



GAPS IN THE PENNSYLVANIA MEDICAL MARIJUANA LAW

Proposed Solutions

Danielle Sapega, Esq.

Former Associate Counsel

Penn Medicine Lancaster General Health

INTRODUCTION

The Rise of Medical Marijuana and Growing Trends

Humans have used marijuana in one form or another for thousands of years. Once considered a medication, marijuana was dropped from the United States Pharmacopoeia in 1941 for lack of any accepted medical use.¹ In 1972, as part of President Richard Nixon's "war on drugs," Attorney General John Mitchell placed marijuana on the federal list of controlled substances, indicating that it had a high potential for abuse. It has remained on the Schedule I list ever since. (Schedule I is defined further below.) Other Schedule I substances include, but are not limited to: heroin (diacetylmorphine), mescaline (peyote), lysergic acid diethylamide (LSD) and methaqualone (Quaaludes).

Despite its illegal status under federal law, there has been growing interest in marijuana's potential for medical use, and in 1996 California became the first state to legalize medical marijuana. Proposition 215, also known as the Compassionate Use Act,² aimed to ensure "that seriously ill Californians have the right to obtain and use marijuana for medical purposes..." This landmark legalization conflicted with federal law, and though 29 states have followed California's lead,* the conflicts remain unresolved, and marijuana remains on the Schedule I list.

PENNSYLVANIA LAW

Pennsylvania became the 29th state to legalize medical marijuana in April 2016, with passage of the Pennsylvania Medical Marijuana Act ("the Act"). Following its passage, the Department of Health published temporary regulations for patients, providers, caregivers, growers, and dispensaries.³ In developing the legislation and regulations, the legislature and the Department of Health obviously had the benefit of learning about other states' experiences.

While the Act establishes a legal state process for

patients to obtain medical marijuana, it omits crucial guidelines, protections, and parameters for both patients and providers. These omissions include, for example, immunity of physicians and other providers for actions taken outside the scope of the Act; how hospitals should handle medical marijuana brought into an inpatient facility; and how to resolve conflicts with other Pennsylvania laws and regulations. The rigidity and, at times, ambiguity, of the Pennsylvania law and regulations likely result from its inherent conflict with federal laws, obvious concern about legalizing this substance at the state level, and conflicts among legislators and their constituents.

The Act exists for the benefit of patients, and its preamble states: "The General Assembly finds and declares as follows: Scientific evidence suggests that medical marijuana is one potential therapy that may mitigate suffering in some patients and also enhance quality of life." As a foundational capstone for the legalization of medical marijuana, the Act's goal is improvement in the quality of life of patients suffering from serious medical conditions.

To become eligible for medical marijuana, a patient must be a Pennsylvania resident. A licensed practicing physician must certify that the patient is suffering from one of the serious medical conditions delineated in the law, and that medical marijuana will provide therapeutic or palliative benefit. Patients who meet all the criteria receive state-issued identification cards, which they can present at a dispensary to obtain the medical marijuana product.

The growth, processing, manufacture, acquisition, possession and consumption of medical marijuana, as permitted under the terms of the Act, are specifically deemed not to violate Pennsylvania's Controlled Substance, Drug, Device, and Cosmetics Act, which classifies marijuana as an illegal Schedule I substance. While the legislature specifically included this reference, it also noted that any use of medical marijuana

*As of the date this article was submitted. Of those states, nine permit the sale of recreational marijuana.

outside of the legal parameters of the Medical Marijuana Act is illegal and a violation of the state's Controlled Substances Act, which remains unchanged.

Notably, at this time the Act and the regulations omit mention of hospital facilities, nursing homes, long-term care facilities, and other similar providers who are impacted by certification of patients for use of marijuana. The Act also does not provide explicit immunity for various acts and practices by health care providers that would involve medical marijuana. It does contain specific legal protection for providers, patients, and caregivers "solely for the lawful use of medical marijuana or manufacture or sale or dispensing of medical marijuana, or for any other action taken in accordance with this act." However, this promise of immunity is less comprehensive than it seems, because the Act's other provisions are very light on detail from the perspective of health care providers. Additionally, while the Act explicitly permitted minors to use medical marijuana obtained outside the Commonwealth, this provision expired in May 2018. This was the only legally permissible "outside" marijuana allowed in the state, which, by omission, renders illegal all "outside" marijuana brought into the state by residents or non-residents.

FEDERAL LAWS AND FEDERAL CASE LAW – SCHEDULE I

The federal Controlled Substances Act classifies marijuana as a Schedule I substance, with Schedule I defined as a "drug or substance with high potential for abuse, no currently accepted medical use in treatment in the United States, and there is no accepted safety level for use of the drug or other substance under medical supervision." Pursuant to the Supremacy Clause of the United States Constitution, federal law preempts state law in the occurrence of conflict.⁴ This means that legality under state law cannot impact marijuana's illegal status under federal law, which has major implications for anyone planning to become active in any aspect of the Medical Marijuana Program.

Congress has, to date, declined to amend the federal Controlled Substances Act to decriminalize marijuana, though these issues have been raised in the past. In 2011, the Drug Enforcement Agency (DEA) denied a petition to remove marijuana from the Schedule I classification, explaining that there was no scientific evidence to support the rescheduling.⁵

In 2013, Deputy Attorney General James Cole of the Department of Justice (DOJ) issued a memorandum on the topic of marijuana enforcement.⁶ Known

as the Cole memo, it acknowledged that marijuana is illegal, but advised that the DOJ's focus of enforcement would be to higher level, more serious crimes such as prosecuting criminal gangs, cartels, and other enterprises that sell and transport marijuana. Cole stated that the DOJ would leave enforcement of personal, private use of marijuana to state authorities, emphasizing that it relies on state government to establish, monitor, and enforce its own laws about marijuana-related conduct, and to ensure safety and controls around marijuana use. While this memo provided some insight into the otherwise looming conflict between the states and the federal government, the Cole memo was formally withdrawn on January 4, 2018, by Attorney General Jefferson Sessions, when Sessions issued a memorandum of his own.⁷ Sessions' memo reiterates the illegality of marijuana, and notes that prosecution of crimes related to marijuana will be determined by objective factors without regard to the guidance previously provided by Cole.

Despite the conflicting messages from the DOJ, other federal-level actions have provided some hope and guidance for advocates and stakeholders seeking clarity. In 2014, Congress passed a financial restriction rider to a government spending law that prohibits the DOJ from spending federal funds to interfere with state medical marijuana programs.⁸ This rider, known as the Rohrabacher-Farr Amendment ("the Amendment"), prohibits funds made available through the federal budget law to be used by the DOJ to interfere with any states' implementation of their own medical marijuana laws that authorize the use, possession or cultivation of medical marijuana. Although the rider is intended to protect all legal state-level operations, the DOJ continues to prosecute growers and other industry businesses. After being charged with multiple federal criminal drug charges, a group of marijuana growers in the Washington and California areas appealed the federal charges, claiming protection under the Amendment's terms. The appeals were consolidated and heard before the Ninth Circuit in the case of *United States v. McIntosh*. The court acknowledged the conflict, and in handing down the decision, ultimately found for the growers.

This decision was crucial for growers and other medical marijuana stakeholders, but its national benefit is limited. First, the Ninth Circuit's jurisdiction only covers the westernmost part of the country, and therefore the ruling is merely persuasive and not precedential in the other federal jurisdictions. If, for

example, a similar case were brought in the Third Circuit, which covers the entire Commonwealth of Pennsylvania, the court could look to the Ninth Circuit decision for guidance, but would not be required to rule the same way. Second, the *McIntosh* ruling only lasted as long as the Amendment remained valid law, which was through September 2018. At the time of writing this article, Congress had not officially announced if it was contemplating another extension, so it had already expired. If the Amendment is not renewed, any protections – legislative or judicial – disappear along with it. While limited, the *McIntosh* decision does show that the Amendment fulfilled its purpose of protecting legal, state-sanctioned, marijuana programs.

FEDERAL AGENCY LAWS AND REGULATIONS AND PRIVATE ACCREDITING BODIES

The Centers for Medicare and Medicaid (CMS) is the single largest payer for health care services in the United States. Medicare and Medicaid cover approximately 60 million and 74 million beneficiaries, respectively. The vast majority of health care providers accept patients with this form of coverage, and in order to accept payment from CMS for health care services, providers must abide by laws and regulations on numerous matters, including billing, licensure, quality, privacy, and anti-discrimination. Nonetheless, CMS has remained silent on medical marijuana, and has not issued any definitive statements or guidance for health care providers or for patients.

Still, the silence of CMS on medical marijuana does not eliminate the aforementioned conflicts. According to CMS regulations, billing Medicare entails certification of compliance with all state and federal laws and regulations. These Medicare-specific regulations are known as the “Conditions of Participation,” and according to CMS, “these health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.” Certain Conditions of Participation conflict with the Pennsylvania Medical Marijuana Act directly or indirectly, including certain pharmacy and physician/nursing requirements, discussed below in the Recommendations section.

CMS is not the only federal agency about which health care providers have significant concerns when deciding how to address medical marijuana. Physicians who maintain DEA licensure are not permitted to prescribe a Schedule I substance.⁹ In addition to the prohibition on *prescribing*, the DEA also prohibits a practitioner from *administering* a Schedule I substance,

which means that physicians and other clinicians with DEA licenses cannot assist patients to administer medical marijuana.

While the Medical Marijuana Act specifically labels the physician documentation provided to a patient as a “certification,” as opposed to a “prescription,” the certification serves a purpose that is essentially identical to that of a prescription. The legislature was cognizant of the conflict caused by the DEA’s prohibition against prescribing marijuana, which is why the word “certification” was selected over “prescription.”¹⁰ The Controlled Substances Act defines prescription as “an order for a medication which is dispensed to or for an ultimate user.” If the choice of words is viewed as a mere technicality, a court or administrative body may interpret the words to mean the same thing in the event of a hypothetical criminal prosecution or an administrative licensure revocation. Pharmacists have a similar prohibition against dispensing Schedule I substances under their DEA licenses.¹¹

There is internal conflict on the federal level, in addition to conflict with state laws. Health care providers and patients alike must navigate the conflicts, and assess risk related to recommendation, certification, and use of medical marijuana.

RECOMMENDATIONS

By legalizing medical marijuana on a state level, the Pennsylvania legislature and Department of Health have opened the door to participation in the program to a wide variety of stakeholders across the Commonwealth. While it is clear that neither the Pennsylvania legislature nor the Department of Health can change the federal law, nor directly mitigate the federal risks of taking part in the program, they do have an obligation to address internal legal conflicts with other Commonwealth laws, and to make the state-level protections as strong as possible. To do so, the legislature should amend the current laws to facilitate patient access, and to assuage concerns of health care providers (both individuals and facilities), related to a few key areas discussed herein.

States cannot promise immunity against federal enforcement, but they do have the power to create protections internally.

I. Immunity for Health care Providers

A key component of any medical marijuana program law is a broad, clear provision promising immunity against state criminal or civil sanctions for any type of legitimate involvement with the Program. This includes

protections not only for health care providers, but also for patients, caregivers, dispensary owners, growers, and any other potentially involved or impacted parties.

Civil immunity for health care providers does not mean immunity under the Medical Care Availability and Reduction of Error Act, colloquially known as Pennsylvania's "medical malpractice" law. To date, there have been no lawsuits filed in Pennsylvania courts based upon a violation of the MCARE Act related to medical marijuana, so there is only speculation as to how such a case would be handled. With no precedent, it is difficult to provide guidance on this specific issue. Nonetheless, an alarming number of insurance brokers now offer special medical marijuana insurance coverage, and marijuana business insurance coverage, to marijuana organizations.¹²

The Pennsylvania Controlled Substances, Drugs, Device, and Cosmetic Act was not amended following implementation of the Medical Marijuana Program, so marijuana continues to be listed as a Schedule I substance under Pennsylvania criminal law. While this is not surprising, since Pennsylvania did not legalize *recreational* marijuana, the fact that marijuana, regardless of whether it is medical or not, is still illegal, means that unless explicitly permitted by the Act, any use or action involving the substance is technically illegal. This is problematic in general, but in the wake of other applicable, but inadvertently conflicting laws, health care providers in particular need better protection than the law currently provides.

Pennsylvania law prohibits the inpatient administration of a patient's home medications brought to the hospital, unless and until the attending practitioner has written an order for their administration.¹³ Additionally, the law prohibits self-administration of *any* medication in the inpatient setting unless prescribed in writing by the attending practitioner.

If a patient brings his or her legally obtained medical marijuana into an acute care facility, an attending practitioner cannot write an order or prescription for the medical marijuana for several reasons. First, it is an illegal Schedule I substance under federal law, and as discussed previously, DEA licensure does not permit Schedule I prescriptions. Second, there is no such thing as a "prescription" for medical marijuana, only a "certification" as specified in the Medical Marijuana Act, so it is virtually impossible for health care providers to comply with these regulations. This also creates an issue for acute care hospitals, because the hospital cannot comply with the laws if the patient wishes to continue

use of the medical marijuana in the inpatient setting. It also raises the loaded question of the appropriate steps to take when a patient brings medical marijuana to the hospital.

Health care providers clearly play a significant role in the success and growth of the Medical Marijuana Program. The state should, ideally, amend the Pennsylvania Controlled Substances Act to account for medical marijuana, and it should also amend the Medical Marijuana Act to clarify that providers can do more than simply certify patients. The more comprehensive the immunity protections, the more reassurance to health care providers that their involvement with the program, in one way or another, is low to no risk on a state level.

The Medical Marijuana Act addresses immunity as follows:

(a) None of the following shall be subject to arrest, prosecution or penalty in any manner, or denied any right or privilege, including civil penalty or disciplinary action by a Commonwealth licensing board or commission, solely for lawful use of medical marijuana or manufacture or sale or dispensing of medical marijuana, or for any other action taken in accordance with this Act:

- (1) A patient.
- (2) A caregiver.
- (3) A practitioner.
- (4) A medical marijuana organization.
- (5) A health care medical marijuana organization or university participating in a research study under Chapter 19.1
- (6) A clinical registrant or academic clinical research center under Chapter 20.2
- (7) An employee, principal or financial backer of a medical marijuana organization.
- (8) An employee of a health care medical marijuana organization or an employee of a university participating in a research study under Chapter 19.
- (9) An employee of a clinical registrant or an employee of an academic clinical research center under Chapter 20.
- (10) A pharmacist, physician assistant or certified registered nurse practitioner under section 801(b).3 (35 P.S. § 10231.2103(a))

While this immunity appears broad at first glance, a more discerning read highlights unfortunate omissions. The protections are specifically limited to actions taken "in accordance with" the Act. The Act does not address

administration of medical marijuana; instruction on its administration; or assistance with self-administration by health care providers. Nor does it address inpatient use or how facilities (including nursing homes, extended care facilities, and other types of residential facilities) should handle a patient's bringing medical marijuana into the facility. Since none of these situations is specifically addressed in the law, as it is now written the law's protections would not extend to those particular actions or places. This means that health care providers are not guaranteed complete protection from criminal prosecution or licensure sanctions even under state law, which is confusing and contradictory.

Contrast this situation with Arizona's medical marijuana law. The Arizona Medical Marijuana Act not only provides criminal immunity and licensure board protections for physicians who provide patient certifications, it also provides broad protections (e.g., criminal immunity, immunity from licensure penalties) for *any individual* who assists a qualifying patient with administration of medical marijuana.¹⁴ The latter provision would include any health care provider of any kind, because the law does not limit the protection to any certain individual, and specifically says any "person." Ideally, any given medical marijuana law should contain protections for anyone (health care provider or otherwise) who is administering or assisting a patient with administration of medical marijuana.

II. Facilities

Considering the various federal laws and regulations, and standards of accreditation bodies, a hospital or other licensed facility has good reason not to permit anyone to bring medical marijuana on premises, even if it is legally obtained under state law. This does not, however, mean that facilities should necessarily take a harsh stance, as patient care and satisfaction are prominent concerns of every facility. If a hospital maintains a strict "no medical marijuana" policy, this can lead to patients having their marijuana forcibly taken from them and discarded if they are admitted as inpatients.¹⁵ Nevertheless, when assessing how to deal with medical marijuana, one of the main concerns of a hospital or health care facility is the risk to its Medicare license, and its need to comply with Medicare's Conditions of Participation.¹⁶

“*Health care providers are not guaranteed complete protection from criminal prosecution or licensure sanctions...*”

As discussed previously, facilities licensed by CMS are accountable to maintain compliance with these Conditions of Participation, which essentially means they must uphold state and federal

law in every aspect of practice,¹⁷ and are frequently surveyed by CMS and other accrediting survey bodies to ensure compliance. Otherwise, they will not be able to bill and receive payment for services, and may have their Medicare license revoked.¹⁸ When a hospital bills for any service provided to a Medicare beneficiary, the facility is certifying compliance with all Conditions of Participation. If medical marijuana is permissibly administered to or by a patient, for example, this certification to Medicare may be considered false, which could result in debarment from the Medicare and Medicaid programs or other related penalties.

One example of a conflicted Condition of Participation specific to acute care hospitals is the requirement for a hospital to provide pharmaceutical services. The Condition of Participation states, "in order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law."¹⁹ The law further provides that "all drugs and biologicals must be kept in a secure area, and locked when appropriate." According to the Medicare Conditions of Participation Survey Guidelines, which provide more detailed information and guidance on the law, this means that the hospital's pharmacy is responsible for procurement, distribution, and control of all medication products used in the hospital. The Guidelines also require that all controlled substances must be securely locked away to avoid diversion or other improper use. Similar to the DEA laws governing practitioners, the DEA Pharmacist's Manual specifically prohibits the prescription, administration, or dispensing of any Schedule I substances. This prohibition creates a legal problem for a hospital and the hospital's pharmacy department if the hospital admits a patient who brings in medical marijuana with the intent to use. The pharmacy could not meet applicable standards of practice by securing, dispensing, or controlling the marijuana because of the broad federal prohibition, and therefore, the hospital would not be compliant with the Condition of Participation.

Similar to the Pennsylvania self-administration law

governing inpatient use, a Condition of Participation requires the hospital staff to evaluate the safety and integrity of self-administered medications brought from home, and the responsible practitioner must issue an order permitting the self-administration of that medication. This requirement is problematic for several reasons. First, facility health care providers likely will not be qualified to evaluate the safety of the patient's marijuana; second, a practitioner cannot legally issue an order (prescription) for medical marijuana. Therefore, the hospital would not be compliant with a Condition of Participation if it permitted patients to bring in medical marijuana for inpatient use. Given these compliance issues, the simplest solution seems to be to ban marijuana, but as previously stated, the simplest solution is not necessarily the best, from the patient's perspective.

Pennsylvania's law does not mention facilities, leaving each facility to decide independently whether to permit inpatient/resident use. This involves weighing the interests of the patient against legal and licensure problems. The lack of legal guidance for facilities in general is not unique to Pennsylvania, as most states' laws do not address facilities. However, a handful of states have medical marijuana laws that do contain provisions governing facilities (including nursing care facilities and acute care facilities). While the state clearly cannot advise a facility to violate federal law, it can, at the very least, acknowledge that facilities face this problem.

Minnesota's health care facilities law was amended to include a specific provision addressing medical marijuana in its facilities:

(a) Health care facilities licensed under chapter 144A, boarding care homes licensed under section 144.50, and assisted living facilities, and facilities owned, controlled, managed, or under common control with hospitals licensed under chapter 144, may adopt reasonable restrictions on the use of medical cannabis by a patient enrolled in the registry program who resides at or is actively receiving treatment or care at the facility. The restrictions may include a provision that the facility will not store or maintain the patient's supply of medical cannabis, that the facility is not responsible for providing the medical cannabis for patients, and that medical cannabis be used only in a place specified by the facility.²⁰

“*One of the main concerns of a hospital or health care facility is the risk to its Medicare license...*”

Note that the law does not tell hospitals or other facilities what to do, but rather, provides parameters on how the facility can choose to govern inpatient/resident use. Admittedly, the law is not particularly strong in its directives, but it is more beneficial than omitting facilities entirely.

III. Reciprocity – Qualifying Patients from Other States

Pennsylvania's law limits legal use and possession of medical marijuana to Commonwealth residents who procured the product from a legally designated Pennsylvania dispensary. Residents of other states who may be visiting or obtaining medical care in Pennsylvania are omitted from the Act's scope of access or protection, which potentially impacts health care providers and negatively affects non-residents. For example: if a hospital decides to implement a process by which it will allow patients to bring in and use medical marijuana, providing they can show proof they are a legally qualifying patient as permitted by the laws of the Commonwealth, this automatically eliminates non-residents from the same hospital privileges held by Commonwealth residents. Another example would be someone visiting family in the Commonwealth who needs an additional supply of medical marijuana pursuant to a valid certification issued out of state. He or she cannot obtain it from a Pennsylvania dispensary. The Pennsylvania law is very proscriptive about who may legally possess and obtain medical marijuana, and the law was drafted without regard to visiting patients.

Pennsylvania can implement a simple fix in its law to allow for some level of reciprocity with other states to permit non-residents to legally use and possess medical marijuana within the Commonwealth. The reciprocity can also include

permissions for non-residents to *obtain* medical marijuana directly from a Commonwealth dispensary.

Several states have reciprocity provisions in their laws. For example, California's medical marijuana law permits an individual with an out-of-state identification card, and proof of temporary residence (e.g., a renter with a utility bill), to legally procure medical marijuana from a dispensary without the need to change their state of residence.

Protection of patients, and permission to possess and use medical marijuana, should not be limited by

state borders. This simple addition to the Pennsylvania law would recognize other states' medical marijuana programs, and eliminate the concern of non-residents who plan to bring their medical marijuana into the Commonwealth.

IV. Public Registry

Under Pennsylvania law, any physician who wishes to certify a patient to receive medical marijuana must undergo a formal registration process with the Department of Health that includes an education requirement, the provision of all pertinent demographic information, and an agreement to have the physician's name listed on a public registry on the Department of Health website. The public registry is intended to facilitate ease of access for patients who wish to be certified to receive medical marijuana, but it raises physician concerns.¹⁰ Anecdotally, physicians have expressed concern about being listed on a public registry due to the potential influx of new patients asking for certification, though not all requests are necessarily legitimate.²¹ While the requirement for education and registration with the Department of Health promotes best practices and patient safety, a forced public practitioner registry could serve as a potential disincentive for otherwise concerned physicians who do not wish to take on the added hassle of drug seekers, patients

who have a condition the physician does not treat (e.g. someone with Crohn's disease who requests certification from an oncologist), and other stigmatizing fears. Pennsylvania is not the only state with this requirement: currently, New York, New Jersey, West Virginia, Florida, and Maryland have public registries similar to Pennsylvania's. However, as the numbers demonstrate, these states are in the minority.

Optimally, Pennsylvania should follow the example of those states that do not have a registry, and permit every licensed physician to certify a patient to receive medical marijuana. Not only would this eliminate physician worries related to the public list, but it would help alleviate patient access issues, to the extent they exist, for patients who are looking for certification. Physicians would still have the choice not to certify, and this decision would be left to their clinical judgment without additional considerations based upon legal requirements.

CONCLUSION

Given the trend toward increasing use of medical marijuana, federal law will, in all likelihood, catch up with state laws at some point in the future. Until then, states and all parties involved in medical marijuana programs, will continue to grapple with the outstanding conflicts.

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LGH POLICY ON MEDICAL MARIJUANA USE FOR INPATIENTS

Editor's Note: *The following medical marijuana policy was adopted by Penn Medicine Lancaster General Health effective August 10, 2018.*

POLICY PURPOSE:

To provide guidance on the appropriate handling of patient medical marijuana use by inpatients in Lancaster General Health (LG Health) licensed inpatient facilities.

POLICY STATEMENT:

LG Health acknowledges that the legalization of Medical Marijuana introduces a new therapeutic option for select residents of the Commonwealth of Pennsylvania diagnosed with serious medical conditions and otherwise meet the criteria to be certified to use Medical Marijuana. LG Health prohibits the use, presence, or consumption of any type of marijuana in all of its facilities, except as explicitly set forth in this policy. Nothing in this policy should be interpreted to require a member of the Lancaster General Hospital (LGH) Medical and Dental Staff to certify a patient as eligible to obtain Medical Marijuana, or to provide blanket authorization for continued Medical Marijuana use by an inpatient.

APPLICABILITY/SCOPE/EXCLUSIONS:

This policy is applicable to all personnel and staff.

DEFINITIONS:

Medical Marijuana: marijuana legally obtained by a Patient or Caregiver for a certified medical use by a Patient. The only legal forms permitted inside LGH are pills, oils, topical forms such as gels, creams or ointments, tinctures, and liquid. **While legal under the Act, Medical Marijuana that must be vaporized or nebulized is not permitted inside LGH. This includes dry leaf form.**

Certifying Physician: The physician who provided the medical certification necessary for the Patient to obtain an identification card.

Serious Medical Condition: anyone of the following qualifying medical conditions:

- Amyotrophic Lateral Sclerosis (ALS)
- Autism

- Cancer, including remission therapy
- Crohn's Disease
- Damage to the nervous tissue of the central nervous system (brain-spinal cord) with objective neurological indication of intractable spasticity, and other associated neuropathies
 - Dyskinetic and spastic movement disorders
 - Epilepsy
 - Glaucoma
 - Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)
 - Huntington's Disease
 - Inflammatory Bowel Disease
 - Intractable Seizures
 - Multiple Sclerosis
 - Neurodegenerative diseases
 - Neuropathies
 - Opioid use disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions
 - Parkinson's Disease
 - Post-traumatic Stress Disorder (PTSD)
 - Severe chronic or intractable pain of neuro-pathic origin or severe chronic or intractable pain
 - Sickle Cell Anemia
 - Terminal illness

Dispensary: An entity which holds a permit issued by the Pennsylvania Department of Health (DOH) to dispense Medical Marijuana.

Caregiver: an individual 21 years of age or older, unless otherwise authorized by the DOH, who is:

- Designated by a patient;
- A parent, legal guardian or spouse of a patient that is under the age of 18; and/or
- Designated to be a caregiver by a parent, legal guardian or spouse of an individual approved by the DOH if no parent or legal guardian is appropriate or available.

Identification Card: A state-issued document provided to Patients and, as applicable, Caregivers, that authorizes access to Medical Marijuana under the Act. Patients who are minors will not receive Identification Cards.

Patient: A resident of the Commonwealth of Pennsylvania who holds a valid Identification Card and legally obtains Medical Marijuana from a Dispensary.

Medical Marijuana Waiver: a waiver of use that a Patient and Caregiver must each sign acknowledging the risks and unknowns around using Medical Marijuana.

PROCEDURE:

A. In the event a Patient is admitted to (including observation status) an LGH facility without a designated Caregiver and possesses Medical Marijuana, staff shall take the following steps:

1. Request to see the Patient's Identification Card and confirm the card has not expired and belongs to the Patient through photo and name comparison.

2. Request to see the Dispensary label of the Medical Marijuana to ensure the product has the Patient's name on it and that it has not expired.

3. If the Patient is unable to meet the criteria in Sections A.1. and A.2., the marijuana product shall be treated as an illicit substance and Security should be contacted to dispose of the product immediately.

4. Once staff has verified that the Patient legally possesses the Medical Marijuana, staff shall advise the Patient of LGH's policy against permitting self-administration of Medical Marijuana in the hospital, and that the Medical Marijuana will be secured as a patient valuable.

5. Staff should immediately contact Security to handle the Medical Marijuana in accordance with the appropriate process for handling patient valuables, including documenting the form of Medical Marijuana secured.

6. Security shall release the Medical Marijuana to the Patient upon the Patient's discharge from the hospital.

B. In the event a Patient with a Caregiver is admitted (including observation status) to an LGH facility, and the Patient possesses Medical Marijuana, staff shall take the following steps:

1. Request to see the Patient's Identification Card and confirm the card has not expired and belongs to

the Patient through photo and name comparison. If the Patient does not have a Patient Identification Card, proceed to B.3.

a. If the Patient is a minor, staff should request to see the minor's state-issued Patient Authorization Letter or state-issued Safe Harbor letter.

2. Request to see the Caregiver's Identification Card and complete the same verification process.

3. Request to see the Dispensary label of the Medical Marijuana to ensure the product has the Patient's name on it and that it has not expired.

4. If the Patient and Caregiver are unable to meet the criteria in B.1., B.2., and B.3., the marijuana shall be handled as an illicit substance and disposed of immediately. If the Patient fulfills the necessary verification criteria in B.1. and/or B.3. but the Caregiver does not, the Medical Marijuana shall be handled in accordance with Section A of this policy.

5. Staff shall educate the Patient and Caregiver on LGH's policy on Medical Marijuana in the hospital.

6. If the Patient wishes to continue use of the Medical Marijuana during the inpatient stay rather than have the Caregiver bring it home, staff shall contact the attending physician to make a determination as to whether the Patient has a medical need to continue use of the Medical Marijuana. In making this determination, the attending physician should contact the Patient's Certifying Physician or, if the Certifying Physician is unavailable, the Dispensary listed on the label to assist in assessing the clinical necessity of continuing the Medical Marijuana.

a. In the event the attending physician does not agree with the Certifying Physician's or the Dispensary's recommendation to continue use of medical marijuana in the hospital, the attending physician shall consult the Division Chief, Department Chair, or CMO/ President of Medical and Dental Staff to make the decision.

7. Once authorized by the attending physician,

the Patient and Caregiver must each sign a Medical Marijuana Waiver. If the attending physician does not believe continuation of the Medical Marijuana is clinically indicated, the Medical Marijuana will be handled in accordance with Section A or the Caregiver may remove the Medical Marijuana from the hospital.

8. If the Patient is authorized to continue, Staff shall document that the Patient is currently taking Medical Marijuana on the problem list. The Medical Marijuana will not be documented in the Medication Administration Record.

9. Inform the Caregiver that he/she will be responsible for administering the Medical Marijuana, storing the Medical Marijuana, and bringing it to and from the hospital for Patient use as needed.

10. If a Patient has a Caregiver, but the Caregiver is not immediately available to take possession of the Medical Marijuana, staff shall contact Security to take possession of the Medical Marijuana in accordance with Section A of this policy. The Caregiver, upon presentation to the hospital and fulfilling the verification process outlined in B.2. of this Section, may obtain the Medical Marijuana from Security.

In the event a Patient or Caregiver does not follow appropriate Medical Marijuana use procedures as described in this policy, or upon refusal of either Patient or Caregiver to sign a Medical Marijuana Waiver, staff shall immediately notify Security to take possession of the Medical Marijuana to store as a Patient valuable until the Patient is discharged, or instruct the Caregiver that he or she must remove the Medical Marijuana from the premises immediately.

In the event staff feel that continued use of Medical Marijuana by a Patient is contraindicated or puts the Patient's health or safety at risk, staff shall immediately contact the attending physician or, if the attending physician is unavailable, the Certifying Physician, or the Division Chief, Department Chair or CMO/President of Medical and Dental Staff.

C. Staff will not, under any circumstances:

1. Handle or administer the Medical Marijuana;

2. Instruct the Patient on Medical Marijuana use or administration;

3. Bring the Medical Marijuana to the Pharmacy;

4. Store the Medical Marijuana for the Patient;

5. Permit a Patient without a Caregiver to keep the Medical Marijuana in the Patient's room;

6. Permit a Patient to use Medical Marijuana requiring a nebulizer or vaporizer; or

7. Address ongoing usage of Medical Marijuana at the time of discharge.

Staff found in violation of this Policy shall be disciplined in accordance with the Employee Counseling and Progressive Corrective Action Policy.

D. General Procedures and Prohibitions

1. Medical Marijuana is not a medication and is not subject to the requirements of the medication management standards of the Joint Commission, the Centers for Medicare and Medicaid (CMS) or the State Board of Pharmacy, including medication reconciliation, medication education, medication administration, and medication verification.

2. Forms of marijuana other than those provided in this policy, or medical marijuana from another state, regardless of the patient's state of residence, will be handled as an illicit substance and disposed of immediately.

3. Any permitted use of Medical Marijuana will not be documented in the Medication Administration Record.

4. When made aware that a Caregiver has administered Medical Marijuana to a Patient, staff shall make a note in the patient's plan of care record.

5. Questions or concerns related to a Patient's Medical Marijuana therapy should be directed to the Dispensary listed on the Medical Marijuana label.

REFERENCE:

<https://www.pa.gov/guides/pennsylvania-medical-marijuana-program/>

The Pennsylvania Medical Marijuana Act (35 P.S. §10231.101 et seq)



Patient Name: _____
 MRN: _____
 Date of Birth: _____
Complete above information or attach patient label to each page.

MARIJUANA CONSENT WAIVER AND RELEASE

Possession or use of marijuana in any form, including any extract or derivative thereof, is prohibited at all Lancaster General Hospital licensed facilities ("LGH") with limited exception. Patients may request to use their own patient-supplied marijuana during hospitalization if the marijuana has been legally obtained in Pennsylvania, the patient and caregiver can each produce state-issued identification cards, and the Attending Physician determines that interruption of ongoing use may result in clinical implications for the patient. Under no circumstance will LGH store or administer marijuana to the patient, and LGH staff shall not take possession of a patient's marijuana or advise on the use of medical marijuana at any time. Marijuana for medical use may only be administered by a legally designated caregiver for which the patient received certification in accordance with Pennsylvania law in the following forms: pill, oil; or topical forms (including gel, creams or ointments). Other legal forms such as vaporized or nebulized are not permitted at any LGH facility.

It is up to the LGH Attending Physician to determine if the patient may continue using medical marijuana. The Attending Physician may require use to be discontinued at any time, at which point any marijuana would have to be removed from the hospital by the caregiver.

Risks of use of marijuana include, but are not limited to the following:

- Marijuana for a medical use has not been studied thoroughly to determine effectiveness, safety, or drug interactions in the various forms in which patients receive it.
- The FDA does not oversee the manufacturing of marijuana for medical use. In the absence of reliable controls over labeling and manufacturing, it is not possible to guarantee that the product content is accurate or safe.
- The risk of temporarily stopping marijuana for medical use is unknown.
- Use of a product for which there is not reliable data on toxicity and drug interactions makes it impossible to adequately monitor the patient's acute condition or safely administer medications.
- The long term effects of marijuana use are unknown. Short term side effects can include, but are not limited to: problems with memory, attention, learning, mood.

By signing this form you acknowledge that:

- You have been advised by your certifying physician of the risks and/or potential risks associated with the continued use of marijuana for medical use above which include contamination, mislabeling, or that the marijuana contents are not accurately reflected by the label, resulting in potential unforeseen adverse effects.
- You have had the opportunity to ask any questions you might have to your certifying physician regarding the continued use of marijuana, the associated risks, and the possible alternatives.
- You have read and fully understand this consent statement.

You further agree on behalf of yourself or as the patient representative of the patient named below, as well as your agents and assigns, to waive, release and forever discharge the LGH, its affiliates, its agents and employees, for any harm, injuries, or damages whatsoever, which are directly or indirectly related to the use of your marijuana for medical use, including but not limited to physical, mental, and emotional harm and/or distress.

 Patient/Legally Authorized Representative Signature Printed Name Date Time

You certify that you are a caregiver of the patient named above and have lawfully obtained marijuana in a form listed above for medical use in Pennsylvania. By signing this release and waiver you agree to be solely responsible for providing the product, giving it to the patient, removing it from the property for storage when not actively needed, and notifying the nursing staff prior to administering it. Medical marijuana may not be stored by the patient on premises at any time.

 Legally Designated Caregiver Signature Printed Name Date Time

 Attending Physician Signature obtaining consent Printed Name Date Time