



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services  
Commissioner's Office  
221 State Street  
# 11 State House Station  
Augusta, Maine 04333-0011  
Tel: (207) 287-3707  
Fax (207) 287-3005; TTY: 1-800-606-0215

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# **Maine Medical Use of Marijuana Program Annual Report**

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**Submitted by:**

**Department of Health and Human Services**

## **Introduction and Background**

A landmark citizens' initiative made Maine the 14<sup>th</sup> state to have a medical marijuana law, and one of a handful of states to have a dispensary system to improve patient access to marijuana for medical use. The law that passed on November 3, 2009, created a fast paced timetable for the development of a distribution and registry identification system.

Several aspects of the new law were unclear, as was the method of administering the new requirements. Governor John E. Baldacci created, by Executive Order, a Task Force to:

- Review the implementation of similar laws in other states;
- Make recommendations on the implementation of the law in Maine, including recommendations for changes in the enacted law that are deemed necessary to ensure effective implementation and ongoing monitoring of the medical marijuana program, and protection of public health and safety; and
- Advise the Department of Health and Human Services in its development of proposed rules and fee schedules.

The Task Force report was submitted to the Governor on January 27, 2010, with suggested changes to the law. Public Law 2009 Chapter 631 amended the Maine Medical Use of Marijuana Act, with an effective date of April 9, 2010.

The Department of Health and Human Services is required to submit an annual report by April 1st each year that does not disclose any identifying information about cardholders or physicians, but does contain, at a minimum:

- A. The number of applications and renewals filed for registry identification cards;
- B. The number of qualifying patients and primary caregivers approved in each county;
- C. The nature of the debilitating medical conditions of the qualifying patients;
- D. The number of registry identification cards revoked;
- E. The number of physicians providing written certifications for qualifying patients;
- F. The number of registered dispensaries; and
- G. The number of principal officers, board members, and employees of dispensaries.

The purpose of this report is to fulfill that requirement.

The initiated bill also required the Maine Medical Use of Marijuana Program to be self-sustaining and totally funded from fees collected under the program. The law also allows the program to receive donations. In addition to reporting on the program to the Joint Standing Committees on Criminal Justice and Health and Human Services, the law requires a report to the Joint Standing Committee on Appropriations to account for advances made to the program from the General Fund, as follows:

For fiscal year 2010-11, the State Controller is authorized to advance up to \$250,000 from the General Fund to the Medical Use of Marijuana Fund, established under the Maine Revised Statutes, Title 22, Section 2430 in the Department of Health and Human Services, to provide start-up funds for the implementation of this Act.

Funds advanced to the Medical Use of Marijuana Fund under this section for fiscal year 2010-11 must be returned to the General Fund on or before June 30, 2011. Repayment of the working capital advance is considered an expense of the Department of Health and Human Services in administering this Act, and funds in the Medical Use of Marijuana Fund may be used to repay the working capital advance provided during fiscal year 2010-11.

On April 1, 2011, the State Controller and the Department of Health and Human Services shall report to the joint standing committees of the Legislature having jurisdiction over health and human services matters and appropriations and financial affairs on the status of funds advanced and repaid under this section.

This report is intended to provide a report on this requirement, as well.

## **Program Start-Up Challenges, Issues and Policy Considerations**

The work required to implement the Maine Medical Use of Marijuana Program, hereinafter referred to as MMMP, started the day after the initiated bill was passed by the voters. There were many challenges:

1. **Interface between the new and old law.** Clarity between the old informal affirmative defense system of obtaining marijuana with permission of the physician and the new registry identification card system was not provided until Public Law 2009 Chapter 631 was passed on April 9, 2010. It allowed patients using marijuana for medical purposes a six month period of time to become compliant with the new system.

Thus, the window of opportunity to provide public information to patients, caregivers and physicians about how the new program would be structured was small. Transparency in the development of the program was crucial. Information concerning the MMMP was added to the Department's website. The media provided excellent coverage in order to reach as many citizens as possible with developing information.

In the end, many caregivers and patients waited until the informal system expired, or was about to expire, to apply. By November 30, 2010, 109 registry cards had been issued, and the program was keeping up with the incoming applications. March 15, 2011, the number of applications approved grew to 773.

2. **Rule development.** While the Governor's Task Force held its meetings, the Department began to draft conceptual rules to demonstrate how the program might be structured in response to the citizens' initiated law. It wasn't until Public Law 2009 Chapter 631 was passed, however, that rules could be finalized.

By July 1, 2010, the department was required to have routine technical rules in place. The deadline for accepting applications was July 1, 2010. Emergency rules were adopted on May 4, 2010, and permanent rulemaking was completed with an effective August 4, 2010. To obtain as much public comment as possible, the Department utilized all avenues of media to advertise the public hearing on the proposed rules. The hearing took place at the committee room of the Joint Standing Committee on Health and Human Services, allowing the hearing to be broadcast.

3. **Resource allocation.** Two positions were authorized for SFY '11. Neither position was created in time to prepare for the program start-up on July 1, 2010, since the statutory authority only became final on April 9, 2010. The law specified that if the Department was not accepting applications by July 1, 2010, then qualifying patients could commence an action in Superior Court to compel the department to perform the actions mandated pursuant to the provisions of this chapter. The department began accepting applications in May and met the statutory requirement with existing resources. The positions approved to manage the program were filled in July and August 2010.

Two aspects of the new law required the expenditure of resources to develop the technology necessary to manage the Registry identification card system and to implement the requirement that the department verify to law enforcement personnel whether a registry identification card is valid [without disclosing more information than is reasonably necessary to verify the authenticity of the registry identification card]. Law enforcement need for this information is 24 hours a day, 7 days a week.

The Department engaged Sauper Associates of New Jersey to reconfigure their Automated Licensing Management System, hereinafter ALMS, to meet the needs of the Registry. ALMS is the platform for managing professional licensing at the Department of Professional and Financial Regulation, and this provided a fast turnaround for a functional Registry management data system.

The licensing functionality and minimal standard reporting allows staff to manage the program day-to-day. To renew cards, track complaints and schedule inspections under MMMP, additional features must be configured. In order to prepare this report, an additional view of ALMS data was required.

4. **Law enforcement.** Benefits to patients and caregivers under the MMMP are significant. Under the informal law, a patient or caregiver could be arrested for possession of marijuana and have an “affirmative defense” in court if they had a letter from a physician authorizing them to use marijuana for medical conditions. The new law provides a registration process and anyone with a valid Registry identification card will not be arrested if they are engaged in authorized conduct.

There are several reasons why simply relying on a Registry identification card is not enough for law enforcement. Caregivers are authorized to grow marijuana for their patients. If their patient is no longer participating in the program, then their authority ceases, even though they may have a Registry identification card in their position.

Another reason is prompted by drug enforcement. Law enforcement officials may be pursuing an investigation regarding grow operations. Before entering with a search warrant, determining that a legitimate growing operation is approved at that location will save time and resources.

An interface between the MMMP database and the Department of Public Safety metro switch was designed and is ready for testing. This will provide law enforcement roadside access to data to verify a card holder’s participation in the MMMP or to validate the location of a growing operation. Currently, the system is dependent on a telephone call to DLRS, and only limited staff have access to the data.

5. **Dispensary development.** Public Law 2009 Chapter 631 limited the number of dispensaries that could be authorized to eight. It specified that no more than one could be approved in each of the eight public health districts. This necessitated a competitive bidding process and the development of criteria for selection of the most appropriate application for each district.

By July 1, 2010, the Department had selected six applications. Two of the districts failed to attract applications that met the minimum scoring required. Those two districts were rebid and selections made in August 2010.

Municipalities have played a central role in the development and location of growing locations and dispensary sites. Public Law 2009 Chapter 631 provided little guidance to municipalities on local zoning and ordinance development. Immediately, many municipalities began implementing local moratoriums. While many have already completed their local regulation requirements, several have extended their moratoriums.

The Department anticipated that municipalities would need time to carry out their local processes. No points were awarded to applicants based on location. This foresight, in the end, provided applicants the time needed to work with local officials, even if it meant moving their sites to other locations or municipalities within the district.

6. **Medical conditions.** Start-up challenges related to medical conditions involved public education of patients and physicians. It was clear that some patients who were authorized by their physicians under the informal system would not qualify under the new program.

Explaining the definition of “intractable pain” was of the most concern to the Department with regard to physician certification. It is also difficult to explain to patients that their real pain may not reach the level of “intractable” and that might be the reason why their physician is unwilling to authorize their use of marijuana. Other conditions appear to be more objectively diagnosed.

Some physicians have expressed concern that their patients are merely drug seeking, and may be seeing multiple physicians for prescribed medications and for authorization to use marijuana. This perceived conflict may cause physicians to forego this method of treatment in patients who may indeed benefit from it and possibly decrease their use of addicting pain medications and their side effects. A concern expressed is that the recommendation for marijuana is not included on the Maine Prescription Monitoring Program.

Many patients found it difficult to locate physicians who would consider their use of marijuana for medical conditions. The name of physicians in the program was made confidential by the law. The Maine Medical Association provided a great deal of education to its members about the MMMP and the unduplicated count of physicians participating is steadily increasing. The number of unique physicians is currently 118. Physicians are still concerned with the liability attached to their recommendations should a patient either have an adverse reaction, a drug interaction, or be involved in an accident. Some employers have prohibited their physicians from recommending the use of marijuana. The physician certification forms developed by the Department were augmented by a “consent to treatment” form to be signed by their patients.

7. **Caregivers.** There is a fine line between authorized and illegal conduct. Some growers of marijuana for medical use have been in “business” for a long period of time. They will compete with dispensaries for patients. They are very organized and networked throughout the state. They advertise on the internet for patients. They advertise that they buy and sell across state lines. They advertise they can find physicians who will certify patients for marijuana. They advertise they buy and sell seeds and clones. This is reflective of the medical marijuana culture that existed prior to the formalization of the new Registry system and anticipated inspections of caregiver grow sites. The transition to a regulated industry will bring its enforcement challenges. It will take some time for conformance to be achieved.

The Department does not have a law enforcement function. Inspection of caregiver grow locations has not yet been scheduled due to the newness of the program. Inspections will be conducted with 24 hours notice, and limited to those locations where caregivers grow for three or more patients. Inspections will be limited to whether the marijuana is grown in the required enclosed locked facility, and whether the number of plants and amounts of prepared marijuana are within lawful limits. If unlawful activity is identified, a referral to law enforcement will ensue. The Department may also take samples of marijuana to test for pesticides, mold, mildew and heavy metals.

Law enforcement officers have expressed concern that the Department may not have adequately regulated the number of seedlings caregivers can possess for each patient. While some of their investigations found caregivers under the informal system possessed the correct number of mature plants, the excessive number of seedlings in possession was far greater than needed to produce the proper sized crop, suggesting that a black market operation may be occurring.

Unraveling both authorized and unauthorized conduct will continue to be a challenge. The Department is considering whether to further regulate and define the amount of “incidental” marijuana that may be possessed. Not enough is known about the number of seedlings needed to yield six mature plants.

The quality of medical marijuana is not a science that has been rigorously studied. In contrast to dispensaries, which will be highly regulated, patients will have less information about the quality of the marijuana grown by caregivers. Decisions to grow marijuana, obtain it from a caregiver, or obtain it from a dispensary will be solely a patient decision. The department does not promote one source of marijuana over others. It also does not provide information about individual caregivers, but does provide contact information for the dispensaries because it is public information.

Quality can be defined in various ways. Little peer reviewed literature is available concerning the medical qualities of marijuana. Most research available on the internet is anecdotal as are compilations of experiences in the use of marijuana for various medical conditions, some of which are authorized by Maine law.

Patients want marijuana that contains the right amount of THC (delta-9-tetrahydrocannabinol) and cannabinoids that provide relief for their medical condition. Testing for these levels is not required, nor is it readily available since marijuana is still an illegal drug from a federal perspective. Such testing may be routinely done at dispensaries, and the information provided to patients. However, it is not known whether it will be done at the individual caregiver level.

Anecdotally, a few patients have already terminated a relationship with a caregiver over the quality and price of the marijuana. Not only did the patient feel the quality was inferior, the caregiver, who was recommended to the patient by an internet social media site, did not disclose his/her full name, where the marijuana was grown or how it was grown. Marijuana is susceptible to mold and mildew if not properly grown, and this could make sick patients sicker.

8. **Individuals on probation.** Several inquiries to the MMMP have been made by probationers and those who are incarcerated. A general response to incarcerated individuals is that they cannot possess it in jail facilities of any kind.

Probationers at both the state and federal levels who have conditions that qualify for the medical use of marijuana have posed different issues. The Department has conferred on some case-specific issues as well as conducted general training in the MMMP for federal parole officers.

Regardless of whether it is a state or federal probationary case, thought should be given to the conditions for probation on an individual basis when a patient's physician recommends the use of marijuana for medical purposes. Probation officials have generally commented a lack of concern about use for medical reasons, but came short of recommending patients grow it for themselves.

9. **Hash and kief.** Hash and kief are still illegal to possess or sell. When interpreting the Maine Medical Use of Marijuana Act, as amended, it is important to interpret it in concert with the Maine Criminal Code.
10. **Price.** Some individuals have commented that by accepting the proposals from dispensaries, the state has "set the price" of marijuana obtained from dispensaries. This is not the case. Price will be a function of cost of production, demand and competition. All dispensaries have indicated that marijuana will be available on a sliding fee scale, using any number of formulas for determining "inability to pay". The price per ounce indicated in each of the business plans was the assumption used to determine whether the income expected would cover expenses at a set price. Dispensaries will be operated on a non-profit basis and should not be generating large amounts of revenue in excess of expenses, and all should have a plan for distributing their net revenues at the end of each year, after taking into account their business needs, e.g. expansion or renovation needs.



An interesting point regarding price is the relationship between the price of marijuana acquired from dispensaries and that purchased on the black market. Theoretically, if a patient could purchase marijuana at a reduced price from a dispensary, the patient can sell it on the black market and make money. While this concern has been expressed, there is no way to prevent this from occurring.

11. **Substance abuse and addiction.** Dispensaries are required to provide patients information with regard to substance abuse issues, and recognizing the signs of addiction. There is controversy over whether marijuana is in fact addicting. The concern for the MMMP program is for the patient to take the right amount at the right dose and at the right time, as with any legal drug. Dispensaries will assist patients in finding a therapeutic dose and provide tracking sheets for patients to monitor the dosage against the relief. In the event the patient builds a tolerance to the particular strain of marijuana that requires increased dosing, it is recommended that the dispensary work with the patient to find another strain that can be taken at lower doses. The dispensaries have agreed to collect information on the amount of marijuana dispensed for the varying medical conditions to gain more insight into the therapeutic value for those conditions.
12. **Confidentiality.** Public Law 2009 Chapter 631 explicitly states what must be printed on the Registry identification cards. During design and start-up, the Department realized that caregiver cards do not have to identify the patient by name. Having this name on the card could result in unwarranted knowledge that an individual is a patient in the MMMP when there is no need for law enforcement to know this information. Thus, the Department recommends that this information be deleted and that the patient's randomized number be included on the card instead.

Patient concerns about confidentiality of their medical information continue, even though the information is protected by statute. Potential patients also complain that physician and caregiver names are confidential and they are unable to obtain names from the MMMP. The Department does not support a change that would require the release of names of possible physicians and caregivers, even with that individual's permission, because it could have the appearance of a recommendation which could subject the Department to a liability.

13. **Photo identification.** While the statute provides the authority for the Department to require an individual's photograph on the Registry identification card, this was determined to be a costly and impractical requirement. Instead, the Department requires that a copy of the individual's driver license or other state-issued photo identification card be submitted with the application, and that the card holder present their driver license or photo identification in conjunction with their Registry card for positive identification.

14. **Background checks.** At the present time, the Federal Bureau of Investigation has not accepted Maine’s statutory language for national background checks for caregivers and dispensary workers as being sufficient to authorize fingerprint checks. Fingerprints are the only known way to positively confirm the presence or absence of a disqualifying drug offense. The Department and the Department of Public Safety are pursuing a change in statute that would allow fingerprinting in the MMMP program to determine whether individuals have disqualifying drug offenses.

An example of satisfactory statutory language from the Probate Code that authorizes fingerprinting of adoptive parents using FBI records is as follows:

**“2). The court shall request a background check for each prospective adoptive parent who is not the biological parent of the child. The background check must include a screening for child abuse cases in the records of the department and criminal history record information obtained from the Maine Criminal Justice Information System and the Federal Bureau of Investigation.**

**(i) The criminal history record information obtained from the Maine Criminal Justice Information System must include a record of Maine conviction data.**

**(ii) The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.**

**(iii) Each prospective parent who is not the biological parent of the child shall submit to having fingerprints taken. The State Police, upon receipt of the fingerprint card, may charge the court for the expenses incurred in processing state and national criminal history record checks. The State Police shall take or cause to be taken the applicant's fingerprints and shall forward the fingerprints to the State Bureau of Identification so that the bureau can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the State Police for purposes of this paragraph must be paid over to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety.**

**(iv) The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 620.**

**(v) State and federal criminal history record information may be used by the court for the purpose of screening prospective adoptive parents in determining whether the adoption is in the best interests of the child.**

**(vi) Information obtained pursuant to this paragraph is confidential. The results of background checks received by the court are for official use only and may not be disseminated outside the court except as required under Title 22, section 4011-A.**

**(vii) The expense of obtaining the information required by this paragraph is incorporated in the adoption filing fee established in section 9-301. The Probate**

**Court shall collect the total fee and transfer the appropriate funds to the Department of Public Safety and the department. [RR 2001, c. 1, §21 (COR).]**

There is an exception to the disqualifying drug offense if the conduct would have been legal under the new law. The department has had to interpret conviction information to satisfy the requirements of the law, and some potential caregivers have been disqualified and others have been allowed to participate in the program. However, drug offenders may be able to grow and sell marijuana if they pleaded guilty to a misdemeanor.

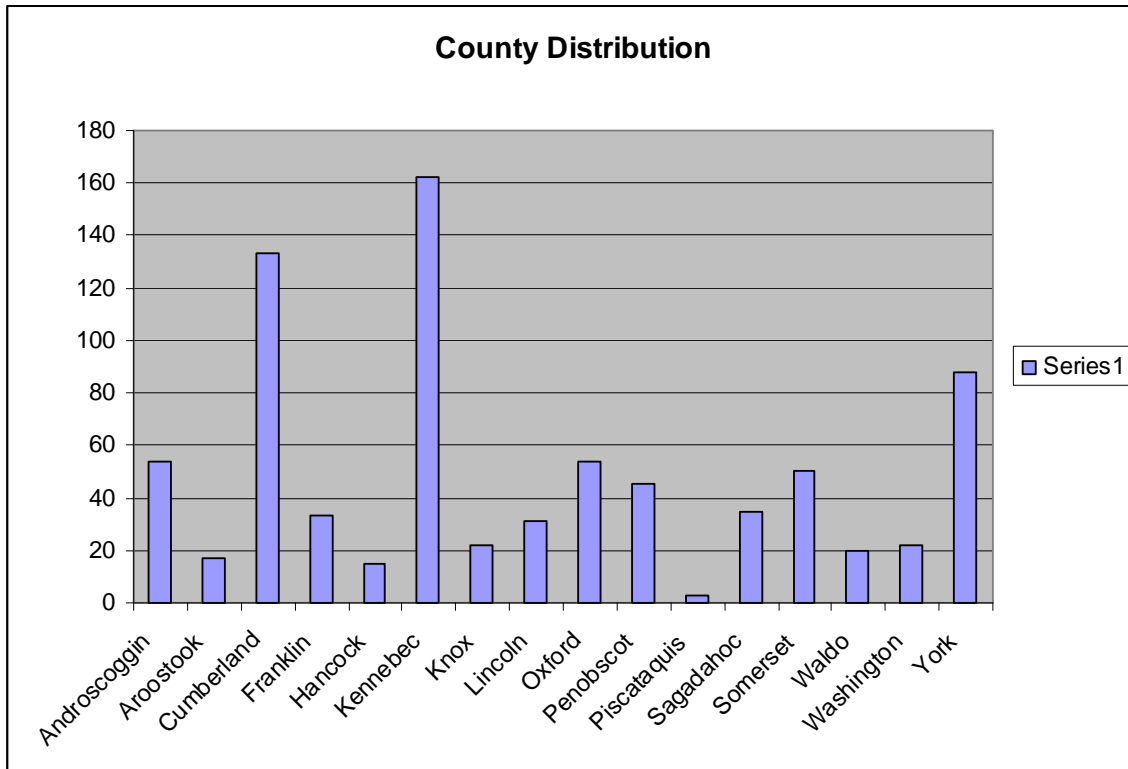
**Reporting**

- 1. The number of applications and renewals filed for registry identification cards as or March 16, 2011:**

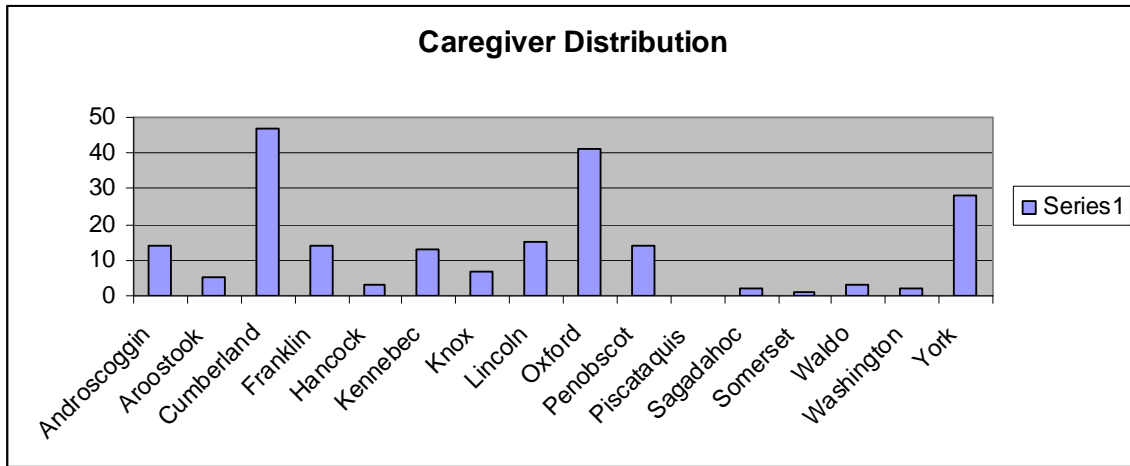
	Active	Pending
Patients	796	310
Caregivers	211	27
Physicians	126	

There have been no renewals issued.

- 2. The number of qualifying patients approved in each county:**



3. **The number of registered caregivers approved in each county:**

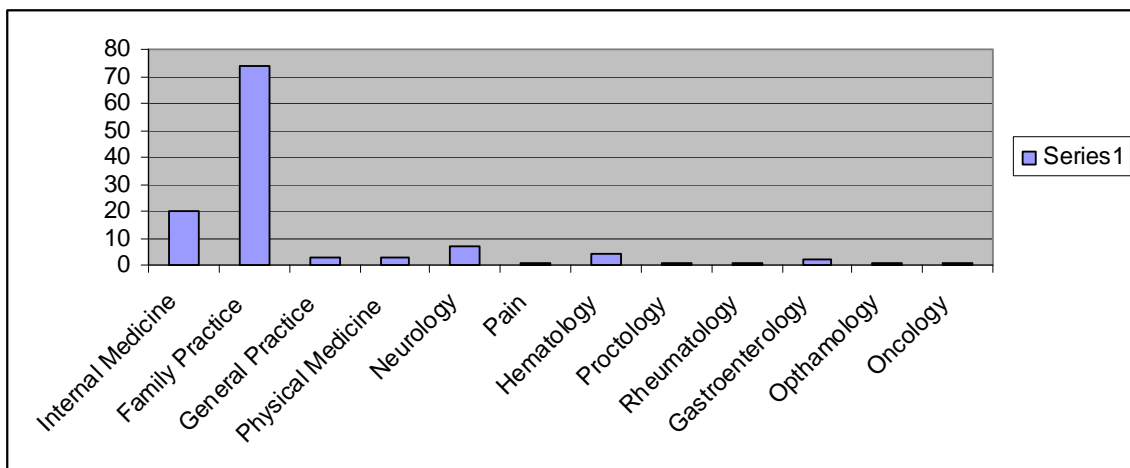


4. **The nature of the debilitating medical conditions of the qualifying patients:**

5. **The number of registry identification cards revoked:**

There have been no registry identification cards revoked as of March 21, 2011.

6. **The distribution of physicians providing written certifications for qualifying patients:**



**7. The number of registered dispensaries:**

The following dispensaries have received their certificates of registration and are currently in operation:

Maine Organic Therapy, Ellsworth, certified 12/22/10 (District 7)  
Remedy Compassion Center, Auburn, certified 1/7/11 (District 3)  
Safe Alternatives, Frenchville, certified 10/4/10 (District 8)

Five additional dispensaries certifications are pending finalization of cultivation sites:

Northeast Patients Group (Districts 2, 4, 5 and 6)  
Canuvo (District 1)

**8. The number of principal officers, board members and employees dispensaries.**

Maine Organic Therapy, 3  
Remedy Compassion Center, 2  
Safe Alternatives, 4

**Revenue and Expenses:**

Maine law requires that the MMMP operate on the revenue it receives from patients, caregivers and dispensaries. The legislature authorized a working capital advance, if needed, effective July 1, 2010. By that time, the department had collected fees from the solicitation of dispensary applications sufficient to support the program until other program fees were collected. No money was drawn down on the working capital advance.

As of March 21, 2011, the department had a cash balance in the MMMP special revenue account of \$124,517.37.

As of March 21, 2011, a total of \$211,176 has been expended, including technology costs of \$113,995 to configure a data system to manage the program. Two staff work full time on the program with the authorized headcount of 2.0.

However, additional department staff are charging to the account as additional assistance to process applications, process walk ins and respond to phone and e-mail requests has required additional resources be assigned. Despite cross training other staff in DLRS to assist with backlog, a backlog of 300 patient applications remains steady.

Many patient and caregiver complaints regarding the fee schedule have been received. However, until the program is fully implemented and enrollment becomes steady, it is difficult to assess whether fees can be lowered.