FEDERAL MEDICAL CANNABIS POLICY UPDATE FOR THE 119TH CONGRESS
FY2026 Appropriations & Medical Cannabis Policy, Other updates

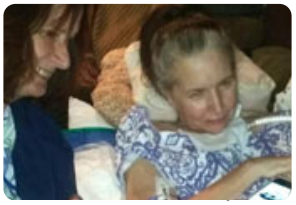
Prepared by: Americans for Safe Access
February 12th , 2026

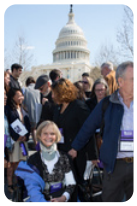
This briefing provides Members of the 119th Congress and congressional staff with a patient-centered overview of how the FY2026 budget will shape federal medical cannabis policy in the coming year. It includes an analysis of President Trump's December Executive Order, the real-world implications of Schedule III classification, and a detailed examination of what a comprehensive national medical cannabis program would entail. **For questions or additional information, please contact Americans for Safe Access at steph@safeaccessnow.org**

BRIEFING INCLUDES:

FEDERAL MEDICAL CANNABIS POLICY UPDATE



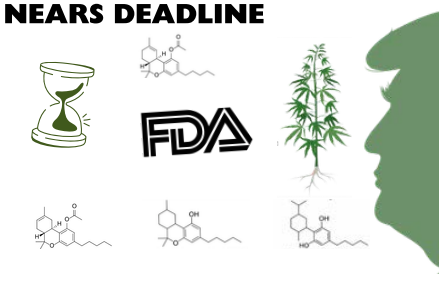




CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
ADVANCES MEDICAL CANNABIS POLICY.
CONGRESS MUST FOLLOW.

In January, the Centers for Medicare & Medicaid Services closed public comments on a **proposed rule that would allow non-cannabinoid hemp products and certain cannabis products legal under state or federal law to be reimbursed under the Special Supplemental Benefits for the Chronically Ill (SSBCI) program**. While a modest step forward, it offers little practical relief for many patients. Individuals in hospice, assisted living, and long-term care facilities are still often prohibited from accessing these therapies until federal law changes—leaving some of the nation's most vulnerable patients caught between policy reform and legal reality.

Read more: www.safeaccessnow.org/cms_advances_medical_cannabis

TRUMP ADMINISTRATION'S ROLE IN NEW HEMP LAW NEARS DEADLINE



This week, the Food and Drug Administration faces a deadline under the new hemp law. By February 10, the FDA must publish a list of all cannabinoids produced by the plant, clarify the definition of THC-related compounds, and define container limits. But this technical exercise will not prevent the loss of access due to the hemp laws. When released, the agency will be implementing the statute, not rewriting it.

See page 3 for more details.

Americans for Safe Access

Founded in 2002, the mission of Americans for Safe Access (ASA) is to ensure safe and legal access to cannabis (marijuana) for therapeutic uses and research.

The widespread misunderstanding of President Trump's December 2025 Executive Order, "Increasing Medical Marijuana and Cannabidiol Research," persists. Although the Order emphasizes research and coordination, it does not resolve core access barriers, create new patient protections, or replace the need for congressional action. **See page 12.**

FY2026 IMPACT ON MEDICAL CANNABIS

"With President Trump's signature this week, more than 95% of the federal government is funded through full-year FY26 appropriations—delivering stability, certainty, and results for the American people."

- The House Appropriations Committee

This appropriations cycle was significant for medical cannabis patients, leaving very few feeling stable or certain about the future of their medicine, particularly those who rely on hemp-derived cannabinoid therapies, veterans dependent on VA healthcare, and patients in newly authorized or underdeveloped state programs.

The following analysis outlines how FY2026 appropriations will impact medical cannabis patients and identifies critical gaps that remain.

H.R. 5371—THE CONTINUING APPROPRIATIONS, AGRICULTURE, LEGISLATIVE BRANCH, MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND EXTENSIONS ACT, 2026

H.R. 5371 delivered two major blows to patient access in November 2025. Under the Agriculture portion of the spending bill, Congress permanently redefined hemp and hemp-derived cannabinoid products. While these changes were long overdue, these provisions, set to take effect in November, will also remove full-spectrum cannabinoid medicines from the hemp marketplace. From a regulatory standpoint, the new language brings clarity. From a patient standpoint, it will bring disruption.

The second blow came in the Veterans Affairs portion of the FY2026 legislation, where hard-fought provisions that were successfully passed in previous House and Senate versions were removed.

A. Agriculture, Rural Development, Food and Drug Administration, and Related Agencies

SEC 781 H.R. 5371 added statutory definitions for hemp products that were omitted from the 2018 Farm Bill, specifically "industrial hemp" and "hemp-derived cannabinoid products." These provisions close what is commonly referred to as the "hemp loophole," which allowed an unregulated market of intoxicating hemp-derived products to proliferate nationwide—a problem states have struggled to contain for years.

Commonly referred to as the "Miller Amendment," this language first appeared in the House version of the Farm Bill in 2024 and was later incorporated into the House and Senate Agriculture Appropriations bills. The provisions do not expire at the end of FY2026 and will take effect 365 days after enactment.

Leading up to the government shutdown, the fate of hemp-derived products seemed uncertain. Although the House Agriculture Committee voted to close the hemp loophole, the provision was removed from the Senate version through a last-minute amendment by Senator Rand Paul. However, a letter signed by a bipartisan group of 39 Attorneys General* on October 24th, urging congressional action, all but sealed the inclusion of clarifying definitions in the final minibus language.

* www.naag.org/wp-content/uploads/2025/10/NAAG_Hemp-letter-to-Congress-2025.10.24.pdf

For many patients, these changes will come as a shock. Hemp-derived full-spectrum products—often purchased online—have become a primary source of cannabinoid therapeutics, particularly in states without functional medical cannabis programs or in markets where patients must compete with adult-use consumers for limited access. While manufacturers have long assured patients that these products were lawful, the Drug Enforcement Administration has consistently maintained that many of these products are illegal, resulting in seven years of confusion, mixed messaging, and inconsistent enforcement.

HEMP PROVISIONS IN FY2026 AG BILL (H.R. 5371: SEC 781)

- **Amends Section 297A of the Agricultural Marketing Act of 1946** (7 U.S.C. § 1639o); provisions do not expire with FY2026
- **Effective Date: November 11, 2026**
- Establishes new definitions for **Industrial hemp, intermediate hemp-derived cannabinoid products, and hemp-derived cannabinoid products**
- Explicitly excludes cannabinoid products from the definition of industrial hemp
- Revises the THC threshold to include **"total THC" (<0.3%),** capturing all detectable tetrahydrocannabinol compounds, including THCa, on a dry-weight basis
- **Prohibits all synthetic cannabinoids**
- Prohibits products containing **more than 0.4 mg THC per container**
- Prohibits seeds capable of producing cannabis varieties exceeding 0.3% THC

For years, millions of Americans have accessed cannabinoid therapies through full-spectrum hemp products sold online and in retail shops. **Patients who rely on hemp-derived cannabinoid medicines—especially those in states with weak or nonexistent medical cannabis programs—are sitting on a fragile lifeline. These aren't "CBD customers." These are people managing seizures, cancer symptoms, neuropathy, chronic pain, PTSD, autism, sleep disorders, and other chronic medical conditions.**

The clock has officially started ticking. Access for these patients will change in 2026. **Without intervention, patients who already live at the margins of the healthcare system risk losing one of the few therapeutic options available to them.**

Key next dates for implementation:

February 10, 2026 — **H.R. 5371 FDA Deadline on Defining Cannabinoids**
SEC 781(3)(A-D): requires the FDA, "in consultation with other relevant Federal agencies," to publish:

A. a list of all cannabinoids known to FDA to be capable of being naturally produced by a Cannabis sativa L. plant, as reflected in peer-reviewed literature;

B. a list of all tetrahydrocannabinol class cannabinoids known to the agency to be naturally occurring in the plant;

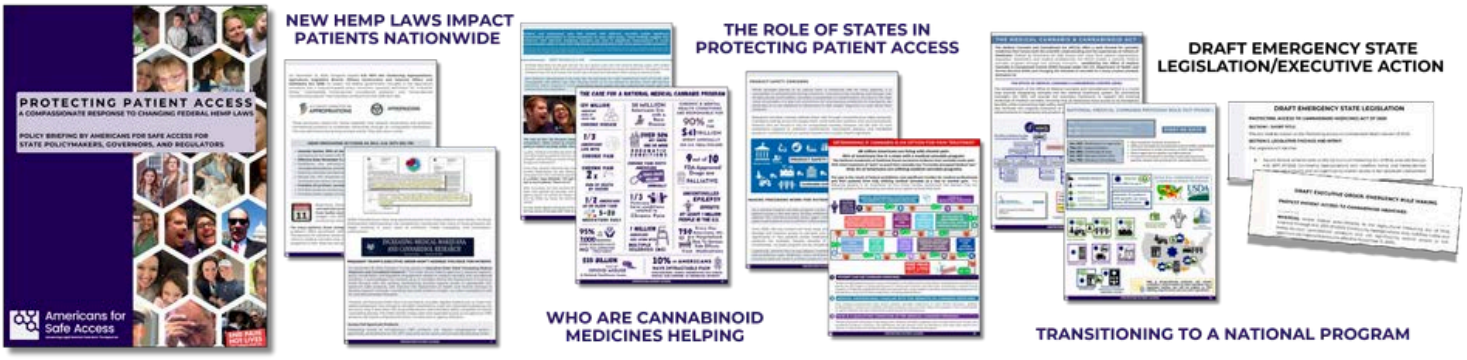
C. a list of all other known cannabinoids with similar effects to, or marketed to have similar effects to, tetrahydrocannabinol class cannabinoids; and

D. additional information and specificity about the term "container," as defined in paragraph (3)(C).*

**[(3)(C)The term 'container' means the innermost wrapping, packaging, or vessel in direct contact with a final hemp-derived cannabinoid product in which the final hemp-derived cannabinoid product is enclosed for retail sale to consumers, such as a jar, bottle, bag, box, packet, can, carton, or cartridge.]*

November 11, 2026 — Effective Date of Hemp Provisions in FY2026 AG Bill (H.R. 5371: SEC 781)

November 11, 2026 — Secretary of Health and Human Services to determine: "any other cannabinoids that have similar effects (or are marketed to have similar effects) on humans or animals as a tetrahydrocannabinol" in accordance with **7 U.S.C. § 1639o(1)(C)(ii)(III)(bb) & (iv)(III)(bb)**



Americans for Safe Access recently released a policy briefing, **Protecting Patient Access: A Compassionate Response to Changing Federal Hemp Laws,** calling on states to create transitional pathways for patients. But state action can only go so far in the absence of federal leadership.

Download Briefing here: www.SafeAccessNow.org/Protect_Patient_Access

OTHER ASA RECOMMENDATIONS- FY2026 AG/FDA APPROPRIATIONS

1. FDA TO REQUIRE HEMP PRODUCT LABELING

ADD language requiring the FDA to issue protocols that require manufacturers of CBD and other hemp-derived cannabinoids to comply with basic federal labeling and safety disclosure requirements.

Labels would include:

- The source of the cannabinoid (e.g., hemp extract)
- A statement noting whether the product has been evaluated for safety by the FDA
- A warning that the product has not been tested for contaminants or adulterants (or a QR code linking to a Certificate of Analysis)
- A batch number for tracking and transparency

2. FRAMEWORK FOR FDA'S REAL-WORLD EVIDENCE PROGRAM & MEDICAL CANNABIS

ADD language directing the FDA to utilize its Real-World Evidence framework—through the Center for Biologics Evaluation and Research and the Center for Drug Evaluation and Research—to generate a comprehensive report on the current use, knowledge base, and educational integration of medical cannabis in the United States. This report should include:

- An overview of medical cannabis research currently underway in the U.S., including NIH-funded studies and research conducted at accredited cannabis research centers;
- A summary of ongoing international medical cannabis research;
- A status update on the inclusion of medical cannabis and endocannabinoid system education across U.S. institutions, including pre-med, medical schools, CME, and other graduate programs;
- An assessment of the impact of the 2018 ACCME guidelines on continuing medical education related to cannabis;
- Recommendations for state medical cannabis programs to (1) harmonize data collection and (2) identify and address key gaps necessary for the integration of cannabis-based therapies into U.S. healthcare systems.

B. Military Construction and Veterans Affairs FY26 bill

The American Legion reports that approximately 22% of veterans currently use cannabis to treat medical conditions, 40% of caregivers know a veteran who uses medical cannabis for symptom relief, and 82% of veterans want to have medical cannabis as a federally legal treatment option. Many veterans find medical cannabis beneficial for managing PTSD, chronic pain, other service-related health issues, and all the other conditions that civilians use cannabis to treat. **However, federal restrictions significantly limit their access.** Although advocates have successfully removed the risk of losing VA benefits for veterans enrolled in state medical cannabis programs, Veterans who need cannabis medicines are on their own.

"VA health care providers are prohibited from recommending, making referrals to, completing forms, or registering Veterans for participation in a State-approved marijuana program. AUTHORITY: 38 U.S.C. § 7301(b)-"Access to VHA Clinical Programs for Veterans Participating in State-Approved Marijuana Programs (111 KB, PDF)." (VHA Directive 1315)

EVERY DAY 19 VETERANS & ACTIVE MILITARY MEMBERS DIE BY SUICIDE

For veterans relying solely on the Veterans Health Administration (VHA) for healthcare, their providers are prohibited from recommending medical cannabis. As a result, veterans must pay out-of-pocket not only for cannabis treatments and state ID card fees but also for consultations with cannabis specialists. Veterans unable to afford these expenses often turn to adult-use markets without medical oversight, unregulated hemp-derived products, or the illicit market. 22% of Veterans report using medical cannabis, VHA medical professionals should have more tools to serve them, and the VA should be learning more from the Veterans' experiences.

For more than fifteen years, advocates have sought to allow Veterans Health Administration (VHA) providers to recommend medical cannabis and assist veterans with state program enrollment. Although such language appeared in both the House and Senate versions of the Military Construction and Veterans Affairs, Agriculture, and Legislative Branch Appropriations Act, 2026, H.R. 3944 SEC 421, it was removed from the final H.R. 5371 package.

H.R.3944 SEC. 421.

None of the funds appropriated or otherwise made available to the Department of Veterans Affairs in this Act may be used to enforce Veterans Health Directive 1315 as it relates to—

(1) the policy stating that ''VHA providers are prohibited from completing forms or registering Veterans for participation in a State-approved marijuana program'';

(2) the directive for the ''Deputy Under Secretary for Health for Operations and Management'' to ensure that ''medical facility Directors are aware that it is VHA policy for providers to assess Veteran use of marijuana but providers are prohibited from recommending, making referrals to or completing paperwork for Veteran participation in State marijuana programs''; and

(3) the directive for the ''VA Medical Facility Director'' to ensure that ''VA facility staff are aware of the following'' [t]he prohibition recommending, making referrals to or completing forms and registering Veterans for participation in State-approved marijuana programs''.

ASA OTHER RECOMMENDATIONS-FY2026 VETERANS APPROPRIATIONS

22% OF VETERANS CURRENTLY USE CANNABIS TO TREAT MEDICAL CONDITIONS

- **UPDATE THE VHA'S ELECTRONIC MEDICAL RECORD SYSTEM TO INCLUDE A CODE FOR "MEDICAL CANNABIS USE."**
- **VHA & MEDICAL CANNABIS REPORT:**

a. Utilizing data from state and international medical cannabis programs, explore cost savings to VHA physicians having medical cannabis as a tool for their patients.

b. Education and protocols would that be required to implement:

- VHA physicians and staff are utilizing cannabis medicines with patients
- VA pharmacies' ability to dispense cannabis medicines
- VA hospitals and hospices accommodating medical cannabis patients
- VHA coverage of cannabis medicine costs

II. CONTINUING RESOLUTIONS FY2026

Provisions affecting medical cannabis patients were also contained in the Commerce, Justice, Science, and Related Agencies and the Labor, Health and Human Services, Education, and Related Agencies appropriations bills.

A. Commerce, Justice, Science, and Related Agencies Appropriations

Since 2014, the Medical Marijuana CJS Amendment has protected state medical cannabis programs, patients, and healthcare providers from federal prosecution, arrest, asset forfeiture, and harassment. The provision has received bipartisan support for over a decade and serves as a critical safeguard as Congress works toward comprehensive medical cannabis legislation.

In July 2025, a coalition of 45 national and state-based organizations representing millions of patients, healthcare professionals, veterans, and caregivers sent a joint letter to congressional appropriators urging them to preserve these crucial protections in the FY2026 CJS Appropriations bill.

Fortunately, the Medical cannabis program protections were included in H.R. 6938, the Commerce, Justice, Science, Energy and Water Development, and Interior and Environment Appropriations Act, 2026(SEC 531), which was signed into law (Public Law No. 119-74) on January 23, 2026, by President Trump.

Americans for Safe Access (ASA) successfully removed the two major provisions from the final funding bill that had appeared in the House version of the FY2026 Commerce, Justice, Science, and Related Agencies (CJS) Appropriations bill passed in September 2025. These provisions sought to block cannabis rescheduling and modify the Medical Cannabis Amendment in ways that would reopen the door to federal interference in state medical cannabis programs, including the imposition of double penalties.

Although these provisions were removed from the Senate version, advocates feared they would reappear in the final bill. This concern was heightened by recent precedent, including the reinsertion of hemp provisions in H.R. 5371 after their removal from the Senate version, as well as the complete removal of medical cannabis provisions that would have allowed VHA physicians to recommend medical cannabis to veterans—despite those provisions having passed both House and Senate versions H.R. 3944.

95% of the 7,000 known rare diseases have no treatment.

Chronic & Mental Health Conditions are Responsible for 90% of the $4.1 Trillion Spent Annually on U.S. Healthcare

$35 Billion Annually on Opioid Misuse & Related Healthcare Costs

NEBRASKA'S EXCLUSION FROM MEDICAL CANNABIS PROTECTIONS

ASA was unsuccessful in having Nebraska included on the list of states receiving protections under the Medical Cannabis CJS Amendment—commonly known as the Rohrabacher-Farr Amendment—which prohibits the Department of Justice (DOJ) and the Drug Enforcement Administration (DEA) from interfering with state-authorized medical cannabis programs.

In November 2024, Nebraska voters approved ballot initiatives establishing a medical cannabis program, which Governor Jim Pillen signed into law in December 2024. ASA had hoped that Nebraska's exclusion was a technical oversight, as this marks the first time since the amendment's initial passage in 2014 that a newly authorized medical cannabis state was not added.

More concerning is that even Senator Deb Fischer, a member of the Senate Appropriations Committee, did not offer an amendment to correct this omission. Although their state had been excluded, all Nebraska delegates voted to pass the amendment, including long-time medical cannabis opponent, Senator Pete Ricketts. Ricketts, Nebraska's Former Governor, has publicly opposed and often has been blamed for Nebraska's particularly contentious struggle for safe access. In March 2025, Senator Pete Ricketts, weighed in on the state legislature's implementation efforts in an op-ed in the Omaha World-Herald, co-authored with the state's Attorney General, warning lawmakers not to allow the program to move forward—an intervention widely viewed as an overreach of his federal position

6 Million+ medical cannabis patients | **70 Million Americans use CBD** | **2/3 of Medical Professionals recognize the medical value of cannabis**

ASA RECOMMENDATIONS-FY2026 CJS APPROPRIATIONS

TECHNICAL OVERSIGHT – ADD NEBRASKA (Sec. 529(a)):

This appears to be an oversight: In November 2024, Nebraska voters approved ballot initiatives establishing a medical cannabis program, which Governor Jim Pillen signed into law in December 2024. Nebraska now meets the criteria for protection under this section and should be explicitly added.

REMOVE SEC. 529(b):

This new language undermines the Congressional intent behind the medical cannabis protections upheld for over a decade. Regulation of dispensary locations is the responsibility of individual states. Adding federal penalties risks destabilizing established, well-regulated programs and unfairly jeopardizes patient access.

SEC. 529(b): "Funds made available under this Act to the Department of Justice may be used to enforce violations of 21 U.S.C. 860.

"21 U.S.C. 860"	Any person who is distributing, possessing with intent to distribute, or manufacturing a controlled substance in or on, or within one thousand feet of, a public or private elementary, vocational, or secondary school or a public or private college, junior college, or university, or a playground, or housing facility owned by a public housing authority, or within 100 feet of a public or private youth center, public swimming pool, or video arcade facility, is subject to: (1) twice the maximum punishment and (2) at least twice any term of supervised release for a first offense.

REMOVE SEC. 607:

This section threatens to derail the federal cannabis rescheduling process, which has been underway since 2022. This effort has involved extensive scientific review and public engagement and is currently under administrative review. Congress maintains oversight authority, but interrupting a robust, science-based process midstream undermines both evidence-based policymaking and public trust.

SEC. 607. None of the funds appropriated or otherwise made available by this Act may be used to reschedule marijuana (as such term is defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) or to remove marijuana from the schedules established under section 202 of the Controlled Substances Act (21 U.S.C. 812).

OPEN LETTER TO HOUSE AND SENATE COMMERCE, JUSTICE, SCIENCE, AND RELATED AGENCIES SUB-COMMITTEES AND THE COMMITTEES ON APPROPRIATIONS:

PROTECT MEDICAL CANNABIS PROGRAMS AND THE 6 MILLION PATIENTS THEY SERVE

Chairman Hal Rogers, Ranking Member Grace Meng, Chairman Jerry Moran, Ranking Member Chris Van Hollen, Chairman Tom Cole, Ranking Member Rosa DeLauro, Chairwoman Susan Collins, Vice Chair Patty Murray, and Honorable Members of the Committees:

We, the undersigned organizations and individuals, **representing millions of Americans who depend on state-authorized medical cannabis programs,** urge you to extend the critical protections in the FY2026 Commerce, Justice, Science, and Related Agencies (CJS) Appropriations bill until Congress creates a permanent solution to align federal medical cannabis policy with state laws.

Since 2014, bipartisan Congressional action has protected patients, caregivers, state regulators, and legitimate cannabis businesses from federal prosecution, arrest, asset forfeiture, and harassment. The Medical Cannabis CJS Amendment, also referred to as the Rohrabacher-Farr Amendment, serves as a crucial safeguard, preventing interference by the Department of Justice (DOJ) and Drug Enforcement Administration (DEA) in states with medical cannabis programs. **President Trump's proposed FY2026 budget omits these longstanding protections, which would put the health of more than six million Americans and those who support their treatment at risk.**

Forty states, the District of Columbia, and four U.S. territories have passed laws creating medical cannabis programs to provide a regulated pathway for individuals living with chronic pain, epilepsy, PTSD, multiple sclerosis, chemotherapy-induced nausea, and other severe medical conditions to access cannabis medicines under the care of their healthcare providers. **The removal of these federal protections would subject patients and the programs they rely upon to unacceptable uncertainty and harm.**

Medical cannabis patients are living with one or more medical conditions or experiencing symptoms for which cannabis or a cannabinoid-based product may be the only treatment option, a more suitable option, or work as an adjunct treatment, including side-effect mitigation from other medications in their treatment plans. Patients consistently report improved symptom relief, better daily functioning, and enhanced mental health with access to medical cannabis.

Medical cannabis programs have become a lifeline for millions of Americans, including many of the 30 million Americans living with one of 7,000 known rare diseases (95% of which have no FDA-approved treatment available) as well as the one-third of Americans who live with chronic pain and the 10% of Americans living with debilitating, intractable pain. In fact, **research generated from the state programs suggests medical cannabis may help some patients reduce or avoid certain high-risk medications, including opioids, contributing to lower rates of overdose and medication-related complications.**

Over the last decade, significant barriers to cannabis reform have been dismantled. Advocates have successfully championed regulatory changes enabling U.S.-based cannabis research, debunked outdated misconceptions in federal agencies, changed the scheduling of cannabis under United Nations treaties, established rigorous safety standards, and demonstrated clear medical benefits recognized by the FDA.

You have the power to protect the health, safety, and dignity of millions of Americans. Until comprehensive, permanent federal legislation is enacted to align federal cannabis policy with state laws and integrate medical cannabis into mainstream healthcare, maintaining the Medical Cannabis CJS Amendment is essential.

We respectfully request your active participation in ensuring these vital protections are renewed in the FY2026 budget. Millions of patients are counting on your leadership.

Sincerely,

Steph Sherer, Founder & Executive Director
Americans for Safe Access

Stephen Dahmer, MD, Director
Andrew Weil Center for Integrative Medicine

Deondra Asike, MD, Clinical Associate
Johns Hopkins School of Medicine

Melissa Chubbuck, MD, Hospice Physician

Bonni Goldstein, MD
Goldstein Wellness

Michelle Novack, Caregiver & Parent

Karen Jaynes, Integrative Health Professional

Anton Harb Jr , Disabled Veteran/1Lt (Ret) USA

Graham Rigby, President & CEO
American Herbal Products Association (AHPA)

Marshall Clabeaux, Vice Chair
Republican Cannabis Caucus

David Hairston, Chairman
Safe Access Tennessee

Gretchen Bergman. Executive Director
A New PATH

Sunil Aggarwal, MD Co-Founder
AIMS Institute

Brandy Zink, Chair
Americans for Safe Access, Michigan Chapter

Leigh Vinocur, MD, MS
Ananda Medical Practice

Sasha Kalcheff-Korn, Executive Director
Realm of Caring

Heather Jackson Founder, Board President
Realm of Caring Foundation

Jill Swing President
SC Compassionate Care Alliance

Mark Harrington, Executive Director
Treatment Action Group

Ellen and Stuart Smith, Co-Directors
Cannabis Advocacy, US Pain Foundation

Yolanda Bennett, Co-Founder
Georgia Medical Cannabis Society

Angela Weston, Co-Founder
Georgia Medical Cannabis Society

Robert Head, Chair
Hemp for Victory

Laurie Kappe, President,
i.e. Communications

Erin Kirk
Connecticut Cannabis Ombudsman

Michael Brennan
CMM-New Jersey

Ryan Vandrey, PhD, Professor
Johns Hopkins School of Medicine

Shanetha Lewis, Executive Director
Veterans Initiative 22

Rene Reisinger, NP
Veterans Initiative 22

Anthony Bowles, Chair
Bay Area Chapter of ASA

Elisabeth Mack, RN, Co-founder
Holistic Caring

Jennifer Bailey, Founder
Homegrown4Heroes

Jeremiah MacKinnon, Executive Director
MPPA

Eric Foster, National Policy Director
M4MM

Laura Barrett, RN Executive Director
National Clinical Director Consortium

Jan Whitney, Executive Director
Parkinson's Association of N. California

Mary Lynn Mathre, RN President
Patients Out of Time

Americans for Safe Access
Safe Access Tennessee
AIDS Action Baltimore
AIDS Foundation Chicago
AIDS United
American Cannabis Nurses Association
American Herbal Products Association (AHPA)
American Legion Blue Sky Post 426
Americans for Safe Access, Michigan Chapter
Asian Cannabis Roundtable
Bay Area Chapter of Americans for Safe Access
Cannabis Business & Professionals United for National Medical Cannabis
Caregivers for National Medical Cannabis
Coalition for Medical Marijuana-New Jersey, Inc.
Epilepsy Foundation of America
Firefighters for Plant Medicine
Global Cannabis Network Collective
Georgia Medical Cannabis Society
Hemp for Victory
Holistic Carings
International Society of Cannabis Pharmacists
A New PATH (Parents for Addiction Treatment & Healing)
The Advanced Integrative Medical Science (AIMS) Institute
International Cannabis Bar Association
Iraq and Afghanistan Veterans of America
Minority Cannabis Business Association
Minorities for Medical Marijuana
Montel Media, Inc.
National Clinical Director Consortium
National Multiple Sclerosis Society
Nebraskans for Medical Marijuana
Parkinson's Association of Northern California
Patients Out of Time
Pharmacists' Cannabis Coalition of California
Realm of Caring
Rhode Island Patient Advocate Coalition (RIPAC)
Republican Cannabis Caucus
Safe Access Virginia
San Diego Chapter of Americans for Safe Access
SC Compassionate Care Alliance
Society of Cannabis Clinicians
State Officials of Connecticut
State of Maine
Texans for Safe Access
Tourette Association of America
Treatment Action Group
US Pain Foundation
Veterans Initiative 22

B. LABOR, HEALTH& HUMAN SERVICES, EDUCATION, & RELATEDAGENCIES

Cannabis medicines are used to treat a variety of medical conditions in the U.S., with patients consistently reporting improved quality of life, reduced pain, better sleep, enhanced mood, and increased mobility with fewer side effects. These experiences have been validatedby a growing body of scientific evidence and by HHS, the FDA, the NIH, and the National Academies of Science.

ASA has long argued that HHS is the natural oversight agency for medical cannabis, and they should find ways to learn more about the experiences of patients and medical professionals are having with cannabis medicines as they wait for Congress to create a framework for nationwide access and healthcare integration strategies.

Despite Trump's executive order emphasizing research and coordination, no dedicated resources were provided in the new HHS budget. The order directs HHS to explore real-world evidence and standards of care, but without funding or statutory authority, these efforts will remain limited.

ASA FY2026 HHS APPROPRIATIONS REQUEST

Medical cannabis is legally used for therapeutic purposes in most U.S. states, yet federal health programs and research agencies lack the infrastructure needed to understand, monitor, and safely integrate patient use into clinical practice. These amendments provide the basic data, research consistency, fiscal analysis, and administrative structure necessary for Congress and HHS to make informed, cost-effective policy decisions.

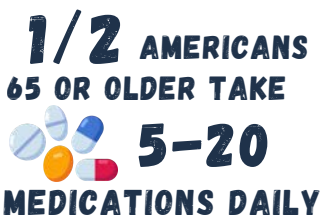
Standardized Medical Cannabis Use Data Collection and Guidance.

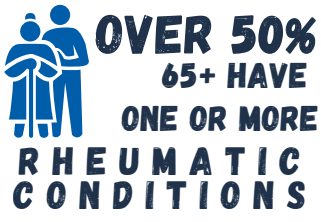
The Secretary of Health and Human Services shall use funds made available under this Act to implement standardized data fields and terminology for documenting a patient's therapeutic cannabis use including route of administration, chemical composition, dose, and frequency of use.—distinct from any questions related to illicit or non-medical cannabis use—within all Medicare (Parts A through D) and Medicaid electronic medical records and patient intake systems. The Secretary shall seek advice from professional organizations such as State medical associations and from clinical experts with demonstrated experience in medical cannabis therapeutics and patient care.

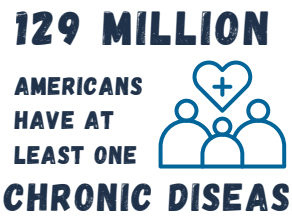
The Secretary shall also develop recommendations and training materials for VHA, private electronic medical record system vendors, and healthcare providers to incorporate comparable data fields to support continuity of care across healthcare settings.

The Secretary shall require that all National Institutes of Health research grants involving cannabis or cannabinoid-related studies utilize the same standardized medical cannabis data set for participant intake and data collection to ensure consistency across federally funded research.

RATIONALE: Standardizing medical cannabis data collection across Medicare, Medicaid, private EMR systems, and NIH research will reduce costly clinical errors, potentially prevent avoidable drug-interaction events, and improve continuity of care. Creating uniform federal data standards also ensures policymakers have reliable, comparable information when evaluating future regulatory or coverage decisions.







Medical Cannabis Cost Savings, Coverage Models, & Implementation Costs.

The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a study assessing potential cost savings to Medicare and Medicaid associated with the therapeutic use of medical cannabis, including impacts on pharmaceutical expenditures, hospitalizations, long-term care, assisted living, and hospice services.

The study shall also evaluate potential coverage models for medical cannabis under Medicare, Medicaid, and Medicare Advantage, including clinically supervised pathways, supplemental benefits, pilot programs, and other mechanisms that may improve patient outcomes or reduce program expenditures.

The study shall further assess the implementation costs associated with incorporating medical cannabis into federal health programs, including but not limited to the standardization of medical cannabis product information, the development of product and billing codes, physician and clinical integration requirements, documentation and data collection systems, and any additional administrative or regulatory adjustments necessary.

RATIONALE: States with medical cannabis programs have reported cost savings to health programs. As Congress is presented with cannabis- and cannabinoid-related policy, it should understand the cost savings for Medicare and Medicaid expenditures—including reductions in pharmaceutical spending, hospitalizations, assisted living, and hospice costs—while also clarifying the administrative resources needed for safe implementation. Understanding both savings and system requirements provides Congress with the evidence base necessary to evaluate future coverage models and broader reforms.

Centralize Cannabis/Cannabinoid Regulations and Oversight

The Secretary of Health and Human Services shall use funds made available under this Act, including funds available within the Department's discretionary budget, to establish an Office of Medical Cannabis and Cannabinoid Control (OMC) within the Department of Health and Human Services. The Office shall be responsible for coordinating and overseeing the implementation of the directives contained in Sections __ and __ of this Act regarding standardized medical cannabis data collection, CMS studies on cost savings and coverage models, and the integration of such data into Medicare and Medicaid programs.

The Office shall also oversee the responsibilities of the Secretary and the Food and Drug Administration under section 781 of H.R. 5371 relating to cannabis and cannabinoid regulation; coordinate with the Centers for Medicare & Medicaid Services regarding requirements under 42 CFR 422.102(f)(1)(iii)(G); and ensure that cannabis- and cannabinoid-related research funded by the National Institutes of Health is conducted in accordance with applicable federal standards, including standardized data sets and documentation practices.

The Secretary shall ensure that the Office is staffed with individuals possessing clinical, regulatory, scientific, and public health expertise relevant to medical cannabis and cannabinoid therapeutics.

RATIONALE: Establishing a centralized Office of Medical Cannabis and Cannabinoid Control within HHS ensures that the Department can hire experts to address cannabis and cannabinoid policy issues and to prevent duplicative spending across agencies. Centralizing responsibility also provides Congress with a clear structure for future policymaking, reducing uncertainty and enabling long-term regulatory planning.

CANNABIS SCHEDULING & TRUMP'S EXECUTIVE ORDER

On December 18, 2025, President Trump signed an Executive Order titled "**Increasing Medical Marijuana and Cannabidiol Research."** The Order directs several federal agencies to advance research and policy coordination related to medical cannabis and cannabinoid products—but does not itself reschedule cannabis, legalize medical use, or create new patient protections.

The Executive Order directs:

The Attorney General to expedite completion of the ongoing process to reschedule marijuana to Schedule III of the Controlled Substances Act (CSA).

The White House Deputy Chief of Staff for Legislative, Political, and Public Affairs to work with Congress to allow Americans to benefit from access to appropriate full-spectrum CBD products, while restricting products that pose serious health risks.

The Department of Health and Human Services (HHS) to develop research methods and models utilizing real-world evidence to improve access to hemp-derived cannabinoid products in accordance with federal law and to inform standards of care.

The Order further specifies that these activities are to be carried out using existing HHS budget authority, underscoring that implementation will depend on agency prioritization and congressional appropriations decisions.

CLARIFICATION: The Executive Order Does Not Reschedule Cannabis

Despite widespread media reporting, the Executive Order does not itself reschedule cannabis. Any change to cannabis' classification under the CSA will not take effect unless and until the Drug Enforcement Administration (DEA) completes the formal rescheduling process initiated under the Biden Administration.

That process had reached one of its final stages—an Administrative Law Judge (ALJ) hearing—before stalling just days before the hearing was scheduled to begin due to an interlocutory appeal filed by a witness. Under the Executive Order, the Attorney General may direct the DEA to move forward using one of several procedural options:

Resume the existing ALJ process, which would require resolving the pending interlocutory appeal and appointing a new Administrative Law Judge to replace Judge Mulrooney.

Terminate the current ALJ proceedings and issue a new Notice of Hearing on Proposed Rulemaking. Under established ALJ case law, any new hearing would still center on HHS's Schedule III recommendation.

Issue a final scheduling determination without an ALJ hearing, proceeding directly to a final rule that would then be subject to judicial review.

Alternatively, the Attorney General could attempt to bypass the existing process by invoking authority under 21 U.S.C. § 811, if sufficient justification can be established. This approach could still require an ALJ hearing, would almost certainly trigger extensive judicial review, and could invite congressional scrutiny under the Congressional Review Act.

Each option carries legal and political risk, particularly given congressional efforts to intervene through the appropriations process.

Schedule III: What It Does—And Does Not—Do For Patients

The Executive Order reinforces public narratives that rescheduling represents a major policy shift. In practice, Schedule III does not meaningfully change patients' legal status or access to care.

While rescheduling acknowledges what patients and clinicians have long known—that cannabis has medical value—it does not:

- **Legalize medical cannabis**
- **Improve state medical cannabis programs**
- **Restore federal rights for patients**
- **Protect patients from discrimination**
- **Ensure nationwide access**
- **Integrate cannabis into federal healthcare systems**

> **CANNABIS HAS CURRENTLY ACCEPTED MEDICAL USE IN THE U.S.**
>
> DEA, DOJ: Notice of proposed rulemaking: Schedules of Controlled Substances: Rescheduling of Marijuana May 21, 2024

Under Schedule III, cannabis remains illegal under federal law outside of tightly regulated federal channels. Patients remain vulnerable to loss of housing, employment, parental rights, veterans' benefits, and other serious consequences simply for following a physician's recommendation.

State-authorized medical cannabis products would remain outside federally regulated medical frameworks unless Congress acts. There is no automatic registration pathway, no prescription model, no federal recognition of state products as lawful medicines, and no clear route for these products to be used in federally sanctioned clinical efficacy trials.

> If marijuana is transferred into schedule III, the manufacture, distribution, dispensing, and possession of marijuana would remain subject to the applicable criminal prohibitions of the CSA.

DEA, DOJ: Notice of proposed rulemaking: Schedules of Controlled Substances: Rescheduling of Marijuana May 21, 2024

Even under Schedule III, cannabis manufacturing and distribution outside federal protocols remain classified as drug trafficking under federal law.

For Schedule III substances, penalties can include:

- **Up to 10 years in prison and a $500,000 fine for a first offense**
- **Up to 20 years and $1 million for subsequent offenses**

State medical cannabis programs are currently protected only through the annually renewed CJS medical cannabis amendment, which applies to medical programs—but not adult-use markets—and must be reauthorized each year. Without this protection, patients and providers face renewed federal risk.

Schedule III & Cannabis Business Tax Deductions

One frequently misunderstood aspect of cannabis rescheduling involves federal tax treatment. While placing cannabis in Schedule III would remove the automatic application of Internal Revenue Code Section 280E, this change alone would not guarantee that cannabis businesses can deduct ordinary business expenses.

Other provisions of federal tax law still apply to activity that remains illegal under federal law. For example, 26 U.S.C. § 162(c) limits deductions related to illegal payments, and longstanding Supreme Court rulings—United States v. Sullivan (1927) and James v. United States (1961)—confirm that income from illegal activity is taxable even when related expenses may not be deductible.

Rescheduling may remove one tax barrier, but without congressional action to create a lawful federal medical cannabis framework, tax treatment for cannabis businesses will remain uncertain.

Access Full Spectrum Products

Expanding access to appropriate full-spectrum CBD products, however, will require congressional action—specifically, amendments to H.R. 5371. Executive action alone cannot override statutory limits.

Securing that legislative pathway will be difficult. The chairs of the House and Senate Commerce, Justice, Science, Health and Human Services, and Agriculture Committees remain strongly opposed to cannabis reform. Compounding that challenge, letters condemning Schedule III were delivered to the White House the day before the Executive Order, signed by 22 U.S. Senators and 26 House Members.

United States Senate

WASHINGTON, DC 20510

December 17, 2025

The Honorable Donald J. Trump
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Trump,

We write to ask you to uphold marijuana's status as a Schedule I drug. Rescheduling marijuana to a Schedule III drug will undermine your strong efforts to Make America Great Again and to usher in America's next economic Golden Age. The only winners from rescheduling will be bad actors such as Communist China, while Americans will be left paying the bill.

Marijuana continues to fit the definition of a Schedule I drug due to its high potential for abuse and its lack of an FDA-approved use. The evidence shows that marijuana is harmful to its users, especially to young people and women who are pregnant and nursing.[1] According to the Substance Abuse and Mental Health Administration, studies show that marijuana is linked to "depression, anxiety, suicide planning, and psychotic episodes."[2] Tragically, mass shootings have a link to marijuana use, including school shootings; in fact, the shooter who attacked a Catholic school in Minneapolis blamed his actions on "gender and weed" and wrote, "I wish I never tried experimenting with either."[3] Additionally, marijuana has long-term effects on brain health, including "permanent IQ loss" when a person starts using marijuana at a young age.[4] Lastly, babies are also at risk from marijuana, as marijuana use during pregnancy may result in "fetal growth restriction, premature birth, stillbirth, and problems with brain development, resulting in hyperactivity and poor cognitive function."[5]

We cannot underfederalize America if we encourage marijuana use. America's workplace and America's roads are endangered by marijuana use. The National Institute for Occupational Safety and Health at the Centers for Disease Control and Prevention has identified studies finding marijuana use to "impaired judgment" and "lack of concentration," as well as research finding increases in industrial accidents, injuries, and absenteeism among employees who tested

We write to ask you to uphold marijuana's status as a Schedule I drug. Rescheduling marijuana to a Schedule III drug will undermine your strong efforts to Make America Great Again and to usher in America's next economic Golden Age. The only winners from rescheduling will be bad actors such as Communist China, while Americans will be left paying the bill.

Tedd Budd, (R-NC) John Barrasso (R-WY), Tom Cotton (R-AR), Shelley Moore Capito (R-WV), James Lankford (R- OK) Roger Marshall (R- KS), Pete Ricketts (R- NE), Tommy Tuberville (R-AL), John Cornyn (R-TX), Marsha Blackburn (R- TN), Jim Banks (R-IN), Ron Johnson (R-WI), Mike Crapo (R-S.D.), Rick Scott (R-Fla.), Bill Hagerty (R-Tenn.), Jim Risch (R-ID), Kevin Cramer (R-ND), Cindy Hyde-Smith (R-MS), Lindsey Graham (R-SC), Cynthia Lummis (R-WY), Dave McCormick (R-PA), and Mitch McConnell (R-KY)

Congress of the United States
Washington, DC 20515

December 18, 2025

The Honorable Donald J. Trump
President of the United States of America
White House
1600 Pennsylvania Ave NW
Washington, DC 20500-0005

Dear President Trump,

We write to urge you to oppose rescheduling marijuana, a harmful drug that is worsening our nation's addiction crisis. Rescheduling marijuana as a Schedule III drug will send the wrong message to America's children, erode drug controls, and make our roads more dangerous.

The Biden Administration rescheduling decision was wrong. Rather than following the science, the Biden White House tried to expand the use of an addictive drug for partisan gain. Contrary to the marijuana industry's assertion that rescheduling will result in more research, the U.S. has already conducted research for decades on this drug. Congress even passed a bipartisan law to expand marijuana research while keeping the drug in

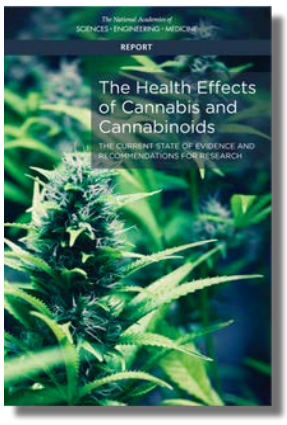
Rescheduling marijuana will not make America great. You have always been a role model for America's youth, telling young people for years that they should never do drugs. We hope that you consider the harms of marijuana rescheduling and continue sending that strong message of hope to the next generation.

Pete Sessions (R-TX), Andy Harris, M.D.(R-MD), Doug LaMalfa (R-CA) , Mary E. Miller (R-IL), Paul A. Gosar, D.D.S. (R-AZ), Michael V. Lawler (R-NY),Robert B. Aderholt (R-AL), Ralph Norman (R-SC), John H. Rutherford (R-FL), Russ Fulcher (R-ID), Chuck Edwards (R-NC), Sheri Biggs (R-SC), David Rouzer (R-NC), Michael K. Simpson (R-ID), Christopher H. Smith (R-NJ), Diana Harshbarger, Pharm.D (R-TN), Mark Harris (R-NC), Aaron Bean (R-FL), Blake D. Moore (R-UT), Michael Cloud (R-TX), Ron Estes (R-KS), Joe Wilson (R-SC), Barry Loudermilk (R-GA), John Rose (R-TN), Mike Flood (R-NE), and Nathaniel Moran (R-TX).

Rescheduling does not create a lawful pathway for state medical cannabis programs or integrate cannabis into federal healthcare systems. The Executive Order's directive for HHS to develop research methods and models utilizing real-world evidence to improve access to hemp-derived cannabinoid products, in accordance with federal law and to inform standards of care, could represent an initial step toward integrating cannabinoid-based treatments into U.S. healthcare systems. See ASA's HHS Appropriations Requests.

The Executive Order acknowledges medical reality—but acknowledgment is not access.

Rescheduling is a necessary step, but a small one. Without congressional leadership to establish federal protections, create a lawful regulatory pathway for medical cannabis, and integrate cannabis and cannabinoids into healthcare and research systems designed around patient safety, patients remain stuck in a holding pattern—recognized, but unprotected.



"There is conclusive or substantial evidence that cannabis or cannabinoids are effective for the treatment of chronic pain in adults, as anti-emetics in the treatment of chemotherapy-induced nausea and vomiting, and for improving patient-reported multiple sclerosis spasticity symptoms."

National Academies of Sciences, Engineering, and Medicine: The Health Effects of Cannabis & Cannabinoids, January 2017

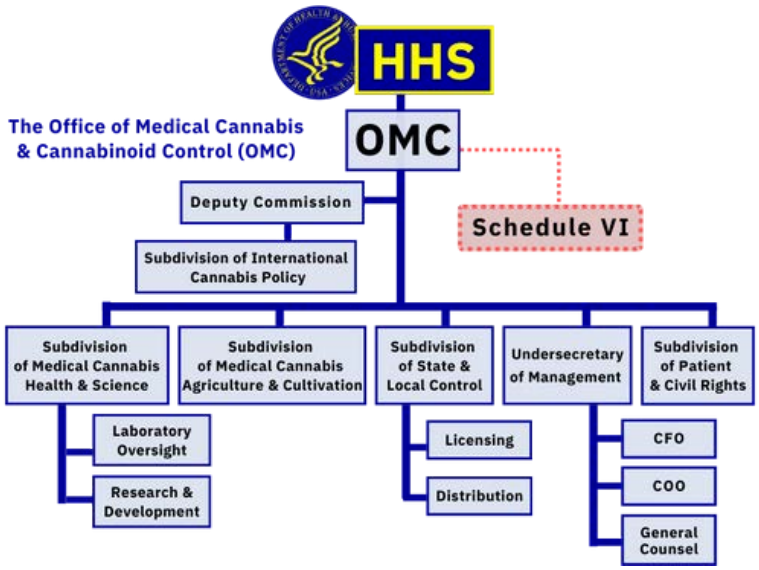
"None of the evidence from the systematic reviews included in our analysis demonstrated substantial safety concerns that would argue against the use of marijuana in any of the indications where there exists some support for its benefit."

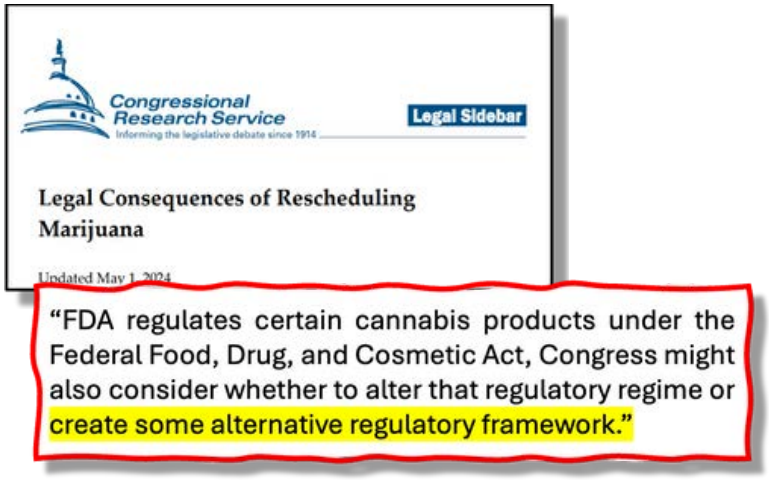
FDA's Center for Drug Evaluation and Research (CDER) "Considerations for Whether Marijuana Has a Currently Accepted Medical Use in the United States for Purposes of Section 202(b) of the Controlled Substances Act"

THE PATH FORWARD: ASA'S MEDICAL CANNABIS & CANNABINOID ACT (MCCA)

Cannabis medicines have become a lifeline for millions of Americans, offering relief when conventional treatments fail or pose risks. The absence of a national medical cannabis program hinders access for many, and unregulated markets pose potential health threats for many more. Integrating cannabis into healthcare systems will enhance the overall quality of healthcare in the United States. Creating a regulatory pathway that acknowledges cannabis as a medicine will allow healthcare stakeholders to adapt to evolving scientific knowledge and offer patients comprehensive care.

The Medical Cannabis & Cannabinoid Act (MCCA), was drafted by Americans for Safe Access (ASA) with input from patient organizations, regulators, researchers, and medical professionals. **The MCCA creates a national medical cannabis program through two primary functions: establishing the Office of Medical Cannabis & Cannabinoid Control (OMC) housed under the U.S. Department of Health and Human Services (HHS) and changing the schedule of cannabis to a newly created schedule (Schedule VI).**




Congressional Research Service
Informing the legislative debate since 1914
Legal Sidebar

Legal Consequences of Rescheduling Marijuana

Updated May 1, 2024

"FDA regulates certain cannabis products under the Federal Food, Drug, and Cosmetic Act, Congress might also consider whether to alter that regulatory regime or create some alternative regulatory framework."

"LEGAL CONSEQUENCES OF RESCHEDULING MARIJUANA"
CRS Report: January 16th, 2024 (updated May 1, 2024)

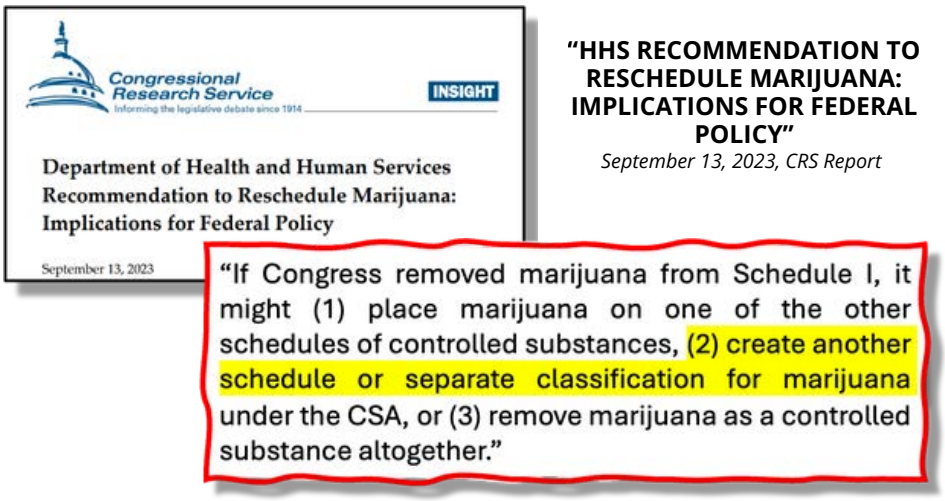
A NEW AGENCY: OMC

The mission of the OMC is to facilitate access to medical cannabis & cannabinoids for therapeutic use and research, regulate the production of medical cannabis and cannabinoid products, facilitate private-public partnerships for product development and research, and oversee the new Schedule VI.

A NEW SCHEDULE: Schedule VI

A Schedule VI classification recognizes cannabis as a botanical medicine with a unique profile. Placing cannabis in its own category would allow regulations tailored to its specific properties and uses. Under Schedule VI, the OMC would oversee these regulations, providing a centralized authority dedicated to cannabis.

Download Full Text: SafeAccess4All.org


Congressional Research Service
Informing the legislative debate since 1914
INSIGHT

Department of Health and Human Services Recommendation to Reschedule Marijuana: Implications for Federal Policy

September 13, 2023

"If Congress removed marijuana from Schedule I, it might (1) place marijuana on one of the other schedules of controlled substances, (2) create another schedule or separate classification for marijuana under the CSA, or (3) remove marijuana as a controlled substance altogether."

"HHS RECOMMENDATION TO RESCHEDULE MARIJUANA: IMPLICATIONS FOR FEDERAL POLICY"
September 13, 2023, CRS Report

WHY CREATE A NEW AGENCY?

Medical cannabis is a new product category (not a dietary supplement, foodstuff, or FDA-approved drug) with a supply chain that spans multiple agencies; effectively enforcing regulations would require an agency with oversight authority. Regulating cannabis medicines will entail more than simply enforcing regulations; it will also require oversight of research to improve product development and inform standards of care. Embracing medical cannabis as part of a national healthcare strategy will demand innovation to forge a new path in American medicine. Botanical medicines are used worldwide but represent a significant departure from allopathic medicine and pharmaceutical protocols.

TREATY OBLIGATIONS

According to the International Narcotics Control Board (INCB), signatories to 1961 International Drug treaties should have a designated agency to oversee medical cannabis programs.

The INCB Report 2022 stated:

The Convention requires that States license and control cannabis production for medical use, establish a national cannabis agency, provide estimates of the national requirements for cannabis for medical purposes, and ensure that medicinal cannabinoids are used in accordance with evidence on their safety and effectiveness and under medical supervision. As far as the specific control measures for cannabis are observed, these medical cannabis programmes are in compliance with the conventions.

WHY NOT PUT OVERSIGHT IN THE FDA?

Today, "FDA-approved" has become synonymous with "medicine" in the U.S. healthcare lexicon. **However, at its core, the Food and Drug Administration (FDA) is a consumer protection agency.** It was initially established in 1906 by the Pure Food and Drug Act to ensure that food and drug labels sold across state lines were accurate and free of harmful adulterants. In 1962, Congress expanded its authority to evaluate health claims through the Kefauver-Harris Drug Amendment for new drugs, ultimately shaping the modern FDA drug approval pathway.

The Act also instructed the FDA to conduct a retrospective review for drugs already on the market. At the time, approximately 19 percent of the U.S. Pharmacopeia's medicinal preparations were plant-based. The majority were synthetic drugs whose efficacy was based on the "single-target/single-drug" or "magic bullet" approach to commercial drug development. **The Kefauver-Harris Drug Amendment did not give the FDA the mandate to determine which medicines work best, but rather to assess whether a company's claims about a drug are accurate, leaving only commercially backed products with sufficient capital to pursue "FDA approval."**

In turn, the FDA drug approval was developed to accommodate synthetic "single-target/single-drugs." approaches. This model—while successful for many conventional pharmaceuticals—is poorly suited to the complex therapeutic profiles of whole-plant cannabis products. **Efforts to isolate and synthesize individual cannabinoids for approval have consistently produced results that fall short of the therapeutic outcomes reported with natural, full-spectrum cannabis.** This gap is reflected in the strong preference among both patients and healthcare providers for botanical cannabis over currently available cannabinoid-based prescription drugs.

In recent years the the FDA has pointed to it's Botanical Drug Development Guidance for Industry as a pathway for cannabis medicines. However, this would not be a viable option, as the document concedes that it is often "not feasible" to determine each component's contribution to efficacy in complex botanicals. This is why, in the twenty years since that guidance was issued, only a handful of botanical products—such as Veregen (green tea extract) and Fulyzaq (crofelemer)—have achieved drug approval, all as single-compound therapeutics rather than full-spectrum medicines.

THE WORLDWIDE TREND OF USING BOTANICAL DRUGS & STRATEGIES FOR DEVELOPING GLOBAL DRUGS

"Botanical drugs are, by nature, plant-derivative materials and their complexes. This makes them unfit for conventional "single-target/single-drug" development processes and thus have been largely disregarded in the field of medicine. However, it is widely understood in synthetic medicine that the single-drug "magic bullet" strategy is not adequate for treating chronic illnesses (e.g. cancers, immune disorders, mental illnesses, cardiovascular diseases, lifestyle diseases) due to their complex pathogenetic mechanisms and that a "multi-target/multi-component" approach involving control over a number of target sites is more effective."

Ahn K. The worldwide trend of using botanical drugs and strategies for developing global drugs. BMB Rep. 2017 Mar;50(3):111-116. doi: 10.5483/bmbrep.2017.50.3.221. PMID: 27998396; PMCID: PMC5422022.

RESPONSIBILITIES OF THE OFFICE OF MEDICAL CANNABIS & CANNABINOID CONTROL

The Office of Medical Cannabis and Cannabinoid Control (OMC) will facilitate the integration of cannabis medicines into the national healthcare infrastructure, as the federal authority responsible for the governance of all medical cannabis and cannabinoid-based therapeutics. The OMC would be positioned to coordinate between federal and state agencies, harmonize product safety requirements, and provide a centralized licensing and registration system for the entire cannabis supply chain — including hemp-derived and synthesized cannabinoids.

The OMC would establish national classification guidelines distinguishing controlled-access therapeutic cannabis products from those appropriate for over-the-counter availability. It would also create a standardized frameworks for clinical prescribing, compassionate-use pathways, and evidence-based health claims for botanical cannabis medicines.

The FDA would retain its essential functions in labeling oversight and post-market safety monitoring and would continue to evaluate cannabinoid-based products seeking approval through traditional drug pathways. OMC and FDA will collaborate to create new federal pathways that appropriately reflect the nature of botanical therapeutics.

REGULATORY COORDINATION

The OMC will coordinate with other federal agencies, including the FDA, DEA, and USDA, to align regulations and policies across the government, ensuring consistent enforcement and clear guidance.

RESEARCH & DEVELOPMENT

One of the primary roles of the OMC will be to promote and fund research on the medical uses of cannabis. This will include clinical trials to better understand its efficacy and potential side effects and studies to explore new medical applications of cannabis.

PRODUCT SAFETY PROTOCOLS & STANDARDS

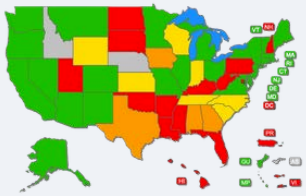
The OMC will adopt comprehensive safety protocols for cannabis cultivation, production, and distribution, including limits on contaminants, labeling requirements, and testing standards for all cannabis products.

REGULATORY COMPLIANCE

Overseeing the entire cannabis supply chain, from cultivation to distribution, including issuing licenses, monitoring compliance, and enforcing standards to prevent misuse and ensure patient safety.

CENTRALIZED LICENSING SYSTEM

A centralized licensing system will standardize the requirements for cannabis producers and processors. This system will facilitate compliance with national standards, simplify the regulatory burden on businesses, and enhance monitoring to ensure that products reaching consumers are safe and high-quality.



USDA

MCCA WILL HARMONIZE EXISTING LICENSES & PERMIT PROGRAMS

MEDICAL & PATIENT EDUCATION

The OMC will also be responsible for educating healthcare providers and patients about the benefits and risks of cannabis based on the latest scientific research.

SCHEDULE VI: A NEW SCHEDULE FOR CANNABIS & CANNABINOIDS

MCCA creates a new schedule, a Schedule VI for cannabis and cannabinoids. This not just a legal formality—it's a critical development that acknowledges that cannabis is not just another drug—it's a botanical medicine with a unique profile. Placing cannabis in its own category would allow for regulations to be tailored to its specific properties and uses. Under Schedule VI, the OMC would oversee these regulations, providing a centralized authority dedicated to cannabis.

WHY SCHEDULE VI?

Cannabis was placed in Schedule I as a political decision in 1970, not based on scientific evidence. Creating Schedule VI will correct this historical wrong, allowing cannabis to be classified based on its actual medicinal value and safety profile.

Creating Schedule VI acknowledges that cannabis is not just another drug—it's a botanical medicine with a unique profile. Placing cannabis in its own category, Schedule VI, would allow for regulations tailored to its specific properties and uses and would expedite research.

Cannabis is a complex botanical medicine with multiple active compounds that interact with the body in unique ways. A new Schedule VI will recognize its distinct nature, allowing for appropriate regulation that doesn't force it into an ill-fitting category designed for synthetic and single-compound drugs.

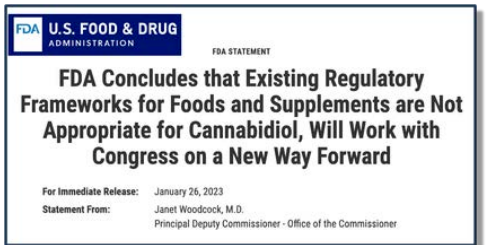
A Schedule VI classification would resolve the issues of regulating "hemp-derived" cannabinoid products by formally codifying cannabis as medicine and extending protections for patients under the Americans with Disabilities Act. This approach would prioritize patient rights alongside business interests, creating a framework that balances commercialization with the essential protections that patients deserve.

SCHEDULE VI & OTHER SCHEDULES

CANNABIS FEDERAL CLASSIFICATION	DE-	SCHEDULES I	III	VI
Recognizes Medical Use of Cannabis			✓	✓
Regulation & Access for Hemp-Derived Cannabinoid Products				✓
Increases & Improves Patient Access				✓
Expands U.S. Definition of Medicine				✓
Removes Federal Criminal Penalties for Possession	✓			✓
Removes Federal Criminal Penalties for Cultivation & Distribution	✓			✓
Ensures Product Safety Across the Supply Chain				✓
Ensures Employment Protections				✓
Ensures Healthcare Rights				✓
Ensures Housing Protections				✓
Harmonizes State & Federal Medical Cannabis Laws				✓
Levels the Playing field for Research, Development,& Innovation				✓
Improves Access to Cannabis for Research	✓		✓	✓
Improves Quality of Cannabis Research				✓

RESCHEDULING ALONE WON'T HELP PATIENTS

Rescheduling would undeniably be a victory for medical cannabis patients and advocates. By recognizing cannabis' "currently accepted medical use in treatment in the United States," the federal government has validated decades of patient-led advocacy and the role of state programs as "laboratories of democracy." However, rescheduling alone will not address the systemic challenges faced by patients or businesses in the current state medical cannabis programs. Schedule III does not legalize medical cannabis, improve state medical cannabis programs, or restore federal rights for patients. Instead, it should shift the conversation from debating cannabis' medical value to exploring how patients can safely access it.


FDA U.S. FOOD & DRUG ADMINISTRATION

FDA STATEMENT

FDA Concludes that Existing Regulatory Frameworks for Foods and Supplements are Not Appropriate for Cannabidiol, Will Work with Congress on a New Way Forward

For Immediate Release: January 26, 2023

Statement From: Janet Woodcock, M.D.
Principal Deputy Commissioner - Office of the Commissioner

MCCA ADDRESSES HEMP-DERIVED CANNABINOID PRODUCT REGULATIONS

Short-term: MCCA requires the FDA to issue labelling requirements for products containing cannabinoids to include: 1) The source of the cannabinoids, 2) "The safety of this product has not been evaluated by the FDA," 3) "This product has not been tested for contaminants," or a QR code to Certificate of Analysis, and 4) Batch number on labels until the OMC issues product safety guidelines.

Long-term: Through oversight over the new schedule, Schedule VI, the OMC will issue classification guidelines for over-the-counter as well as controlled access products (Schedule VI (A) vs Schedule VI). **Additionally, the OMC would issue product and system guidelines for compassionate use prescriptions and the framework for full-spectrum cannabis-based products to achieve evidence-based health claims.**

NATIONAL MEDICAL CANNABIS PROGRAM ROLE OUT-PHASE I

Title I- Office of Medical Cannabis & Cannabinoid Control

Sec. 801- Amend Controlled Substance Act

Sec. 802- Amend Hemp Authorization Act.

FIRST 60 DAYS

Sec. 602- Notification to Agencies
Title VII- Implementation
Sec. 604- Continuity of care
Sec. 603- Reorganization Plan
Sec. 705– Advisory Committee

- New Schedule Created: Schedule VI
- Office of Cannabis & Cannabinoid Control (OMC) established
- Commissioner & Under Secretary of OMC Appointed
- Direct agencies to update cannabis policies
- Provisional Schedule VI permits & specialty pharmacy permits, issued with protocols for interstate distribution

= FINISHED PRODUCTS

= RAW INGREDIENTS

= PERMITTED BY STATE

= SCHEDULE VI PROVISIONAL PERMIT

= STATE/TRIBAL LICENSE

REQUIRE (except B2B Transport)

Schedule VI products with permits can move across US between permitted businesses

MCCA WILL HARMONIZE EXISTING LICENSING & PERMIT PROGRAMS

USDA

STATE-ID CARDS REMAIN VALID

HOME CULTIVATION

CULTIVATION

PROCESSORS

MANUFACTURERS

TESTING LABS

B2B TRANSPORT

RESEARCHERS

DISPENSARY

HOSPITAL/HOSPICE ASSISTED LIVING

CBD & Hemp-derived products will remain available in retail markets as they transition into a regulated market, but will be subject to FDA labeling requirements and any state regulations.

ALL FEDERAL AGENCIES- Current or past cannabis use shall not be a factor in hiring, continuity of employment, or promotions, or determining the security clearance eligibility or any suitability determination under part 731 of Title 5, Code of Federal Regulations for an officer or employee of a Federal agency, a member of the Army, Navy, Air Force, or Marine Corps who is on active duty or is in active status; or an officer or employee of a contractor of a Federal agency as described in section 3002 of the Intelligence Reform and Terrorism Prevention Act of 2004 50 U.S.C. 3343 and Drug-free Federal Workplace-51 FR 32889, 3 CFR, 1986.

OFFICE OF PERSONNEL MANAGEMENT- Update hiring and employment policies concerning past or current cannabis use and create a process for agencies to reinstate or appeal past actions.

HOUSING & URBAN DEVELOPMENT- Exempt cannabis from drug-free housing policies and tax credits, and issue a non-discrimination policy for patients.

VETERAN AFFAIRS- Update policies to allow agency physicians to recommend medical cannabis, amend policies that impact VA benefits, and add cannabis therapeutics to intake forms. Provide the OMC with protocols needed for VHA to administer, dispense, and cover the cost of medical cannabis for patients under their care.

HEALTH & HUMAN SERVICES- Inform hospitals, health clinics, rehabilitation centers, hospice services providers, their medical professionals, or any other patient service provider that is participating in medical cannabis programs or allowing clients/patients in their care to lawfully possess and/or consume cannabis products in their care will not jeopardize HHS funding or any accreditations.

DEPARTMENT OF JUSTICE- Review and formalize guidelines in the 2013 DOJ Cole Memo and expunge all non-violent federal cannabis convictions and adjudications for and any arrests associated with each.

DEPARTMENT OF AGRICULTURE- Agriculture Marketing Services of the Department of Agriculture will instruct USDA-licensed hemp producers and state partners that they will be required to notify the department within 60 days if their crops are intended to produce cannabinoid-containing products for human or animal consumption.

SEC. 601 NOTIFICATIONS TO AGENCIES

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)- Provide the OMC with protocols needed to cover the cost of medical cannabis, like any other prescription medication.

INDIAN HEALTH SERVICES- Update all applicable regulations, guidance, memoranda, and policies of the Indian Health Service to authorize healthcare providers to provide recommendations and opinions to patients relating to the participation of those patients in State or Tribal cannabis programs authorized under Federal or State law and to complete forms reflecting those recommendations and opinions.

STATE DEPARTMENT- Work visa eligibility includes employment with any businesses with a Schedule VI permit/license.

BUREAU OF ALCOHOL, TOBACCO, FIREARMS & EXPLOSIVES- Remove cannabis warning from Form 4473.

SMALL BUSINESS ADMINISTRATION- Notify all development centers and program administrators that all services and support granted under the Small Business Act apply to qualifying businesses with Schedule VI or Schedule VI (A) permits or licenses.

FOOD & DRUG ADMINISTRATION- Issue requirements for products containing cannabinoids to include 1) source of the cannabinoid, 2) "The safety of this product has not been evaluated by the FDA," 3) "This product has not been tested for contaminants," or a QR code to Certificate of Analysis, and 4) Batch number on labels.

TRANSPORTATION SECURITY ADMINISTRATION- Cannabis does not need to be confiscated.

DEPARTMENT OF THE TREASURY- Provide guidance for financial institutions on providing banking services, loans, and any other financial services to Schedule VI licensed businesses.

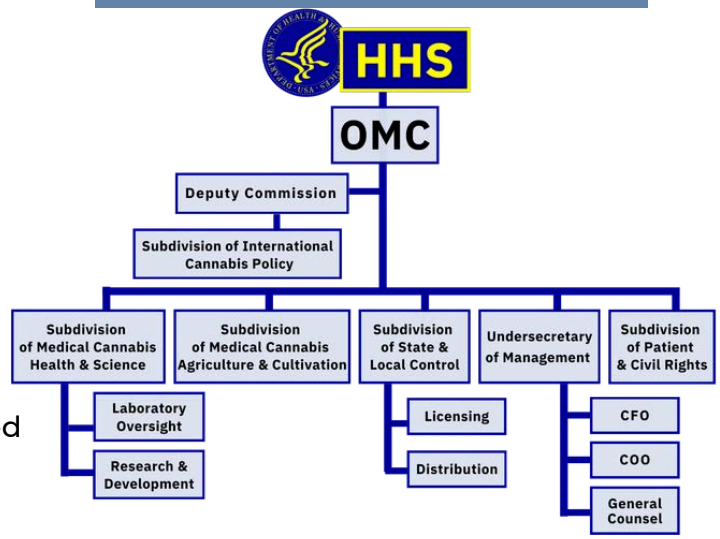
INTERNAL REVENUE SERVICE- Permit medical cannabis businesses with Schedule VI permits/licenses to file as legal businesses and create a process for these businesses to refile tax returns with deductions to lower or eliminate tax debt.

NATIONAL MEDICAL CANNABIS PROGRAM ROLE OUT-PHASE II

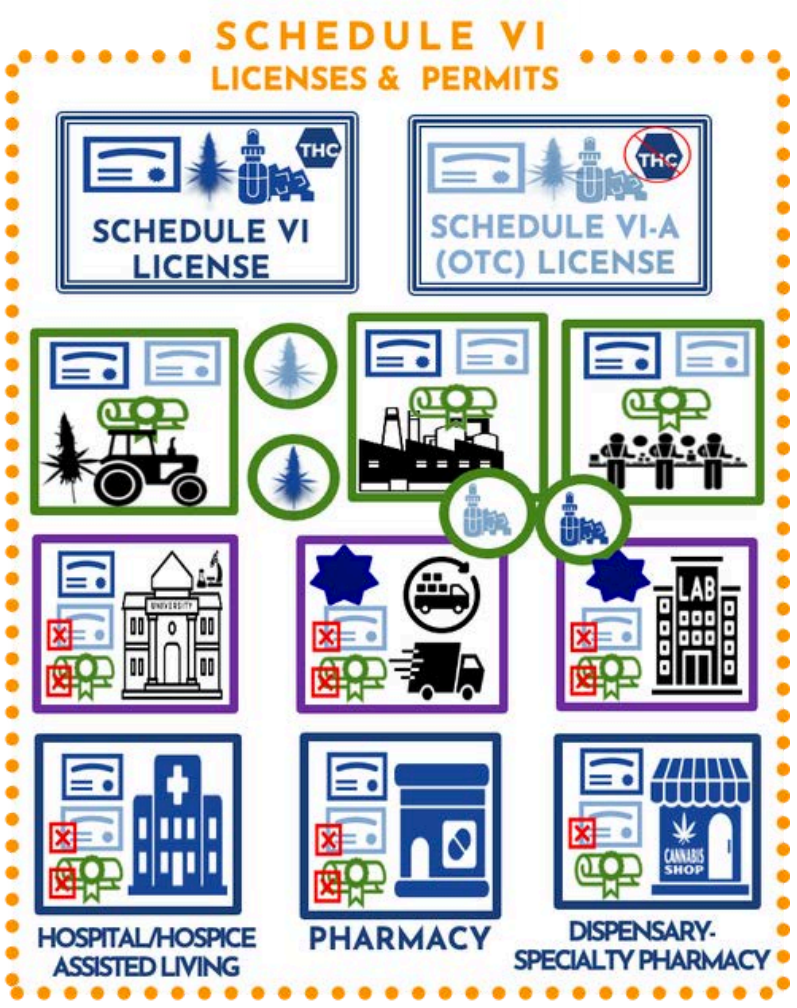
Title I, Title II, Title III, Title IV, Sec. 404, Sec. 501
Sec. 504- Staffing Subdivisions

Sec. 303- Transfer of Functions
Sec. 701- Licensing & Permits; General Provisions
Sec. 305- Cannabis Production; State & Tribal Plans
Sec. 306- Effect on Industrial Hemp
Sec. 701- Licensing & Permits; General Provisions
Sec. 702- Specialty Licensing

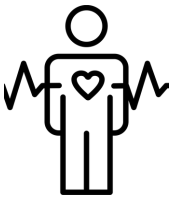
FIRST 12 MONTHS



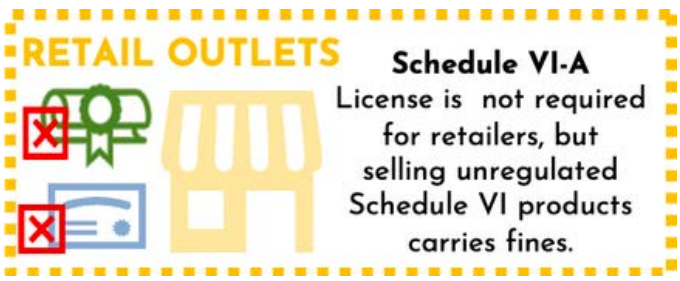
- Agency Staffed Schedule VI licensing program launched
- Advisory groups seated
- Initiate research priority map with NIH
- OTC guidelines for cannabinoid products
- Determination of NDA requirements for synthetic cannabinoid and terpene products
- Establish safe additive list for Schedule VI products
- Labeling, research, and testing requirements for Schedule VI products established
- Determine if additional permits/licenses needed



STATE-ID CARDS REMAIN VALID



HOME CULTIVATION



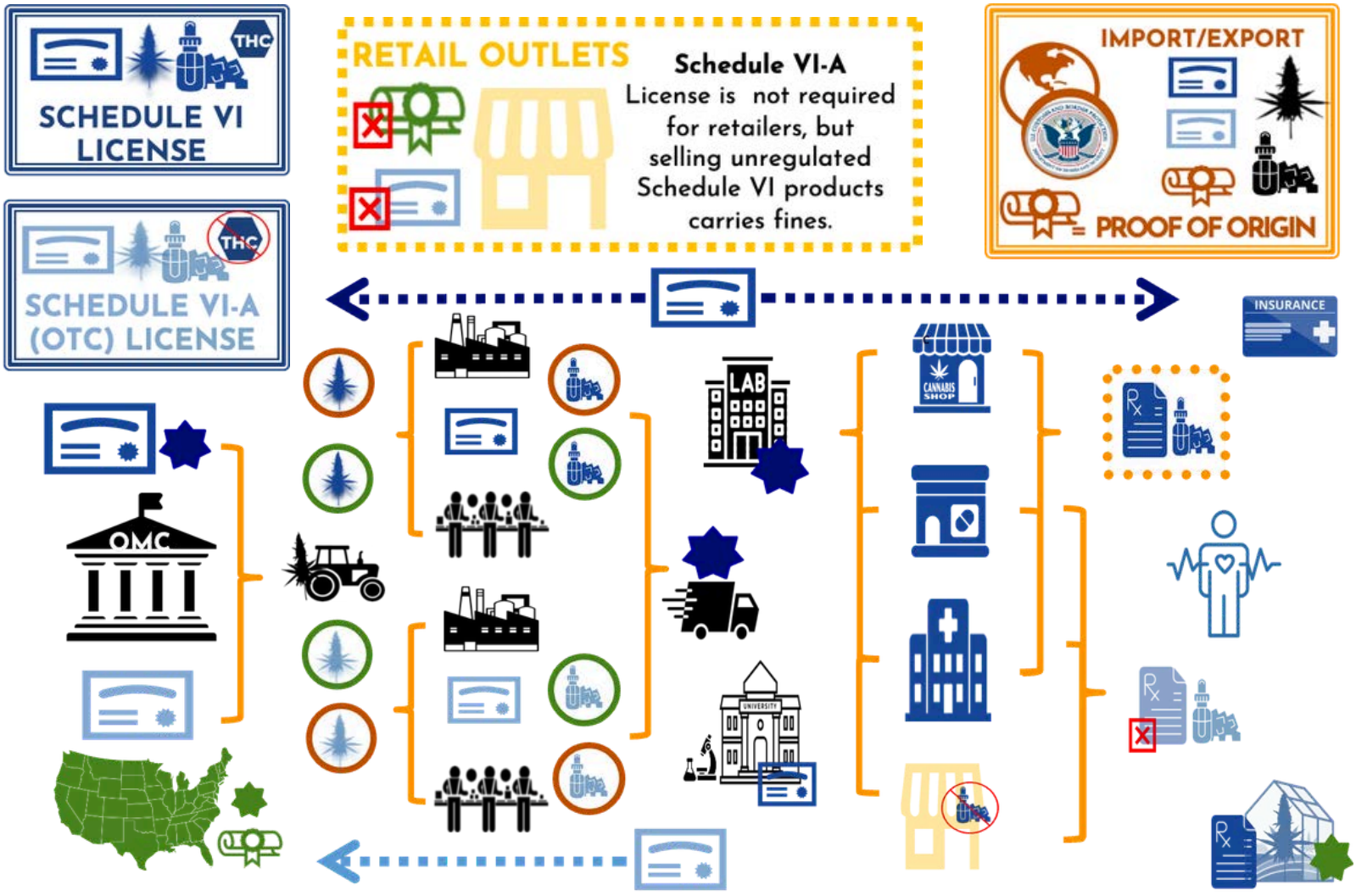
NATIONAL MEDICAL CANNABIS PROGRAM ROLE OUT-PHASE III

Sec. 701- Licensing & Permits
Title VI-Transition
Subtitle A- Coordination with Agencies

Sec. 306- Effect on Industrial Hemp
Sec. 701(d)- Imports, Exports
Sec. 204- Research & Development Center
Sec. 704– Prescription Protocols

FIRST 24 MONTHS

USDA · DEPARTMENT OF JUSTICE · NIH · SBA · DEPARTMENT OF VETERANS AFFAIRS · CMS CENTERS FOR MEDICARE & MEDICAID SERVICES



- Guidance for "prescription system"
- Guidance for importation/exportation of Schedule VI ingredients and products
- Guidance from the Centers for Medicare and Medicaid Services for Schedule VI product coverage
- OMC establishes private-public partnerships for research with NIH
- Each federal district completes a comprehensive review and expungement of all adjudicated and non-adjudicated cannabis cases
- Initiate process for producing guidance document for health claims for Schedule VI products
- Guidance for environmental impact and sustainable agricultural practices
- VHA Medical Cannabis Program Role Out

TITLE I- OFFICE OF MEDICAL CANNABIS & CANNABINOID CONTROL

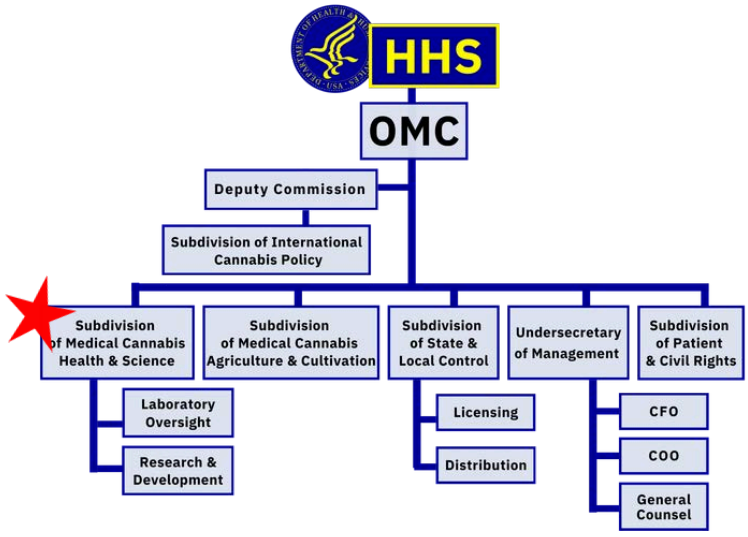
Establishes the **Office of Medical Cannabis and Cannabinoid Control (OMC)** as a central agency under the Department of Health and Human Services. Defines the OMC's legislative mission to regulate and oversee the medical cannabis supply chain, outlines the roles and duties of the Commissioner and other officers, and sets forth responsibilities, including regulatory oversight, public health protection, and enforcement of standards. This structure ensures that all aspects of medical cannabis are centrally managed and consistently regulated across the nation.

TITLE II- SUBDIVISION OF MEDICAL CANNABIS HEALTH & SCIENCE

Creates a subdivision dedicated to the scientific research and health implications of medical cannabis, led by an Under Secretary. This subdivision oversees federally funded research and development centers, conducting comprehensive research, development, testing, and evaluation of medical cannabis. Its mission is to advance the understanding of cannabis' medical benefits and its integration into healthcare practices, ensuring that policy development is informed by rigorous scientific evidence.

OMC STRUCTURE & AGENCY TRANSITION

Sec. 201-206
Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 704– Prescription Protocols
Sec. 205- Research, Testing, & Evaluation
Sec. 705- Advisory Committee



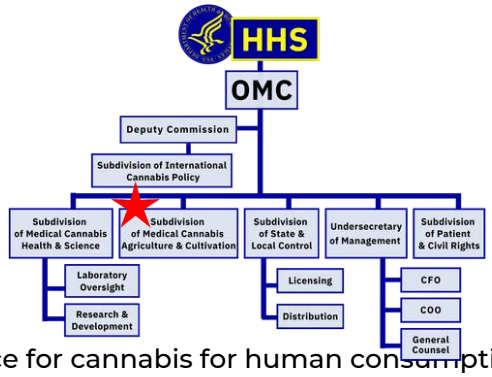
- Work across agencies to create and fund a research priority map
- Spearhead guidelines for standardization of testing and labeling
- Issue permits to laboratories for cannabis (Schedule VI)
- Create prescription protocols and educate physicians

TITLE III- SUBDIVISION OF CANNABIS AGRICULTURE & CULTIVATION

Defines a subdivision focusing on the agriculture and cultivation aspects of cannabis, headed by an Under Secretary. It details responsibilities such as developing sustainable cultivation practices, overseeing federally funded subsidies and crop insurance programs, and ensuring that state and tribal cannabis production plans align with federal standards. This subdivision is essential for managing the agricultural lifecycle of cannabis and supporting farmers through regulatory guidance and financial aid.

OMC STRUCTURE & AGENCY TRANSITION

Sec. 301-306
Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 305- Cannabis Production; State & Tribal Plans



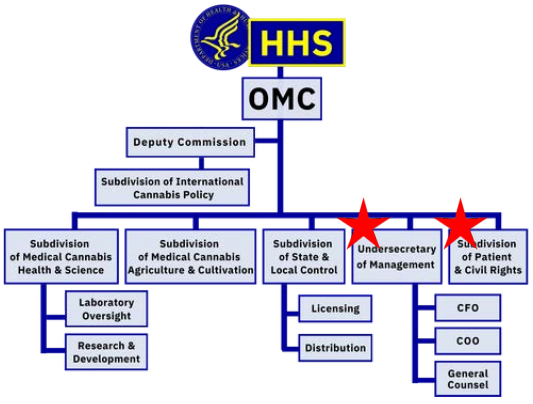
- Pesticides guidance for cannabis for human consumption
- Train inspectors
- Create research and marketing orders
- Work across agencies to create seed registry

TITLE IV - MANAGEMENT

Outlines the infrastructure of the Office of Medical Cannabis and Cannabinoid Control, detailing the roles of key managerial positions, including the Under Secretary for Management, Chief Financial Officer, Chief Information Officer, and an Officer for Patient and Civil Rights. These roles are critical for the efficient administration of the OMC, ensuring effective financial management, information security, and the protection of patient and civil rights within the medical cannabis framework.

OMC STRUCTURE & AGENCY TRANSITION

Sec. 401- Under Secretary for Management
Sec. 402- Chief Financial Officer
Sec. 403- Chief Information Officer
Sec. 404- Establishment of Officer for Patient and Civil Rights



SEC. 404- SUBDIVISION OF PATIENT & CIVIL RIGHTS

- Review and monitor the implementation to ensure patient rights are protected
- Work across agencies to ensure that patient rights are included in their policies
- Work with CMS to ensure cannabis medications are covered

TITLE V- COORDINATION WITH NON-FEDERAL ENTITIES

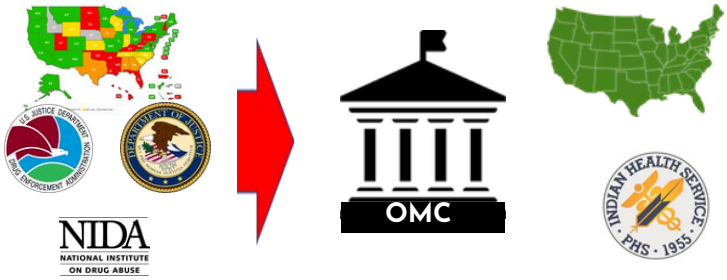
Emphasizes the importance of coordination between the OMC and state, local, and international bodies. It sets up a subdivision for state and local government coordination, addresses the role of advisory committees, and delineates the office's involvement in military and international cannabis policies. This title ensures that federal cannabis policies are harmonized with non-federal entities, facilitating a cohesive approach to cannabis regulation and policy across different levels of government and international borders.

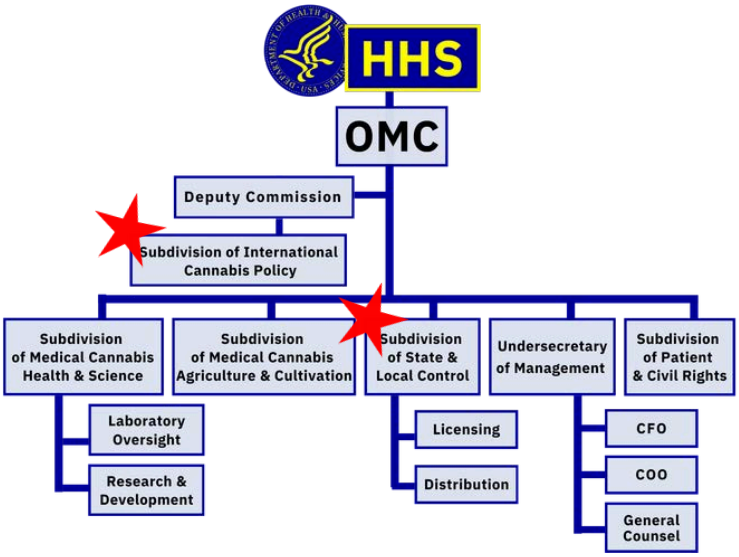
SEC. 501-SUBDIVISION OF TRIBAL, STATE, & LOCAL CONTROL

OMC STRUCTURE & AGENCY TRANSITION

Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 305- Cannabis Production; State & Tribal Plans
Sec. 705– Advisory Committee

- Work with state regulators on Schedule VI Permits for state-licensed medical cannabis businesses
- Create protocols for interstate sales and transportation
- Create vendor/licensee database





SEC. 504-OFFICE OF INTERNATIONAL POLICY

OMC STRUCTURE & AGENCY TRANSITION

Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 701(d)- Imports, Exports

- OMC designated agency for Cannabis under UN single treaty
- Report to INCB on cannabis
- Establish and oversee cannabis/cannabinoid import/export procedures

TITLE VI– TRANSITION

Specifies the practical steps for implementing the Act, including the issuance of general and specialty licenses, guidelines for distribution, prescription protocols, and forming advisory committees.

TITLE VII - IMPLEMENTATION

Provisions necessary for implementing the Act. It defines key terms, outlines the notification process for affected agencies, describes the reorganization plan, and ensures the continuity of care during the transition period. This title is crucial for the smooth transition of functions and responsibilities to the new regulatory framework established by the Act.

TITLE VIII- ESTABLISH SCHEDULE VI UNDER THE CONTROLLED SUBSTANCE ACT

Amends the Controlled Substances Act to establish Schedule VI and Schedule VI (A), creating a new classification for cannabis and cannabinoid products that acknowledges their medicinal use and regulates them under a framework designed for their unique properties. This section amends the Hemp Authorization Act and transfers functions to align with the new regulations, ensuring a comprehensive approach to the nationwide management and oversight of medical cannabis and cannabinoid products. It also amends the Criminal Code and Sentencing Guidelines to align with these changes, ensuring that the legal framework reflects the updated understanding of cannabis' role in medical treatment.

Without comprehensive medical cannabis legislation, medical cannabis patients are denied fundamental federal rights. **Unfortunately, when faced with this harsh reality, millions of Americans can't afford to risk their housing, education, and financial stability to prioritize their health, even when advised by their medical professional.**

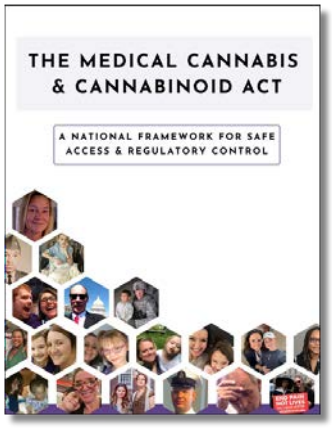
DENIAL OF SERVICES	Federal prohibition prevents medical cannabis patients from accessing services such as subsidized housing, Veterans Affairs benefits, and Medicare.
PURSUIT OF HAPPINESS	Federal cannabis laws restrict the geographical mobility of patients, affecting their ability to travel, relocate for work, or pursue higher education.
HEALTHCARE AUTONOMY	Federal restrictions also extend to healthcare settings, where cannabis use is frequently prohibited in hospitals, hospices, and assisted living facilities.
ADA	Medical cannabis patients are not protected under the Americans with Disabilities Act (ADA) or the Fair Housing Act (FHA).
2ND AMENDMENT RIGHTS	Federal laws restrict the rights of medical cannabis patients to own firearms, conflating responsible medical use with unlawful drug use.

ADULT USE MARKETS DO NOT SERVE PATIENTS

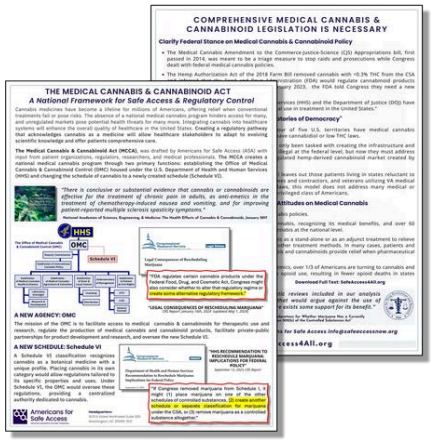
Adult-use markets are primarily designed to generate tax revenue for states and serve a clientele aged 21 and older, focusing on recreational consumers. When states pass laws merging recreational cannabis programs with existing medical markets, the result is often a loss of integrity in the medical cannabis program and neglect of the specific needs of medical patients.

Medical patients require consistent access to standardized formulations and dosages tailored to their health conditions, while recreational consumers are typically interested in "what's new," which is prioritized in these markets. Forcing patients to navigate adult-use markets trivializes their medical needs and fails to respect their right to access treatment with dignity, privacy, and without stigma.

VISIT SAFEACCESS4ALL.ORG FOR



THE FULL TEXT OF THE MEDICAL CANNABIS & CANNABINOID ACT



ONE PAGERS & MCCA FACTSHEETS

MCCA FREQUENTLY ASKED QUESTIONS

MEDICAL CANNABIS POLICY TALKING POINTS

NEED FOR LEADERSHIP

"The recent recognition of cannabis' medical value by federal health agencies underscores the critical need for Congress to update and harmonize existing laws. While the rescheduling of cannabis marks a significant advance, it does not address all the complexities of its use as a medical treatment."

"States have fulfilled their role as laboratories of democracy for medical cannabis policy. It's now our responsibility as lawmakers to ensure that laws keep pace with science and public opinion and pass comprehensive medical cannabis legislation."

NEED FOR FEDERAL MEDICAL CANNABIS POLICY

"By integrating medical cannabis into our national healthcare framework, we can offer patients more effective treatment options for chronic and debilitating conditions, potentially reducing reliance on more harmful medications."

"Federal reform is necessary to ensure all patients, including veterans, active duty military and federal employees, can benefit from medical cannabis.

"State laws are falling short, leaving many patients behind. We need comprehensive federal policies that guarantee access to affordable medical cannabis for everyone."

RESTORING PATIENT RIGHTS

"Without comprehensive federal legislation on medical cannabis, millions of patients are stripped of basic rights. This forces many Americans into a difficult position: they must choose between following their healthcare provider's advice and the potentially severe consequences of losing critical federal services and rights, a decision that directly threatens their livelihood and well-being."

"The absence of comprehensive medical cannabis legislation leaves millions without essential federal protections, compelling patients to make an impossible choice: their health or their basic rights. For many, prioritizing health could mean risking their housing, education, and financial stability, underlining the urgent need for federal action."

"Patients should not have to choose between their rights and their health. It's time to end the federal prohibition on medical cannabis and restore patient freedoms."

MCCA & PRODUCT SAFETY

"A regulated cannabis market is a safer market, ensuring that all products meet the highest standards of public health."

"The current unregulated markets pose risks due to product quality and safety variability. A federal program will ensure that all products meet rigorous health and safety standards, protecting consumers from inferior or dangerous products."

"National standards are essential for ensuring patient safety and product consistency, which can actually foster consumer confidence and drive market growth. These standards would level the playing field, encouraging innovation within a safe and regulated environment. Patient health should be our top priority."

CANNABIS MEDICINES & HEALTHCARE SYSTEMS

"Medical cannabis presents a cost-effective solution for managing refractory symptoms in chronic conditions, highlighting its potential to enhance patient care while reducing healthcare expenditures."

"Embracing medical cannabis as part of our healthcare strategy means embracing innovation and hope for millions of patients."

Americans for Safe Access
Advancing Legal Medical Cannabis Therapeutics

Learn more: SafeAccess4All.org

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