



Greater Phoenix  
Chamber of  
Commerce

January 5, 2011

Director Will Humble  
Arizona Department of Health Services  
150 N 18<sup>th</sup> Avenue  
Phoenix, AZ 85007

Re: Rule and Regulation of Medical Marijuana in the State of Arizona

Dear Director Humble:

Since 1888, the Greater Phoenix Chamber of Commerce has supported the growth and development of business. The Chamber continues to keep business connected to the community and serves as the collective voice of its more than 2,900 members at the local, county, state and federal levels of government. We believe providing input is critical to elected and non-elected government officials and agencies making public policy and regulatory decisions. These decisions can ultimately have either an adverse impact on the business community or benefit the overall business climate in metropolitan Phoenix. As such, we appreciate the opportunity to be part of the process in reviewing legislation and draft rules and providing our perspective to assist in shaping policy in Arizona. On behalf of the Chamber's membership, please accept and review this letter of comment related to the new medical marijuana rules for the state of Arizona.

#### Overview

Several members of the Greater Phoenix Chamber of Commerce with expertise in areas such as human resources, legal, transportation, insurance and agricultural, have reviewed and discussed the first proposed draft rule language to implement the medical marijuana policy in Arizona. Below please find suggestions for progressing toward a more well-rounded policy providing ample direction for employers, as well as, doctors, patients, dispensaries and others related to this Act. While this comment letter applies specifically to regulatory changes for the Act, the Greater Phoenix Chamber of Commerce also believes further legislation may be required to address issues beyond the authority of the Arizona Department of Health Services. We believe that without providing direction to employers and their employees, it is virtually impossible to ensure appropriate compliance with this Act. Our intent is to solidify ways to protect the public-at-large and ensure commerce can proceed safely within the parameters of this language. We hope these suggestions will lead toward the balance of treating the ill and debilitated while maintaining a productive and safe environment for commerce and the citizens of Arizona.

As the final part of this overview we would like to acknowledge and bring to your attention the 2005 US Supreme Court ruling of the case *Gonzales vs. Raich*. The ruling on this case clearly articulated the federal government's right to ban and oppose medical marijuana as directly interfering with its larger overriding war on drugs, even though the marijuana in this case was privately grown for purely personal medical use. This case was also heard in the 9<sup>th</sup> Circuit for further consideration. Acknowledging the Arizona proposed legislation has already passed, we thought it valuable to inform you of these cases in the event the federal government exercises their right to enforce this ban in Arizona. Despite these rulings, we present to you the comments that follow regarding medical marijuana in our state.

#### Rulemaking Authority

The Act as stated in ARS 36-2803 allows for the regulation of nonprofit medical marijuana dispensaries for the purpose of protection against theft and diversion, and the regulation of the process as related to registration and renewal of applications and fees, identification cards and dispensary registration certificates. Due to the way the Act is worded, the business community has additional concerns that ADHS and others cannot address because they have been denied the

necessary authority to provide protection for the citizens of Arizona and the fragile flow of commerce so desperately needed in the state. Therefore, additional legislation will be required to comply with this Act.

### Definition of Terms

The Act, as crafted by medical marijuana interests and passed by the voters in 2010, uses terminology lacking structured definition which in some cases promotes confusion regarding its current use in statute. Terms in the policy allow for a broad interpretation which may provoke litigation for the courts to discern their meaning. Undoubtedly, this will result in costly endeavors to protect the general public and for employers to comply. Therefore, we encourage further definition of terms used throughout the Act to provide clarity to all of Arizona's citizens, meanwhile acknowledging additional legislation may be required for this purpose. The following terms are examples of concern:

**“Benefit under Federal Law or Regulation” (monetary or licensing)** – as described in ARS § 36-2813(B), we suggest the definition of federal benefit to, at minimum, include any employers who receive federal funding and grants, obtain a federal license, and/or secure a federal contract of any kind. In compliance with the federal Drug-Free Workplace Act of 1988, any firm with a single (or more) federal contract of more than \$100,000 is subject to this Act. This would include any employee, full-time or temporary, who works on any activity under the grant or contract and is on payroll. Additionally, contractors or grantees performing work in federal facilities, involved in federal procurement of utility services, issued order contracts or grants to educational organizations are included in these provisions as covered by the Act.

Furthermore, the United States Department of Transportation (USDOT) has internal drug policy regulations under their Drug and Alcohol Testing Regulation – 49 CFR Part 40, at 40.151(e). These regulations do not authorize “medical marijuana” under a state law to be a valid medical explanation for a transportation employee’s positive drug test result. USDOT has declared the following transportation positions as safety-sensitive and therefore, unacceptable for the following employees to use medical marijuana based on these regulations: pilots, school bus drivers, truck drivers, train engineers, subway operators, aircraft maintenance personnel, transit fire-armed security personnel, ship captains and pipeline emergency response personnel. As an employer befitting the above definition, we suggest these occupations also be identified as positions of benefit under federal law or regulation.

Finally, a number of federal agencies (including the Department of Defense, Department of Energy, Nuclear Regulatory Commission and National Aeronautics and Space Administration) have issued regulations that require federal contractors, grantees and licensees to maintain fitness-for-duty requirements or drug-free workplace programs. For example, licensees for the Nuclear Regulatory Commission (NRC) are also held to similar regulations as under USDOT through the NRC Fitness-For-Duty program defined in 10 CFR Part 26. The NRC regulation addresses the concern of trustworthiness and reliability as related to use of medical marijuana and other hallucinogens. Their regulation is imperative to ensure individuals who are subject to Part 26 requirements are not impaired from using drugs when performing duties subject therein. As this prohibition has concurrence from the Department of Justice, Health and Humans Services and the Office of National Drug Control Policy, we request this personnel and others of similar integrity also be identified in the definition of federal benefit under law or regulation.

**“Impairment”** – as described in ARS § 36-2802(D), the definition of impaired will need further characterization. A study done in 1993 at the University of Iowa College of Medicine showed chronic marijuana use, with a frequency of 7 times or more per week for an extended period of time, imposed deficits in mathematical skills and verbal expression as well as selective impairment in memory retrieval processes. Additionally, an article published by the University of North Carolina Charlotte in April 2010 noted frequent use of marijuana promotes amotivational syndrome which decreases the frequency of doing things that need to be done but individuals may not particularly like doing. Under the new Arizona initiative, the option for frequent use is permissible which may result in this type of behavior, undesirable to employers. Similarly, a study published in the American Journal of Psychiatry in 1985 noted that when experienced licensed private pilots smoked a cigarette containing 19 mg of delta 9-tetrahydrocannabinol (THC), their *“mean performance on the flight task showed trends toward impairment on all variables”* 24 hours later. It further stated, *“Despite these deficits, the pilots reported no awareness of impaired performance. These results may have implications for performance of complex tasks the day after smoking marijuana.”*

As administrators of the process, the Los Angeles Police Department (LAPD) and National Highway Traffic and Safety Administration (NHTSA) both utilize a number of field sobriety tests to determine impairment. LAPD uses one-leg stand, finger-to-nose, walk the line, standing steadiness, nystagmus, pupil reaction, pupil size and pulse rate. NHTSA's process includes a post-arrest investigative procedure called the Drug Evaluation and Classification program. It requires a controlled environment and cannot be executed at roadside. As part of the program Drug Recognition Experts observe and question suspects as they perform individual tests prior to chemical analysis. This program is based on the LAPD program and has been implemented in twenty-six states and the District of Columbia. We suggest these tests and behaviors or portions thereof become part of the definition of impairment to further provide structure around this term.

**“Physician/Patient Relationship”** - as it relates to medical marijuana initiative language R9-17-101, the physician-patient relationship is defined as the interaction between a physician and an individual in which the physician has ongoing responsibility for the assessment, care and treatment of the patient's debilitating medical condition. This language does not speak to the history of their relationship leading up to what may require treatment of medical marijuana. We would like to suggest parameters be established in regard to the relationship of these parties to identify a history of visits with a single doctor or doctors within a single office, appointments regarding the debilitating condition and information regarding the previous treatments which were proven ineffective.

**“Health Benefit Plans”** – as it relates to healthcare provided by public and private employers, we suggest further clarification of this term. Current language provides that neither a government medical assistance program nor private health insurer is responsible for reimbursement to a person for the costs associated with the medical use of marijuana. Worker's compensation is constitutionally mandated medical care provided by employers for employees who are injured during the course of employment. Provisions include wage replacement, compensation for economic loss, dependent benefits due to the death of an employee and reimbursement/payment of medical and like expenses. Therefore we believe the definition of Health Benefit Plan should include care provided pursuant to Article XVIII, Section 8 of the Constitution or any statutes enacted by the legislature relating to workers' compensation.

#### Security of inventory, storage and the transport of medical marijuana

For the safety of Arizona's citizenry, security of medical marijuana throughout the distribution process is critical. Every effort should be made to ensure product is not subject to theft, car-jacking, employee misconduct or any other misuse of medical marijuana. It is essential the distribution of medical marijuana be limited to qualifying patients and not illegally distributed to the general public.

#### **Inventory Control and Storage**

As it relates to the ability to track and store inventory, R9-17-313 and R9-17-315, it's important to have checks and balances within the inventory process to be sure all product is accounted for at dispensaries, caregivers, cultivation sites and food establishments. We suggest the development and implementation of a real-time comprehensive tracking and reporting system to log inventories to and from these establishments. As part of the security precaution, system enhancements should include medical marijuana inventories be stored only in secure locations and containers. This system should allow for oversight by DHS while increasing measures of control at the facilities. This system should also allow for a decrease in time-consuming efforts required by DHS to assist in monitoring inventory activities as well as provide them information pertinent to conducting audits or other necessary control processes.

#### **Transport of Inventory**

Security, as it relates to the transport of medical marijuana product, must be ensured throughout the entire distribution process. R9-17-315 addresses security related to dispensaries, however, we suggest broadening this focus to include the supply chain. In an effort to provide further security and insurance that medical marijuana will be preserved for the ill and debilitated, tracking of product during the movement between facilities, caregivers, etc., is critical. We suggest a tracking process be established and implemented in the state of Arizona to further provide this safety net. For example, the state of Colorado has enacted rules requiring medical marijuana be pre-

packaged at the cultivation site in front of a video camera, logged into an inventory book, weighed at its departure and again at the arrival of the receiving licensed dispensary.

For additional security, we suggest routes from the cultivation sites to the dispensaries be identified and submitted to DHS for approval. Approved route information should be shared with law enforcement and the Arizona Department of Transportation (ADOT). Outside of these agencies, we suggest these routes remain confidential to limit risks which may occur while en route. Acknowledging the challenge and risks associated with security, this effort suggests further legislation should be implemented to preserve the medical product for patients and hinder distribution into illegal markets.

Unfortunately, the Act does not account for transport operators, therefore, additional legislation should be considered. Transport operators should be required to apply and be approved for a license to transport medical marijuana from any point within the supply chain and on any basis of frequency. As part of the process to obtain a license, drivers should be required to submit fingerprints and should not have a prior record consisting of a felony. As drivers may also be considered caregivers, they too should be required to adhere to these same provisions for obtaining a transport license.

Additionally, vehicles used to transport medical marijuana should be properly labeled and identified. We acknowledge the risks associated with labeling vehicles, however we suggest at minimum drivers of these vehicles should have demarcation on their registration form recognizing they are legal transporters of medical marijuana. Penalties should apply for violation or duplication of their medical marijuana transporter license and/or registration.

We also suggest medical marijuana transport vehicles should also have some method of identification for authorities and state agencies. For example, United States Department of Transportation (USDOT) requires commercial motor vehicles (CMV) travelling intrastate to mark their vehicles by displaying the name of the carrier and the USDOT assigned number followed by AZ. ADOT requires the company name, USDOT number, address of the business, telephone number and website, if available, be displayed on both sides of the vehicle. The USDOT number must be visible from a distance of 50 feet at all times. Penalties are applied if the number is not visible. Again recognizing there may be risks associated with labeling vehicles, these examples provide insight to existing processes in use by state and federal agencies which may be applicable in whole or in part therein.

### Protection from Fraudulent Behavior

As it relates to the ability to assist public safety officers and the general public in identifying medical marijuana licenses and ID cards appropriately, we submit the following suggestions:

- A legal example of a caregiver or patient ID card should be posted on the DHS website.
- Security provisions to protect legal identification cards should be established, similar to the Motor Vehicle Division standards.
- A process should be established by which employers can inquire about the legality of an ID card. As access to the database is not likely, an exception-based process for employer utilization is desired by the business community.
- The adoption of automated, robust and electronic procedures to address enrollment and provider fraud and to assist in enforcing the Act. Such a system should validate critical pieces of information such as licensure status, sanctions, certification, criminal record, death, LEIE and EPLS exclusion, DEA/NPI/TIN against authoritative sources at the time of enrollment or re-enrollment via a regular data transfer interface.
- An on-going screening of potential and enrolled users via a screening of recipients. This screen should be set against public records information to support program integrity functions to automatically flag individual beneficiaries for potential fraud, including both identity fraud and unreported location or residency changes.

- The implementation of currently available technology to assess the “actual” address of enrollees/applicants. This technology will provide warning notifications to ADHS and law enforcement when the enrollee is misrepresenting their address. This may minimize efforts from enrollees who register themselves as living outside of the 25 mile dispensary limit but are using that address in name only. The interface should also identify when an enrollee is deceased so appropriate action can be taken in relation to the enrollee’s file and prevent unauthorized use.

Network adequacy and access are always areas of critical importance in dispensary enrollment and on-going dispensary relations. We recommend that the ADHS implement an enhanced provider enrollment process that at a minimum, should:

- Maintain and update a dynamic provider risk profile to be used for ongoing fraud and abuse that should examine associations to excluded providers or felons, ownership or corporate affiliations, and other derogatory indicators. Alert program staff or systems when critical changes to licensure, exclusion, address relocation, criminal record, etc. occur.
- Maintain a system with national and state databases for licensure, death records, tax information, address identification and validate and identify physician specialties for provider’s upon enrollment and for ongoing monitoring when changes occur such as a provider’s license has expired, been suspended, or revoked.
- ADHS should develop provider profiles that assess physicians or providers with multiple regulatory sanctions whose records may indicate.

Again, further clarification in statute relevant to the area of fraud will need to be provided.

#### Conclusion

As previously mentioned, we maintain the position additional enhancement to this policy may be required through the legislative process. We support any necessary legislation which may address the concerns of the business community and employers in relation to misuse of medical marijuana in the workplace and we invite further opportunity for dialogue with you on this issue. As previously noted, our intent is to strengthen this policy for the protection of the state of Arizona and preserve a safe and prosperous economic environment within the parameters of this Act. On behalf of the Greater Phoenix Chamber of Commerce, thank you for the opportunity to submit comment on this very important issue.

Sincerely,



Todd Sanders  
President and CEO  
Greater Phoenix Chamber of Commerce