functioning of the

program. For these reasons, we hope the legislature and regulatory agency will consider the layering in, in a responsible, strategic manner, the tools that will make the medical marijuana program in Montana transparent, contained, safe, and functional.

But why pursue these new provisions so soon after passing the citizens’ initiative?

Two reasons:

1. To institute a tracking, canopy-based, mandatory testing environment that works, time, consideration, and planning must be part of the process. Other states have taken a year to put their regulatory systems in place. The basics of the initiative will provide a foundation to sustain the system while preparations are made for the next step.
2. Montana’s legislature meets every 2 years. If we do not pass this next layer of regulations now, it will be three years before Montana has these regulatory elements in place. We do not wish to see the system go that long without the logical next layer of regulations and repeat the mistakes of Montana’s past.

Model for Layering-In Regulatory System Components

Nov 2017	Legislature 2017	Spring 2018	Legislature 2019
I-182 passes	Legislature passes next layer of regulation	Implement tracking, canopy limits/ licensing*	Review updated system De-bug as needed Assess elimination of card system
Licenses & inspections	5 yr residency for providers (current providers grandfathered)		
Visible program	One year to implement tracking, canopy limits/licensing & mandatory testing		

*mandatory testing as soon as standardized, statewide access is available.

Taking Responsibility

There are still those who are not interested in a well-regulated program. There are those who don’t want to see tracking, testing, and the limiting of production because it disallows operating beneath the radar and reduces the opportunity to bend the rules. Though in the minority, there are also those who don’t want a medical marijuana program in Montana to be recognized as responsible and accountable as it interferes with the wish to characterize it as “shady” by nature rather than acknowledging it is the lack of proper regulating that allows “shady” behavior or necessitates rule-bending to perform the service. Some look at what regulation entails and don’t care for the idea of increased bureaucratic activity.

We can't count on those who don't want a system of access to create one that works.

Those who are concerned with bureaucratic oversight must weigh that against the need to ensure the safety of the patients and the integrity of the program. In addition to requiring increased regulatory action at the governmental level, the program also produces jobs in the private sector. Cultivators. Patient services. Accountants. Lawyers. Realtors. Chemists. Software developers. These jobs support families in Montana.

The MTCIA is concerned there will be consequences to failing to develop our state Medical Marijuana Act. We're concerned about out-of-state "green rush" interests. We're concerned about over-production which can feed a black market. We're concerned about a lack of transparency which leaves law-abiding providers open to unsubstantiated accusations of criminal behavior. We're concerned that if Montana providers cannot provide the products patients need, patients will look out of state for those products, subjecting sick people to criminal consequences.

When the citizens voted for the second time in support of medical marijuana access, we believe they were voting for more than the law proposed by initiative. They were stating clearly that Montanans deserve access and a system of access that works. The legislature does, and should, have a role in creating that and the MTCIA looks forward to working with the legislature in taking on the important and exciting work before us.

Appendix A

The Federal Government and State Medical Marijuana Laws

Federal Guidelines

In addition to creating a program that is transparent, contained, safe, and functional, the MTCIA seeks to create a program that enables Montana to further meet the Federal Guidelines for state medical marijuana programs. I-182 was a solid first step in meeting the guidelines. But there is more the state can do to adhere to the guidelines and help protect the system from federal interference.

According to Americans for Safe Access:

“As of 2016, several federal agencies have issued guidelines and other policy memorandums to manage the conflict between federal and state laws as they pertain to medical marijuana. On August 29, 2013 the Department of Justice (DOJ) issued a guidance memo to prosecutors concerning marijuana enforcement under the Controlled Substance Act (CSA) making it clear that prosecuting state legal medical marijuana cases is not a priority.

The memo included eight guidelines for prosecutors to use to determine current federal enforcement priorities. Fortunately, most medical cannabis program’s regulations require the same guidelines ensuring that any business with a license is meeting these requirements as well.”

The federal guidelines are as follows:

1. Preventing of distribution of marijuana to minors;
2. Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs or cartels;
3. Preventing the diversion of marijuana from states where it is legal under to state law in some form to other states;
4. Preventing state-authorized marijuana activity from being used as a cover or a pretext to traffic other illegal drugs or other illegal activity;
5. Preventing violence or the use of firearms in cultivation and distribution of marijuana;
6. Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
7. Preventing the growing of marijuana on public lands and the attendant public safety and environment dangers posed by marijuana production on public lands;
8. Preventing marijuana possession or use on federal property.

Residency requirements will aid in keeping out unwanted actors, including gangs and criminal enterprises. Tracking and production limits (to be discussed later) prevent diversion and using the program to cover criminal activity. Whereas the initiative enabled Montana to better align with federal guidelines, best practices adopted from other states can further protect the program.

A functional regulatory system is not only our best defense against criminal activity and carpet bagging, it protects Montana from federal interference.

The Consolidated Appropriations Act of 2016

(A provision originating in 2013 and extended each year since)

Under federal law, marijuana is not universally illegal. In addition to the federal guidelines provided above, the 2015-16 Consolidated Appropriations Act (CAA) provided that none of the appropriated funds made available to the Department of Justice may be used with respect to the enumerated states “to prevent such States from implementing their own State laws that authorize the use, distribution, possession or cultivation of medical marijuana.”

Montana is one of those enumerated states.

Analysts report that though the Trump presidency could impact states with adult-use (recreational) laws, medical programs are protected by the CAA. Mark Kleiman, professor of public policy at New York University said, "They could shut down the non-medical parts of the legal industry just by getting injunctions. They can't do that to the medical folks because of the appropriations rider," that is, the CAA, the congressional act that bans use of federal money for such enforcement.

Further, according to a December 5, 2016 article at Politico:

When the moderator, FOX News’s Sean Hannity, pressed Trump on the states’ rights aspect, Trump replied, "If they vote for it, they vote for it. But they've got a lot of problems going on right now in Colorado. Some big problems. But I think medical marijuana, 100 percent.

Twenty-nine states allow for the medical and/or adult-use of cannabis. Nearly one in four Americans live in a state that allows for the medical or adult-use of marijuana. Seventy-five million people live in states where cannabis is available for social adult use. Other states have put effective regulations in place for their medical marijuana programs. Citizens of other states have safe access. Montana can do it, too. Our providers, state agencies, and elected officials can certainly accomplish what other states are accomplishing in the U.S. today.