NEW ERA OF MEDICAL CANNABIS POLICY: A BRIEFING FOR THE 119TH CONGRESS

Prepared by: Americans for Safe Access
May 21, 2026

2026 is shaping up to be the most consequential year for cannabis policy since Congress passed the Controlled Substances Act in 1970. This briefing provides a patient-centered overview of the federal policies driving this historic shift, including AG Order No. 6754-2026, pending changes to federal hemp laws, the CMS cannabis access initiative, and the broader rescheduling of cannabis to Schedule III. The briefing offers a snapshot of medical cannabis and cannabinoid access in the United States, explains what this new phase of federal policy means for patients, and outlines the leadership Congress must provide to ensure patients benefit from these changes. That includes action through the FY2027 appropriations process, immediate federal agency guidance, and the creation of a comprehensive national medical cannabis program.

For questions or additional information, please contact Americans for Safe Access at steph@safeaccessnow.org.








BRIEFING INCLUDES:

- Cannabis Rescheduling Overview
- 2026 Cannabis Policy Timeline
- Medical cannabis & cannabinoid access in the US
- Patient Rights & Agency Guidance
- Appropriation Needs
- MCCA Pathway: National Medical Cannabis Program
- Medical Cannabis Policy Talking Points

CANNABIS RESCHEDULING OVERVIEW

KEY TAKEAWAYS

Qualifying state medical cannabis products are now recognized as Schedule III as of April 28, 2026; all other cannabis remains Schedule I.

State-authorized medical cannabis certifications functionally equivalent to prescriptions within this federal framework.

DEA registration pathway created for state medical cannabis license holders, with a new ALJ hearing moving forward on broader Schedule I-to-Schedule III rescheduling.

Congressional action is needed to update patient protections, agency policies, healthcare access, civil rights guidance, and implementation beyond the DEA and the Treasury/IRS.

CANNABIS SCHEDULING UPDATE SUMMARY

On April 23, 2026, the Department of Justice announced major federal actions in response to the President's directive that the Attorney General complete the process of rescheduling marijuana to Schedule III of the Controlled Substances Act "in the most expeditious manner" consistent with federal law, including 21 U.S.C. § 811(d), as described in Executive Order 14370, "Increasing Medical Marijuana and Cannabidiol Research," issued on December 18, 2025.

These actions included the DEA withdrawing from the August 29, 2024, Notice of Hearing on Proposed Rulemaking, terminating the related proceedings, and issuing a new Notice of Hearing on Proposed Rulemaking. An administrative law judge hearing on the DOJ's proposed rescheduling of marijuana from Schedule I to Schedule III is scheduled to begin on June 29, 2026.

The Acting Attorney General also issued final AG Order No. 6754-2026, placing FDA-approved marijuana products and marijuana products regulated under qualifying state medical cannabis licenses in Schedule III and creating a federal registration pathway for state-licensed medical cannabis manufacturers, distributors, and dispensers.

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.

CURRENT SCHEDULING PROCESS

USC 8119(c):
(RE)SCHEDULING PROCESS

MEDICAL & SCIENTIFIC REVIEW

RECOMMENDATION FOR SCHEDULING

REVIEW
DOJ Office of Legal Counsel (OLC)

PROPOSED RULE

PUBLIC COMMENT

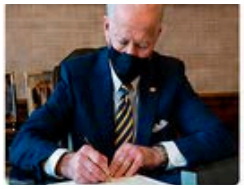
ADMINISTRATIVE HEARING — YOU ARE HERE

DEA REVIEW

OMB/ MAJOR RULE 21 USC 811(D)

FINAL RULE

60 DAY JUDICIAL REVIEW
Lawsuits could include stay orders preventing a change in schedule until after legal proceedings.



OCTOBER 2022
Biden Initiates the 6th Rescheduling Process

In October 2022, President Biden initiated the current cannabis rescheduling process by directing HHS and DOJ to review the scheduling of marijuana. In May 2024, the DOJ published the Notice of Proposed Rulemaking, "Schedules of Controlled Substances: Rescheduling of Marijuana," Schedule III, 2024-11137, 89 Fed. Reg. 44597, announcing its intention to move marijuana from Schedule I to Schedule III. The proposed rule followed HHS's August 2023 scientific and medical review recommending Schedule III.

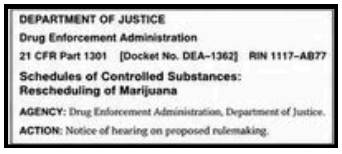
AUGUST 2023
HHS Completes review;
Recommends: Schedule III

"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

MAY 2024
Notice of Proposed Rulemaking:
Schedule III: 2024-11137 (89 FR 44597)

Following a public comment period, the DEA issued a notice of hearing in August 2024. Witnesses were selected, and the hearing was expected to begin in January 2025. That hearing did not move forward. The process stalled after concerns were raised about the fairness and handling of the proceedings. For more than a year, the broader cannabis rescheduling process remained in limbo.

AUGUST 2024
Notice of Hearing on Proposed Rulemaking


DEPARTMENT OF JUSTICE
Drug Enforcement Administration
21 CFR Part 1301 [Docket No. DEA-1362] RIN 1117-AB77
Schedules of Controlled Substances: Rescheduling of Marijuana
AGENCY: Drug Enforcement Administration, Department of Justice.
ACTION: Notice of hearing on proposed rulemaking.

DECEMBER 2024
Witnesses Selected, Hearing Schedule Set

Week	Activity
1/21/2025—1/23/2025	Hearing
1/28/2025—1/30/2025	Hearing
2/4/2025—2/6/2025	Hearing
2/11/2025—2/13/2025	Break—No Hearing Proceedings
2/18/2025—2/20/2025	Hearing
2/25/2025—2/27/2025	Hearing
3/4/2025—3/6/2025	Hearing

JANUARY 2025
Hearing Postponed

APRIL 2026
DEA publishes Notice of Hearing on Proposed Rulemaking: Schedule III

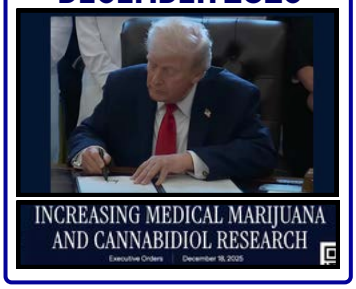
DEA ADMINSTRATIVE LAW JUDGE HEARING ON:
Docket No. DEA-1362; A.G. Order No. 5931-2024

The Department of Justice ("DOJ") proposes to transfer marijuana from schedule I of the Controlled Substances Act ("CSA") to schedule III of the CSA, consistent with the view of the Department of Health and Human Services ("HHS") that marijuana has a currently accepted medical use as well as HHS's views about marijuana's abuse potential and level of physical or psychological dependence.

JUNE 29-JULY 15, 2026
NHPRM states that the hearing will begin on June 26 and conclude by July 15, 2026.

The new ALJ hearing is scheduled to begin on June 29, 2026, and is intended to expedite consideration of the 2024 Notice of Proposed Rulemaking on broader cannabis rescheduling. Unlike AG Order No. 6754-2026, which places FDA-approved marijuana products and marijuana products regulated under qualifying state medical cannabis licenses into Schedule III, the ALJ hearing addresses the proposed rescheduling of marijuana more broadly from Schedule I to Schedule III.

DECEMBER 2025



The notice sets ambitious timelines, including a target for the hearing to conclude by July 15, 2026. That timeline may be optimistic given the history of cannabis rescheduling proceedings, but it signals an intent to move quickly.

Appropriations Threat: Rescheduling Could Be Halted

House Republicans are actively attempting to block DEA authority to complete rescheduling through FY2026 appropriations. The House-passed FY2027 Commerce, Justice, Science (CJS) bill includes the following provision:

SEC. 591. "None of the funds appropriated or otherwise made available by this Act may be used to reschedule marijuana… or remove marijuana from the schedules…"

If this language is enacted before the DEA completes the process, rescheduling will come to a complete halt—regardless of the Executive Order or prior HHS findings. ***See ASA's FY2027 CJS Appropriations Requests pages 15-23.***

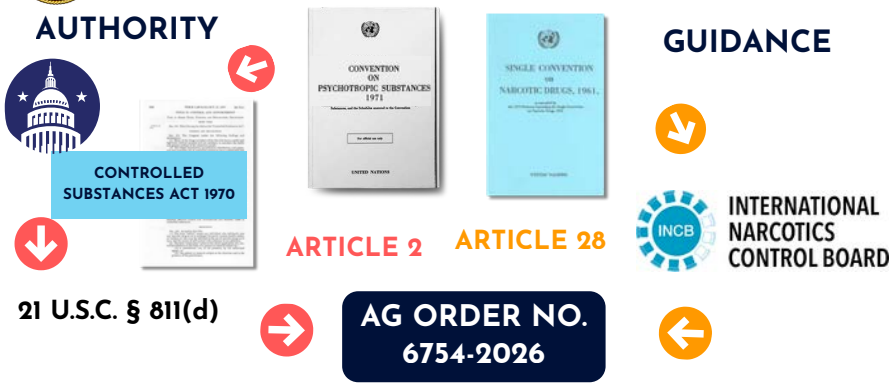
AG ORDER NO. 6754-2026 OVERVIEW

On April 28, 2026, Acting Attorney General Blanche published final AG Order No. 6754-2026, placing FDA-approved marijuana products and marijuana products regulated by qualifying state medical cannabis licenses into Schedule III of the Controlled Substances Act and creating a federal registration structure for state-licensed medical cannabis manufacturers, distributors, and dispensers. The order relies on existing state infrastructure to promote medical access and avoid unnecessary disruption to patients and state medical cannabis systems.

The order relies on 21 U.S.C. § 811(d), which authorizes the Attorney General to carry out scheduling actions necessary for the United States to meet obligations under the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances.

In December 2020, the Commission on Narcotic Drugs voted to reclassify cannabis in recognition of its medical value, following the recommendation of the World Health Organization. Acknowledging this change, the International Narcotics Control Board's 2022 annual report advised countries seeking to operate medical cannabis access programs must observe the specific control measures required for cannabis under Article 28 of the Single Convention to remain in compliance with international treaties. Those measures include licensing and controlling cannabis production for medical use, establishing a national cannabis agency, providing estimates of national medical cannabis requirements, and ensuring that medicinal cannabinoids are used in accordance with evidence on safety and effectiveness and under medical supervision.

AG ORDER NO. 6754-2026 RATIONALE



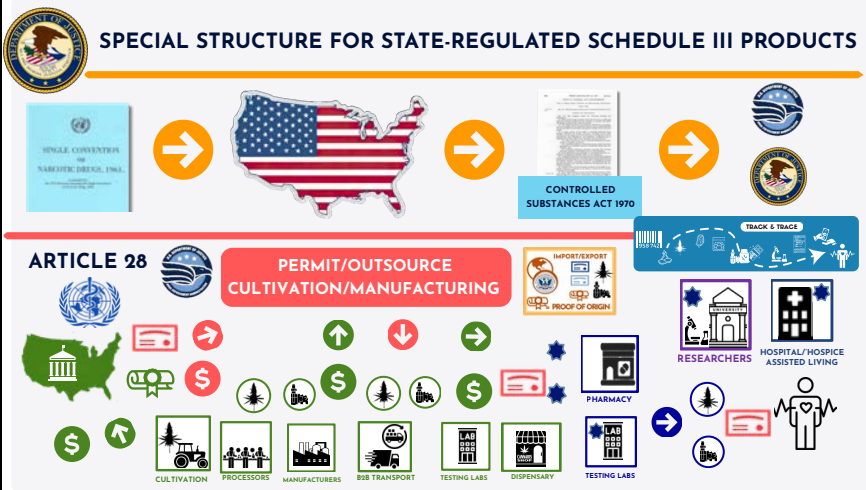
The Acting Attorney General asserted his authority, granted by Congress under 21 U.S.C. § 811(d), to place qualifying medical cannabis products into Schedule III and to establish a federal registration system for state-licensed medical cannabis manufacturers, distributors, and dispensers, relying on existing state medical cannabis licensing systems to support federal oversight. **By reconciling cannabis scheduling and asserting control over medical access, AG Order No. 6754-2026 aligns U.S. federal cannabis policy with its international treaty obligations.**

The Order recognizes state medical cannabis programs as part of the federal healthcare framework, noting that licensed medical professionals oversee patient qualification based on state-specific criteria and qualifying conditions. It confirms that state-authorized medical cannabis certifications or similar patient documents are to be treated as functionally equivalent to prescriptions.

For state-authorized medical cannabis patients in qualifying jurisdictions, the legal premise has changed. Qualifying medical cannabis is no longer Schedule I contraband within this framework. This change in classification impacts civil protections, disability rights, housing, healthcare, employment, veterans' services, and access to federal programs.

AG ORDER NO. 6754-2026 IMPACT BREAKDOWN:

- Moves “FDA-approved marijuana products” and cannabis products covered by qualifying state medical cannabis licenses from Schedule I to Schedule III.
- Recognizes state medical cannabis programs as part of the U.S. healthcare landscape.
- Relies on existing state infrastructure, including patient registration, professional certification, licensing, dispensing, labeling, packaging, security, disposal, and recordkeeping.
- Treats state-authorized medical cannabis certifications or similar patient documents as functionally equivalent to prescriptions for purposes of the federal framework.
- Creates a federal registration process for state-licensed medical cannabis manufacturers, distributors, and dispensers.
- Creates the possibility that researchers may obtain cannabis from DEA-registered state licensees for scientific research, subject to applicable FDA and DEA requirements.



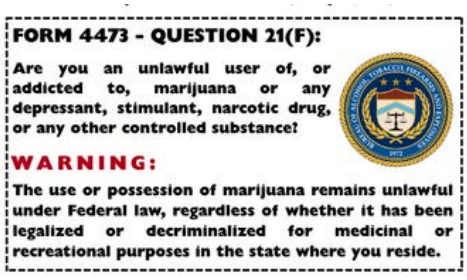
The final order also creates a mechanism intended to satisfy Article 23 of the Single Convention on Narcotic Drugs. It requires DEA-registered cannabis manufacturers to set a nominal purchase price for their crops. DEA then purchases the crops at that price and sells them back to the manufacturer, or a related or subsidiary entity, at the same price plus an administrative fee. Until that transaction is complete, the cannabis crops must be stored in a facility that the DEA can access and inspect on demand. Each manufacturer’s registration must also specify the areas where cannabis cultivation is permitted.

This structure allows the federal government to maintain the purchase-and-resale control required under the Single Convention while allowing state-licensed medical cannabis operations to continue functioning through a DEA registration system.

WHAT THIS MEANS FOR PATIENTS

Patients participating in state medical cannabis programs are now protected under the Americans with Disabilities Act, the Fair Housing Act, and Section 504 of the Rehabilitation Act. They can no longer be denied housing, employment, healthcare, federal benefits and services, participation in federal programs, and/or reasonable accommodations solely because of their state medical cannabis program status.

These protections will not be enforced automatically. Federal agencies must align their policies with the recognition that qualifying medical cannabis is legitimate medicine within this framework.



- Patients should not be denied housing, employment, healthcare, gun ownership, veterans’ care, federal workplace protections, or federal program participation solely because they are registered medical cannabis patients.
- Patients and their caregivers have the right to reasonable accommodations.
- Federal policies concerning medical cannabis in subsidized housing, federally funded hospitals, hospices, nursing homes, and assisted living facilities, federal workplaces, veterans’ care, and military systems need to be revisited and updated to avoid violating patients’ civil rights and protections.
- Federal policies must move from categorical exclusion to individualized assessment and reasonable accommodation.

.While this policy change represents federal recognition of the medical cannabis systems that patients, clinicians, advocates, and states have built over more than two decades, it is only a first step toward a national medical cannabis program, not a substitution for comprehensive legislation.

THE DOJ ORDER DOES NOT

- Legalize or deschedule cannabis or impact cannabis in adult-use markets. All cannabis obtained outside a DEA-registered, state-regulated medical cannabis system is still Schedule I, unless and until the broader rescheduling process makes those changes.
- Apply to synthetic cannabinoids (which are outside the CSA definition of marijuana).
- Change federal criminal penalties for cannabis possession, cultivation, manufacturing, and distribution outside state-regulated medical cannabis.
- Expunge federal cannabis-related criminal records.
- Change the Federal Food, Drug, and Cosmetic Act. FDA requirements still apply, including requirements related to product approval, safety, labeling, and allowable claims.
- Provide access or protections in states without medical cannabis laws.
- Affect the status of hemp, now or after the expected federal hemp-definition changes in November.
- Allow patients to travel freely from state to state with their medicine.
- Automatically update every federal policy used to deny patients housing, employment, healthcare, veterans' services, disability accommodations, or access to federal programs.
- Explicitly allow active-duty military personnel or federal employees to use medical cannabis.

FEDERAL REGISTRATION FOR MEDICAL CANNABIS BUSINESSES

State-licensed medical cannabis manufacturers, distributors, and dispensers must apply for DEA registration. State credentials may be submitted as evidence of state-law authorization. Applications submitted within 60 days of publication are expected to receive expedited review, with a target of completing review within six months.

There are still unanswered questions, especially for businesses that are dual-licensed for adult-use and medical cannabis. Because the order is tied to medical cannabis activity and treaty-based controls, some businesses may have to make strategic decisions about whether and how they participate in the federal medical framework.

One area requiring immediate attention is the public-interest standard. The order states that the Administrator must grant registration unless doing so would be inconsistent with the public interest under 21 U.S.C. § 823 or with the requirements of the Single Convention. One public-interest factor includes the applicant's prior conviction record under federal or state laws relating to the manufacture, distribution, or dispensing of controlled substances.

That raises serious equity concerns. Prior cannabis-related convictions should not be used as a categorical basis to exclude people and communities harmed by prohibition from participating in a lawful medical cannabis framework. **DEA should conduct an individualized review and deny registration only where there is a current, documented risk to public health, safety, diversion control, or treaty compliance.**

WHY USE 21 U.S.C. § 811(d) AUTHORITY?

Rescheduling alone does not create a lawful pathway for state medical cannabis programs or integrate cannabis into federal healthcare systems. 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 without an act of Congress. 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

Schedule III: What it Does—& Does Not—Do for Patients

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

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**

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 activities that remain illegal under federal law. For example, 26 U.S.C. § 162(c) limits deductions for 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 are not 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.

2026 RESCHEDULING & ORDER IMPLEMENTATION TIMELINE

FY2027 SEPT 30, 2026

(see pages 15-23)

KEY TAKEAWAYS

Forty-one state medical cannabis laws and millions of patients relying on state programs, hemp-derived cannabinoid products, or both.

Diverse patient populations, including older adults, veterans, children, cancer patients, chronic pain patients, and people with disabilities.

Persistent access barriers tied to geography, cost, housing, employment, healthcare access, military service, and state law.

AG Order No. 6754-2026 as a major federal shift, but not a national medical cannabis program or full patient-protection framework.

Pending hemp restrictions and limited CMS action leaving many patients without reliable medical access pathways.

FROM STATE EXPERIMENT TO NATIONAL FRAMEWORK

Medical cannabis has moved from the margins of state policy into the center of national healthcare access debates. Forty-one states now have medical cannabis laws, and millions of patients rely on state-regulated medical cannabis programs, hemp-derived cannabinoid products, or both to manage serious and chronic health conditions. **"Medical cannabis patients" represent a diverse population ranging in age, race, abilities, and health conditions.** They include people living with cancer, chronic pain, neurological conditions, PTSD, autism spectrum disorder, seizure disorders, appetite loss, sleep disturbances, arthritis, anxiety, and other serious or persistent illnesses. **Many are older adults, veterans, children with complex conditions, and patients who have exhausted, cannot tolerate, or do not respond well to conventional therapies.**

What many patients have in common is not a single diagnosis, but the external barriers that shape access. Geography, income, housing status, employment, and military service can determine whether a patient can obtain and safely continue using medical cannabis.

The implementation of AG Order No. 6754-2026 may help reduce certain access barriers by recognizing qualifying state medical cannabis products within Schedule III, but it will not eliminate them. **Until cannabis is fully integrated into the U.S. healthcare system through a national medical cannabis program, large portions of the U.S. population will continue to face access issues due to the patchwork of state laws, federal policies, product availability, cost barriers, and inconsistent protections.**

WHO ARE MEDICAL CANNABIS PATIENTS?

Medical cannabis patients include some of the most medically vulnerable and underserved populations in the United States.

More than 18 million people in the United States are living with a history of cancer, and over 2 million new cancer cases are expected in 2026. **Many patients with cancer report using cannabis to manage symptoms such as pain, sleep disruption, anxiety, stress, appetite loss, and treatment-related side effects**.

Chronic pain is one of the most common reasons patients seek medical cannabis. CDC reported that 24.3 percent of U.S. adults had chronic pain in 2023, and earlier CDC estimates found that more than 51 million adults experienced chronic pain in 2021. Among adults with chronic pain living in states with medical cannabis laws, research published in JAMA Network Open found that nearly three in ten reported using cannabis to manage pain.

Older adults are also a rapidly growing population of cannabis users. The United States had 57.8 million adults age 65 and older in 2022, and recent research has found that cannabis use among older adults continues to rise, with many reporting use for pain, sleep, appetite, anxiety, arthritis, and quality-of-life concerns.

Over 40% of patients diagnosed with cancer
report using cannabis for sleep, mood, stress, anxiety, depression, and to manage pain.

18,000,110 PEOPLE ARE LIVING WITH CANCER IN THE UNITED STATES.

3 out of 10 Patients with Chronic Pain
use cannabis to manage pain and improve daily function.

OVER 68 MILLION AMERICANS LIVE WITH CHRONIC PAIN.

1 out of 5 older adults uses cannabis.
Older adults use cannabis in states with medical cannabis programs to manage chronic pain, arthritis, sleep disturbances, and appetite issues.

THE 57.8 MILLION OLDER AMERICANS (65+) REPRESENT THE FASTEST-GROWING DEMOGRAPHIC UTILIZING CANNABIS MEDICINES.

Veterans are another key patient population. Veterans report using cannabis to manage symptoms related to PTSD, chronic pain, sleep disorders, anxiety, depression, and other service-connected or chronic conditions. For many veterans, medical cannabis access is shaped not only by state law but also by VA policy, federal employment rules, disability status, and housing or benefits concerns.

Children and adults with autism spectrum disorder also appear in state medical cannabis and cannabinoid access discussions, especially where families report using CBD or other cannabinoid products to manage anxiety, behavioral challenges, sleep, seizures, or co-occurring symptoms. CDC's most recent autism surveillance found autism spectrum disorder among 1 in 31 children aged eight years at monitored sites, underscoring the size of the population for whom families are seeking more treatment options.

These examples are not exhaustive. They show why medical cannabis access requires healthcare oversight.

22% of Veterans use cannabis
to manage their symptoms from PTSD, chronic pain, and sleep disorders in states with medical cannabis programs.

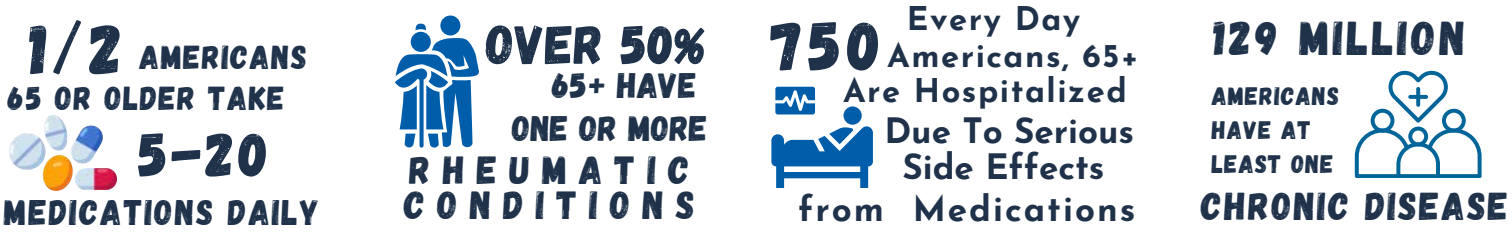
THERE ARE 15.8 MILLION VETERANS, 31% HAVE AT LEAST ONE DISABILITY.

Approx 5% of cannabis patients are children
in states with medical programs. This does not count those who are administering CBD to their children through non-registered programs.

APPROXIMATELY 300K CHILDREN DEPEND ON MEDICAL CANNABIS PROGRAMS.

10-20% those with Autism Spectrum Disorder
use medical cannabis, CBD in particular, regularly used to manage anxiety and behavioral challenges in autism.

5.4 MILLION ADULTS & 1 OUT OF 31 CHILDREN LIVE WITH AUTISM SPECTRUM DISORDER.



U.S. ACCESS DESERTS

Even with most states now having medical cannabis laws, millions of patients still live in medical cannabis access deserts.

An access desert is not limited to states without medical cannabis laws. It can exist anywhere patients technically have legal access to the products they need but cannot realistically obtain, afford, or safely use. A state may have a medical cannabis law on paper while patients still face long travel distances, high registration costs, limited product types, few participating clinicians, inadequate pediatric access, employment risks, or fear of losing housing, benefits, or custody.

Access deserts are especially common for patients in rural areas, low-income communities, federally assisted housing, long-term care settings, hospice, nursing homes, hospitals, military communities, and states with restrictive or underdeveloped medical cannabis programs. They also affect patients who need formulations that adult-use markets often deprioritize, including high-CBD products, balanced-ratio products, non-inhaled formulations, low-dose products, pediatric preparations, and products with consistent cannabinoid profiles.

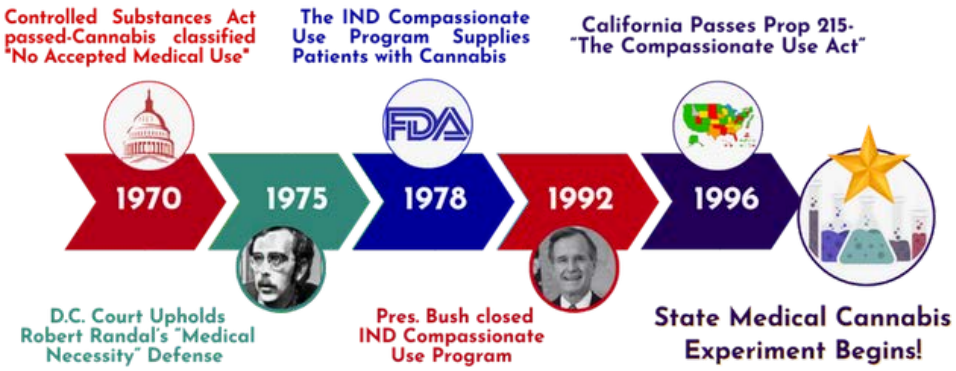
For many patients, hemp-derived cannabinoid products became a bridge across these access deserts, despite the safety concerns of these products. Patients turned to full-spectrum CBD and other cannabinoid products because they were available online, did not require navigating a state medical cannabis bureaucracy, and were often more affordable than dispensary products. **This was not an ideal access system. It was a workaround born of federal inaction and market failures in both medical and adult-use systems.**

Pending federal hemp restrictions may deepen these access deserts. **If full-spectrum hemp-derived products are removed from lawful commerce without a plan to replace them, patients in states with weak medical cannabis programs, no practical access, or limited product availability may lose one of the only cannabinoid options they can legally obtain.** Only a national medical cannabis program can meet these patients' needs.

BACKGROUND: STATES FORCED TO BECOME THE LABORATORIES FOR CANNABIS POLICY

The modern medical cannabis movement was born out of federal failure. When cannabis was placed in Schedule I under the Controlled Substances Act of 1970, patients were denied a lawful federal pathway for therapeutic access.

The first victory came in 1978, when a federal court recognized medical necessity in the case of patient Robert Randall, leading to the creation of the federal Compassionate Investigational New Drug program. For a brief period, cannabis entered U.S. healthcare under federal supervision, demonstrating that regulated medical use was possible.

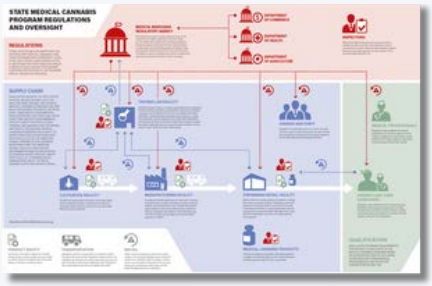


Unfortunately, in 1992, the federal government terminated the IND program under pressure from Drug War advocates, abandoning patients once again and signaling that federal leadership on medical cannabis was not forthcoming. Faced with that vacuum, patients and advocates turned to the states, not out of preference but out of necessity. Early state efforts focused on compassionate use protections and legal defenses, with California's Compassionate Use Act of 1996 marking the first durable state response to federal inaction.

When Americans for Safe Access was founded in 2002, only eight states had medical cannabis laws. These early laws were narrow and limited, often providing little more than a legal defense after arrest. Patient collectives emerged to meet urgent needs, often under constant threat of federal enforcement. Raids, arrests, prosecutions, and asset forfeiture made clear that state medical cannabis activity still operated in the shadow of federal prohibition.

State programs were never the final goal; they were and still are a form of triage. These emergency systems were created to protect patients while advocates worked to dismantle the federal barriers that made those stopgaps necessary.

Over the next three decades, states did far more than decriminalize use; they have served as laboratories of democracy for medical cannabis policy. They created systems for product safety, testing, labeling, patient registration, provider oversight, and real-world evidence generation. They not only disproved long-standing myths embedded in federal policy, but ultimately produced the data that led HHS and the FDA to conclude in 2023 that cannabis has "currently accepted medical use." In effect, states did what the federal government would not: they proved the concept.



Since 2014, Congress has prohibited the Department of Justice (DOJ) from enforcing cannabis laws on participants in the state medical cannabis programs through an amendment to the Commerce, Justice, Science, and Related Agencies (CJS) appropriations bill. This provision applies only to medical programs and must be reauthorized each year. (Adult-use programs have no federal protections at this time.)

HEMP-DERIVED CANNABINOID PRODUCTS FILLED GAPS IN MEDICAL ACCESS

Many Uses of *Cannabis sativa L.*

FLOWER, LEAVES & ROOTS: Terpenes, Flavonoids, & Cannabinoids: Medicinal Preparations

NON-CANNABINOID USES

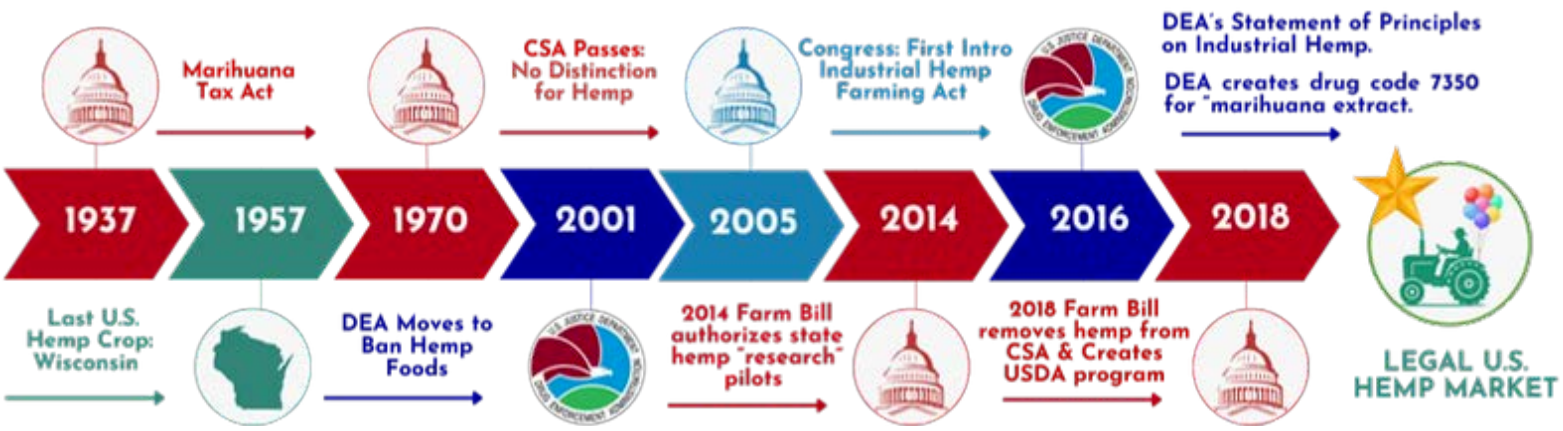
FLOWER- Terpenes/ aromatic Essential oils, Perfumes, Flavorings in Foods & Beverages

SEEDS: Foodstuffs**:** Hemp seed, Hempseed oil, Hemp Milk Products, Flour, Nutritional Powders

STALKS: Fiber: Paper, Clothing, Rope, Plastics, Animal Feed, Building Materials

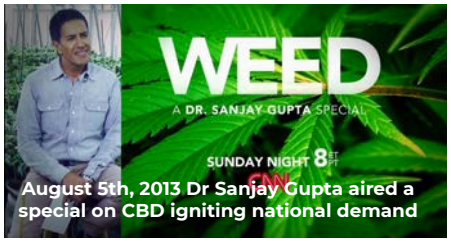
ROOTS: Benefits Crop Rotation, Improves & Chelates Soil, & Reduces Water Pollution

In parallel to the fight for safe access to medical cannabis, another use of the plant—hemp for fiber, food, and commodities—has faced its own regulatory obstacles. Many of the same laws that criminalized medical cannabis also suppressed domestic hemp production, despite the growing global demand for hemp's foodstuffs, textiles, paper, and increasingly, climate-sustainable building materials.

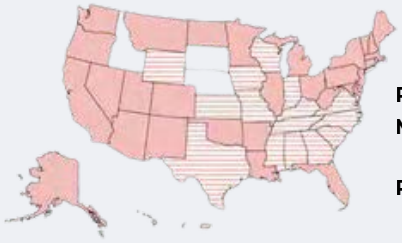


The 2018 Farm Bill was intended to correct that history. It removed "hemp"—defined globally as *Cannabis Sativa L.* containing less than 0.3% THC—from the Controlled Substances Act. But while the Farm Bill legalized hemp cultivation, it failed to define hemp products. **That omission proved consequential.**

At the same time, demand for cannabidiol and other non-intoxicating cannabinoid products was growing rapidly. Many states enacted narrow "CBD-only" laws, often focused on children with seizure disorders. These laws allowed limited possession of certain cannabis oil extracts but generally failed to create functioning access systems. Most did not provide in-state production, distribution, testing, quality control, affordability protections, or reliable patient access.



Medical Cannabis & CBD Laws 2018



Pink-
Medical Cannabis States

Pink stripes- CBD States

The CBD laws were not designed to function as access systems. Most lacked in-state production, quality control, testing requirements, or distribution pathways. They raised a fundamental and unresolved question: how were patients expected to obtain a steady, safe supply of medicine if they could not legally produce or purchase it in their own state?

The hemp market answered that question—imperfectly, but at scale.

While adult-use markets expanded, dispensaries increasingly deprioritized or eliminated high-CBD and non-intoxicating formulations that patients relied on. Products disappeared from shelves. For seniors, veterans, people with disabilities, and low-income patients, these barriers were often insurmountable.

Even though forty-one states have medical cannabis laws with access programs, millions of patients remain functionally excluded. **For many patients, access is blocked by cost, geography, employment restrictions, limited product availability, or competition with adult-use markets.**

Hemp-derived full-spectrum products, often purchased online, has become a workaround. They are accessible, affordable, and widely marketed as legal. **Patients did not choose hemp products because they were novel. They chose it because it worked and it was available.**

The 2018 Farm Bill assumed that the FDA would regulate hemp products. This proved to be another consequential mistake. In 2019, the FDA held hearings on the topic and solicited input from stakeholders. Congressional oversight committees regularly questioned the Agency about progress toward issuing product guidelines. Meanwhile, this unregulated market spread across the country, seemingly unchecked. **States that tried to regulate hemp products found themselves in court.**

In January 2023, almost 5 years after hemp was legalized, the FDA formally concluded that existing regulatory frameworks for foods and dietary supplements are not appropriate for CBD. After convening a high-level internal working group, the FDA announced that a new regulatory pathway would be required and stated it was prepared to work with Congress to develop one. The agency simultaneously denied citizen petitions requesting that CBD be allowed as a dietary supplement.

"Given the growing cannabidiol (CBD) products market, the U.S. Food and Drug Administration convened a high-level internal working group to explore potential regulatory pathways for CBD products. Today we are announcing that after careful review, the FDA has concluded that a new regulatory pathway for CBD is needed that balances individuals' desire for access to CBD products with the regulatory oversight needed to manage risks. The agency is prepared to work with Congress on this matter. "

That determination left patients stranded between regulatory systems—unable to access cannabinoid medicines through healthcare systems, but also unsupported by food and supplement regulatory frameworks.

PENDING HEMP RESTRICTIONS COULD WIDEN ACCESS GAPS

On November 12, 2025, Congress amended hemp laws in H.R. 5371—the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, by establishing statutory definitions for "industrial hemp" and "hemp-derived cannabinoid products" and imposing a new "total THC" standard. Together, when they go into effect on November 11, 2026, these clarifications will close the "loophole" that allowed unregulated intoxicating products to proliferate, but they will also remove most full-spectrum cannabinoid products from lawful commerce, cutting off access for millions of patients who rely on these products as their medicine.

Across the country, seniors, veterans, people with disabilities, cancer patients, children with rare diseases, and people living with chronic pain rely on full-spectrum cannabinoid products purchased from the hemp market. These are not casual consumers. They are patients who turned to hemp because state medical cannabis programs were unavailable, unaffordable, geographically inaccessible, or stripped of the products they need. In many states, adult-use product demand crowded out high-CBD and non-intoxicating formulations. For millions of patients, products from the hemp market filled a gap, even if by default.

Once effective, the law revises the THC threshold to include "total THC" below 0.3 percent, capturing detectable tetrahydrocannabinol compounds, including THCa, on a dry-weight basis. It also explicitly excludes cannabinoid products from the definition of industrial hemp and restricts synthetic cannabinoids, products containing more than 0.4 milligrams of THC per container, and seeds capable of producing cannabis varieties that exceed 0.3 percent THC.

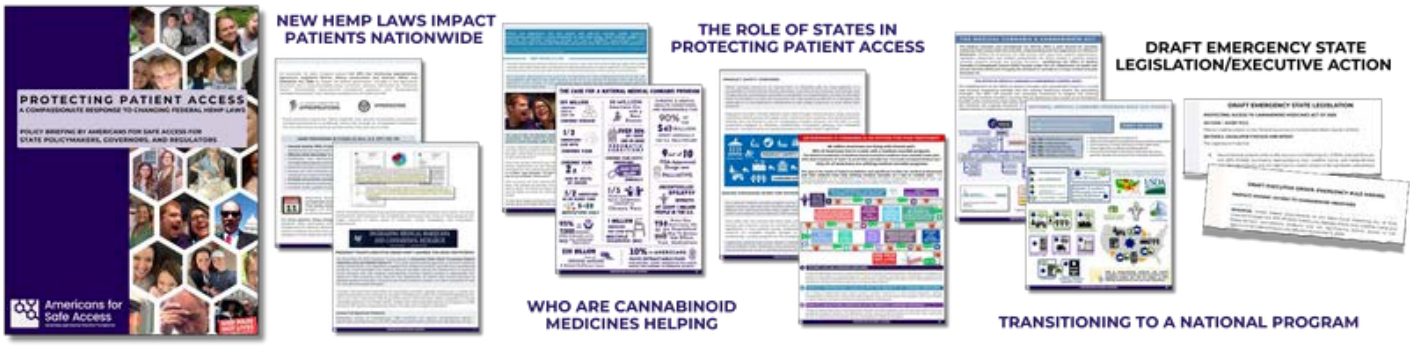
Many patients, businesses, and advocates hoped President Trump's Executive Order would resolve the hemp access problem because it directed the White House Deputy Chief of Staff for Legislative, Political, and Public Affairs to work with Congress to allow Americans to benefit from appropriate full-spectrum CBD products while restricting products that pose serious health risks. However, the Executive Order cannot fix the statutory problem by itself. Once Section 781 takes effect, restoring access to appropriate full-spectrum cannabinoid products will require changes to federal law, which only Congress can make.

A reversal in policy would be politically unpopular. Leading up to the vote on the appropriations package, a bipartisan letter signed by 39 state Attorneys General urged Congress to address intoxicating hemp products and helped build support for including clarifying definitions of hemp in the final minibus language. Their message helped shape the political environment that led Congress to include the hemp provisions in the final appropriations package.

"Unless Congress acts, this gross distortion of the 2018 Farm Bill's hemp provision will continue to fuel the rapid growth of an underregulated industry that threatens public health and safety and undermines law enforcement nationwide."

A congressional reversal seems unlikely. Opposition to hemp-derived cannabinoid products is diverse, well-organized, and includes state officials, public safety voices, law enforcement interests, and members of key committees with jurisdiction over cannabis, hemp, healthcare, and agriculture. Many of these committee leaders have been openly hostile toward cannabis reform, including several who joined letters opposing Schedule III that were delivered to the White House and signed by 22 U.S. Senators and 26 House Members.

The political debate around hemp has largely focused on intoxicating products, youth exposure, public safety, and law enforcement concerns. Those issues are real. But they do not capture the full access picture for patients who rely on non-intoxicating or full-spectrum cannabinoid products for therapeutic use.



Download Briefing here: www.SafeAccessNow.org/Protect_Patient_Access

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. The report also calls on Congress to move forward with a comprehensive solution for the therapeutic issues of cannabis and cannabinoids.

CMS HAS OPENED A NARROW ACCESS PATHWAY

CMS's Substance Access Beneficiary Engagement Incentive is a meaningful federal milestone. It allows certain CMS Innovation Center model participants to consult with eligible beneficiaries about the possible use of eligible hemp products for symptom control and, where model requirements are met, furnish eligible hemp products up to $500 per year per eligible beneficiary. This is the first major federal healthcare access opening for cannabis-derived products in decades and creates a narrow but important bridge between cannabinoid products, clinician-guided care, and federal healthcare systems.

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

Read more: www.safeaccessnow.org/cms_advances_medical_cannabis

This is the first major federal healthcare access opening for cannabis-derived products in decades. It creates a narrow but important bridge between cannabinoid products, clinician-guided care, and federal healthcare systems.

However, this is not Medicare coverage for medical cannabis. The incentive is optional, model-specific, limited to eligible participants and beneficiaries, and restricted to eligible hemp-derived products. CMS does not pay ordinary Medicare claims for these products. The initiative also does not resolve the barriers facing state-authorized medical cannabis patients, including healthcare documentation, VA clinical support, product safety standards, continuity-of-care protections, civil rights protections, or access through federally funded care settings.

The CMS action is best understood as a proof of concept. It shows that cannabinoid access can be connected to federally supported healthcare settings, but it remains narrow.

6 Million+ medical cannabis patients

70 Million Americans use CBD

2/3 of Medical Professionals recognize the medical value of cannabis

AG ORDER NO. 6754-2026 CHANGES THE FEDERAL LANDSCAPE

This is a major shift. For nearly thirty years, federal agencies and courts generally made no distinction between state-authorized medical cannabis use and illegal drug use under federal law. Patients were treated as categorically engaged in unlawful drug use even when complying with state medical cannabis laws. That framework shaped housing policy, employment policy, healthcare access, veterans' care, disability accommodations, federal benefits, and federally funded services.

AG Order No. 6754-2026 changes the legal landscape, creating a federal pathway for qualifying state-regulated medical cannabis products. It does not, by itself, resolve access deserts, affordability barriers, travel restrictions, product shortages, inconsistent state rules, or the broader lack of integration between medical cannabis and healthcare systems.

U.S. ACCESS

The United States now has a medical cannabis and cannabinoid access landscape defined by overlapping systems rather than a unified framework. State medical cannabis programs provide regulated access for many patients, but protections and product availability vary widely. Hemp-derived cannabinoid products filled gaps for patients who could not access state programs. While the lack of oversight made this market a less-than-ideal solution for cannabinoid access, the pending federal restrictions on hemp will greatly limit that pathway for patients. CMS has opened a narrow window for healthcare access, but not for broad coverage or integration.

AG Order No. 6754-2026 represents a major federal recognition of medical cannabis, but the patient experience remains plagued with uncertainty. For many patients, access still depends on where they live, what they can afford, whether appropriate products are available, and whether state and federal systems recognize their medical needs. The limitations of the AG's order could impact access for all patients if not enough cannabis businesses apply for the DEA licenses.

State programs proved that regulated medical cannabis access is possible. The current landscape shows that possibility is not the same as equity, consistency, or healthcare integration.

CONGRESS MUST ACT TO ENSURE THIS FEDERAL SHIFT BECOMES MEANINGFUL FOR PATIENTS

For decades, medical cannabis patients have been forced to hide their medicine or avoid disclosure because of the real risk of losing housing, employment, healthcare, child custody, public benefits, services, medical procedures, or reasonable accommodations. AG Order No. 6754-2026 changes the legal posture of medical cannabis, but it does not automatically update the federal, state, local, or private policies that exclude or punish patients.

Congress should utilize FY2027 appropriations to protect state medical cannabis programs, prevent riders that derail rescheduling, and require federal agencies to update outdated policies affecting patients, veterans, housing, healthcare, federal employment, research, product safety, DEA registration, and implementation of federal medical cannabis policy.

By placing certain medical cannabis products in a schedule that recognizes medical value and asserting federal oversight over state-regulated medical cannabis access, AG Order No. 6754-2026 has aligned U.S. drug policy more closely with international treaty obligations and taken a significant step toward a national medical cannabis framework. However, the legal pathway available to the Attorney General has real limitations. It places the administration of medical cannabis access largely within an enforcement agency, rather than within a health agency equipped to oversee medicine, patient care, product safety, clinical data, and healthcare integration.

Medical cannabis policy should be led by experts in cannabis medicines and public health through an Office of Medical Cannabis and Cannabinoid Control housed within HHS, as described in ASA's Medical Cannabis and Cannabinoid Act (MCCA). **Congress should pair FY2027 implementation directives with the introduction and passage of the MCCA to ensure federal policy creates durable patient access, healthcare integration, product safety, civil rights protections, and national standards.**

KEY TAKEAWAYS

Patients need DOJ to issue nationwide guidance on ADA, Fair Housing Act, and Section 504 protections for state-authorized medical cannabis patients.

Federal agency review of outdated policies treating medical cannabis patients as categorically engaged in disqualifying illegal drug use.

Shift from automatic exclusion to individualized assessment, reasonable accommodation, patient safety, clinical judgment, actual impairment, and documented risk.

Immediate guidance is needed for housing, healthcare, employment, veterans' care, federal workplaces, military systems, and federally funded programs.

Stigma and discrimination have remained prevalent for patients even in states that have passed medical cannabis laws. Patients have lost housing, jobs, healthcare access, medical procedures, child custody, public benefits, and basic dignity because federal cannabis scheduling has been used to justify exclusion and punishment. AG Order No. 6754-2026 changes that legal premise, but it does not automatically update the policies, forms, guidance documents, enforcement practices, and institutional habits that have harmed patients for decades.

The White House and Congress must press the Department of Justice to issue nationwide civil rights guidance clarifying that state-authorized medical cannabis patients are entitled to individualized assessment and reasonable accommodation. That guidance should make clear that patients may not be denied services, housing, healthcare, employment, benefits, reasonable accommodations, or federal program participation solely because they participate in a state-approved medical cannabis program or use medical cannabis in accordance with state law.

Similarly, every federal agency should be directed to immediately identify, review, and update policies, guidance documents, forms, enforcement practices, funding conditions, and data systems that treat medical cannabis patients as categorically engaged in disqualifying illegal drug use. Federal agencies must move away from automatic exclusion and toward individualized review, reasonable accommodation, patient safety, clinical judgment, actual impairment, documented safety risk, and program-specific legal requirements.

The following examples represent the most urgent agency guidance needs and should not be treated as a comprehensive list:

Department of Housing and Urban Development: HUD should withdraw and replace housing guidance that permits denial of admission, eviction, termination of assistance, lease nonrenewal, or refusal of reasonable accommodation for state-authorized medical cannabis patients in federally assisted housing.

Department of Veterans Affairs: VA should replace VHA Directive 1315 so VA clinicians may discuss medical cannabis with veterans, recommend medical cannabis where permitted by state law, complete state medical cannabis forms, make referrals, document therapeutic cannabis use, and treat medical cannabis use as part of clinical care rather than substance use or misconduct by default.

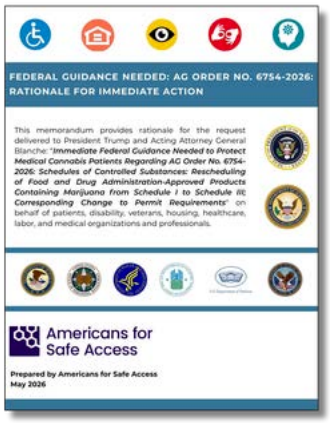
Office of Personnel Management, HHS, SAMHSA, & DOJ: These agencies should review federal cannabis testing practices and clarify that a cannabis-positive test alone does not establish impairment, misconduct, deficient performance, or lack of fitness for duty for qualified medical cannabis patients absent evidence of on-duty impairment, unsafe conduct, or demonstrable job-related safety risk.

HHS & CMS: HHS and CMS should instruct hospitals, hospices, nursing homes, assisted living facilities, federally qualified health centers, Medicare- and Medicaid-participating providers, transplant programs, pain clinics, and other federally supported healthcare settings not to deny care, refuse documentation, or force discontinuation of medical cannabis solely because of outdated federal policy. Medical cannabis-related care decisions should be based on clinical judgment, patient safety, care coordination, and individualized review.

Department of Defense: DOD should create a responsible medical cannabis review pathway for active-duty service members and end zero-exception policies that treat therapeutic medical use as automatic misconduct. Military policy must preserve readiness and safety while allowing appropriate clinical review, transition planning, disability evaluation, and continuity-of-care planning.

Treasury and IRS have already recognized the need for implementation guidance for businesses, including guidance on Section 280E and related tax issues. Patients need the same urgency. Congress should ensure that federal recognition of cannabis medicines translates into practical protections for patients, caregivers, families, veterans, workers, tenants, and people who depend on federally funded healthcare, housing, and services.

FY2027 appropriations and agency oversight authority present opportunities for Congress to ensure that federal agencies update outdated policies following AG Order No. 6754-2026 and the recognition of qualifying medical cannabis within Schedule III of the Controlled Substances Act. These requests are intended to require agencies to implement existing federal law consistently, protect patients from discrimination, update obsolete guidance, and ensure federal programs do not continue to rely on outdated Schedule I assumptions.



Read Americans for Safe Access Memo: *"AG Order No. 6754-2026: Federal Guidance Needed for Patient Protections: A Rationale for Immediate Action"* for specific policy citations.

www.SafeAccessNow.org/Guidance_Rationale_AG_Order

APPROPRIATIONS FY2027 & MEDICAL CANNABIS

Congress should use the FY2027 appropriations process to ensure that federal agencies implement AG Order No. 6754-2026 in ways that protect patients, preserve state medical cannabis programs, and update outdated federal policies that still rely on Schedule I assumptions. Appropriations language can move agencies immediately by directing DOJ, HUD, HHS, CMS, VA, OPM, SAMHSA, DOD, FDA, Treasury, IRS, FinCEN, DEA, and other federal entities to issue guidance, review existing policies, report back to Congress, and align implementation with patient safety, civil rights, healthcare integration, research, and product safety needs.

These directives cannot replace comprehensive legislation, but they can prevent harm, create accountability, and ensure that federal recognition of medical cannabis translates into practical protections for patients.

APPROPRIATION ASKS OVERVIEW BY SUBCOMMITTEES:

COMMERCE, JUSTICE, SCIENCE, & RELATED AGENCIES

Retain the Medical Cannabis CJS Amendment; remove anti-rescheduling language; require DOJ civil rights guidance; require DEA registration fairness and reporting.

LABOR, HEALTH & HUMAN SERVICES, EDUCATION, & RELATED AGENCIES

Require HHS/CMS healthcare guidance, standardized medical cannabis data fields, CMS cost and coverage studies, and creation of the Office of Medical Cannabis and Cannabinoid Control.

TRANSPORTATION, HOUSING & URBAN DEVELOPMENT, & RELATED AGENCIES

Require HUD to withdraw and replace outdated medical marijuana housing guidance and protect patients from categorical housing exclusions.

AGRICULTURE, RURAL DEVELOPMENT, FOOD & DRUG ADMINISTRATION, & RELATED AGENCIES

Require FDA hemp-derived cannabinoid labeling/safety disclosure, real-world evidence reporting, and product-safety standards for medical cannabis and cannabinoid products.

MILITARY CONSTRUCTION, VETERANS AFFAIRS, & RELATED AGENCIES

Require VA clinician-support policy, VHA medical cannabis documentation, and a VA report on cost savings, clinical integration, and veteran access.

FINANCIAL SERVICES & GENERAL GOVERNMENT Require OPM workplace policy updates.

DEPARTMENT OF DEFENSE Require DOD review of cannabis, hemp-derived cannabinoids, CBD, and medical disclosure policies for service members.

A. THE MEDICAL CANNABIS CJS AMENDMENT

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. This year, the House Appropriations Committee passed amendments that would block efforts to reschedule cannabis and modified the Medical Cannabis Amendment to open the door for federal interference in state medical cannabis programs again (with double penalties).

SEC. 531. (a) None of the funds made available under this Act to the Department of Justice may be used, with respect to any of the States of Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, or with respect to the District of Columbia, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Guam, or Puerto Rico, to prevent any of them from implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

1. REMOVE SEC. 531(b):

Purpose: 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. 531(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.

2. REMOVE SEC. 591:

Purpose: 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. 591. "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)."

B. FEDERAL MEDICAL CANNABIS PATIENT PROTECTIONS: AG ORDER NO. 6754-2026

Committee members should use the appropriations process to ensure that AG Order No. 6754-2026 and the federal recognition of qualifying medical cannabis within Schedule III of the Controlled Substances Act protect patients from discrimination.

Direct the Department of Justice to issue civil rights guidance clarifying how the Americans with Disabilities Act, Fair Housing Act, and Section 504 of the Rehabilitation Act apply to state-authorized medical cannabis patients following AG Order No. 6754-2026.

Purpose: Patients continue to face discrimination in housing, employment, healthcare, federally funded programs, public accommodations, benefits, services, and reasonable-accommodation requests because many policies still rely on obsolete Schedule I assumptions.

SAMPLE BILL LANGUAGE:

SEC. __. MEDICAL CANNABIS PATIENT CIVIL RIGHTS GUIDANCE.
Not later than 30 days after the date of enactment of this Act, the Attorney General, acting through the Assistant Attorney General for the Civil Rights Division, shall issue guidance regarding the application of the Americans with Disabilities Act, the Fair Housing Act, and section 504 of the Rehabilitation Act to individuals participating in state-authorized medical cannabis programs following AG Order No. 6754-2026.

The guidance required under subsection (a) shall address housing, employment, healthcare, federally funded programs, public accommodations, benefits, services, and requests for reasonable accommodation, and shall provide standards for individualized assessment, actual impairment, documented safety risk, and program-specific necessity.

C. DEA REGISTRATION & PRIOR CANNABIS-RELATED CONVICTIONS

Direct DOJ and DEA to ensure that prior cannabis-related convictions are not treated as a categorical basis to deny DEA registration to state-licensed medical cannabis manufacturers, distributors, or dispensers.

Purpose: The DOJ order creates a federal registration process for state-licensed medical cannabis entities. Because the public-interest factors under 21 U.S.C. § 823 include prior controlled-substance convictions, DOJ and DEA must not use prior cannabis convictions as a blanket exclusion against people who helped operate state medical cannabis systems before federal law caught up.

SAMPLE BILL LANGUAGE:

None of the funds made available by this Act may be used by the Drug Enforcement Administration to deny registration to a state-licensed medical cannabis manufacturer, distributor, or dispenser solely on the basis of a prior cannabis-related conviction, absent an individualized determination that the applicant presents a current and documented risk to public health, safety, diversion control, or compliance with applicable international treaty obligations.

LABOR, HEALTH & HUMAN SERVICES, EDUCATION, & RELATED AGENCIES

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 validated by a growing body of scientific evidence and by HHS, the FDA, the NIH, and the National Academies of Science. 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.

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.

A. HHS & CMS HEALTHCARE GUIDANCE FOR FEDERALLY FUNDED HEALTHCARE ENTITIES

Direct HHS and CMS to issue guidance requiring federally funded healthcare entities and Medicare- and Medicaid-participating providers to evaluate state-authorized medical cannabis patients through individualized review and reasonable-accommodation standards.

Purpose: Patients entering hospitals, hospices, nursing homes, assisted living facilities, FQHCs, transplant programs, pain clinics, and other care settings may be told to discontinue medical cannabis or may be denied documentation, care coordination, or accommodation because providers fear federal funding, certification, reimbursement, or licensing consequences.

SAMPLE BILL LANGUAGE:

SEC. __. MEDICAL CANNABIS PATIENTS IN FEDERALLY FUNDED HEALTHCARE SETTINGS.
Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance clarifying that federally funded healthcare entities and Medicare- and Medicaid-participating providers may discuss, document, coordinate care for, and reasonably accommodate patients participating in state-authorized medical cannabis programs. Such guidance shall apply to hospitals, hospices, nursing homes, assisted living facilities, federally qualified health centers, transplant programs, pain clinics, Medicare- and Medicaid-participating providers, and other federally funded healthcare entities, and shall require medical cannabis-related requests to be evaluated through individualized assessment, patient safety, clinical judgment, care coordination, and applicable disability nondiscrimination standards.

B. STANDARDIZED MEDICAL CANNABIS USE DATA COLLECTION & GUIDANCE.

Direct HHS and CMS to develop standardized intake and electronic health record fields for therapeutic medical cannabis use, separate from non-medical cannabis use, illicit drug use, or substance-use-disorder-related documentation. 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.

Purpose: Standardized documentation will improve patient safety, continuity of care, drug-interaction screening, research comparability, and future policy evaluation.

SAMPLE BILL LANGUAGE:

SEC. __. 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.

C. MEDICAL CANNABIS COST SAVINGS, COVERAGE MODELS, & IMPLEMENTATION COSTS.

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.

Purpose: Congress needs reliable information on potential Medicare and Medicaid savings, coverage models, and administrative costs before evaluating broader healthcare integration or coverage reforms.

SAMPLE COMMITTEE REPORT LANGUAGE:

Medical Cannabis and Federal Healthcare Program Research.
The Committee directs CMS to conduct or support research on the impact of state-authorized medical cannabis use on Medicare and Medicaid beneficiaries, including healthcare costs, prescription drug utilization, opioid use, hospitalizations, long-term care utilization, hospice care, pain management, patient-reported outcomes, adverse events, and care coordination. The Committee further directs CMS to evaluate whether standardized documentation of therapeutic medical cannabis use would improve patient safety, care coordination, drug-interaction screening, and federal healthcare program integrity.

D. Establish an HHS Office of Medical Cannabis & Cannabinoid Control

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.

Purpose: Rescheduling alone will not create patient protections, healthcare integration, research advancement, product safety standards, or consistent federal implementation. HHS needs an operational office to coordinate medical cannabis policy across CMS, FDA, NIH, DOJ, HUD, VA, DOD, OPM, SAMHSA, Treasury, IRS, FinCEN, state regulators, Tribal governments, patients, clinicians, and researchers.

SAMPLE BILL LANGUAGE:

SEC. __. OFFICE OF MEDICAL CANNABIS & CANNABINOID CONTROL.
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 support implementation across research, healthcare delivery, civil rights, product safety, clinical documentation, patient access, state-federal coordination, hemp-derived cannabinoid regulation, and federal program alignment including the implementartion of AG Order No. 6754-2026, the Medical Marijuana and Cannabidiol Research Expansion Act, and Executive Order 14370.

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,

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.

AGRICULTURE, RURAL DEVELOPMENT, FOOD & DRUG ADMINISTRATION, & 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.

When these changes take effect on November 12, it will come as a shock to many patients. 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.

Many patients, businesses, and advocates hoped that President Trump's Executive Order would resolve the hemp access problem because it directed the White House Deputy Chief of Staff for Legislative, Political, and Public Affairs to work with Congress to allow Americans to benefit from appropriate full-spectrum CBD products while restricting products that pose serious health risks. But the Executive Order cannot fix the statutory problem by itself. Expanding access to appropriate full-spectrum CBD products after Section 781 takes effect will require congressional action, including amendments to H.R. 5371. Executive action alone cannot override statutory limits enacted by Congress.

That legislative pathway will be difficult. Key congressional committees with jurisdiction over cannabis, hemp, healthcare, appropriations, and agriculture remain divided or hostile to cannabis reform. The result is that the hemp loophole is unlikely to be reopened or repaired quickly.

While intoxicating hemp products took the main stage in the hemp law revisions in FY2026 appropriations, the other controversy surrounding hemp-derived cannabinoid products was the lack of regulations and oversight for these products. Policymakers and patients anticipated forthcoming FDA regulations of these products following the laws legalizing hemp passed in the 2018 Farm bill. In 2023, 5 years later, the FDA announced that it was unable to regulate these products, absent Congress creating a new pathway for it to do so.

For the products that will still be allowed after November 11, 2026, this critical gap in product safety remains. Congress failed to create a regulartory framework for federal agencies to enforce meaningful federal testing, labeling, contaminant screening, batch identification, adverse-event reporting, or product safety standards. Congress should direct FDA to establish hemp-derived cannabinoid labeling and safety disclosure requirements now.

A. FDA HEMP-DERIVED CANNABINOID LABELING & SAFETY DISCLOSURE REQUIREMENTS

The widespread availability of these products on the market has created a false sense of security among patients and consumers regarding their safety. While the FDA cannot regulate these products without Congress creating a new pathway, the FDA can ensure consumers are informed of the absence of regulation and oversight. Direct the FDA to issue protocols requiring manufacturers of CBD and other hemp-derived cannabinoid products to comply with basic federal labeling and safety disclosure requirements.

Purpose: Patients and consumers need transparent labeling, batch identification, and contaminant-testing information, especially while federal cannabinoid policy remains fragmented.

SAMPLE BILL LANGUAGE:

SEC. __. HEMP-DERIVED CANNABINOID LABELING AND SAFETY DISCLOSURES.
Not later than 30 days after the date of enactment of this Act, the Commissioner of Food and Drugs shall issue guidance or protocols requiring manufacturers of CBD and other hemp-derived cannabinoid products to provide basic labeling and safety disclosures, including the source of the cannabinoid, whether the product has been evaluated for safety by the Food and Drug Administration, contaminant or adulterant testing information or a QR code linking to a certificate of analysis, and a batch number for tracking and transparency.

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

B. FDA REAL-WORLD EVIDENCE FRAMEWORK & MEDICAL CANNABIS REPORT

Direct FDA to use its real-world evidence framework to generate a report on current medical cannabis use, research, knowledge gaps, and educational integration in the United States.

Purpose: Federal agencies should learn from state programs, real-world patient use, accredited cannabis research centers, international research, and medical education gaps while Congress considers a national medical cannabis framework.

SAMPLE BILL LANGUAGE:

SEC. __.REAL-WORLD EVIDENCE REPORT ON MEDICAL CANNABIS.
Not later than 1 year after the date of enactment of this Act, the Commissioner of Food and Drugs, acting through the Center for Biologics Evaluation and Research and the Center for Drug Evaluation and Research, shall use the Food and Drug Administration's real-world evidence framework to submit a report to the Committees on Appropriations on medical cannabis use, research, knowledge gaps, and educational integration in the United States. The report shall include an overview of domestic and international medical cannabis research, the status of medical cannabis and endocannabinoid system education in pre-medical, medical, continuing medical education, and graduate programs, an assessment of the impact of the 2018 ACCME guidelines on cannabis-related continuing medical education, and recommendations for state medical cannabis programs to harmonize data collection and identify gaps necessary for healthcare integration.

C. MEDICAL CANNABIS AND CANNABINOID PRODUCT SAFETY STANDARDS

Direct FDA and HHS to develop medical cannabis and cannabinoid product safety priorities, including contaminants, labeling accuracy, stability, shelf life, cannabinoid content, microbial impurities, pesticides, heavy metals, residual solvents, storage, packaging, and recalls.

Purpose: Product safety standards are essential for patients, clinicians, healthcare systems, and regulators to distinguish therapeutic medical cannabis use from unverified or unsafe products.

SAMPLE BILL LANGUAGE:

SEC. __. MEDICAL CANNABIS AND CANNABINOID PRODUCT SAFETY.
The Commissioner of Food and Drugs, in coordination with the Secretary of Health and Human Services and other relevant federal agencies, shall develop guidance or recommendations regarding product safety, labeling accuracy, stability, storage, shelf life, contaminant testing, adverse-event reporting, and recall procedures for medical cannabis and cannabinoid products used by patients in state-authorized medical cannabis programs. The guidance or recommendations shall address contaminants, pesticides, residual solvents, heavy metals, microbial impurities, cannabinoid content, product consistency, packaging, storage, expiration dating, and labeling accuracy.

APPROPRIATIONS SUBCOMMITTEE: FINANCIAL SERVICES & GENERAL GOVERNMENT

Direct OPM, in consultation with HHS, SAMHSA, and DOJ, to update federal workplace guidance so medical cannabis use is distinguished from impairment, misconduct, deficient performance, or job-related safety risk.

Purpose: Federal employees, applicants, and contractors can face adverse employment consequences based on a cannabis-positive test that does not establish impairment, unsafe conduct, deficient performance, or poor job performance. Patients may also be forced to disclose a disability or treatment plan to explain lawful medical cannabis use.

SAMPLE BILL LANGUAGE:

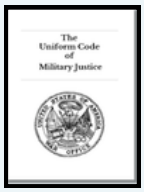
SEC. __. FEDERAL WORKPLACE POLICY AND STATE-AUTHORIZED MEDICAL CANNABIS USE.
Not later than 30 days after the date of enactment of this Act, the Director of the Office of Personnel Management, in consultation with the Secretary of Health and Human Services, the Assistant Secretary for Mental Health and Substance Use, and the Attorney General, shall issue guidance to federal agencies regarding state-authorized medical cannabis use in federal employment and contracting decisions.

Such guidance shall clarify that a cannabis-positive test, standing alone, does not establish impairment, misconduct, deficient performance, or lack of fitness for duty for a qualified medical cannabis patient absent evidence of on-duty impairment, unsafe conduct, deficient performance, or a demonstrable job-related safety risk. The guidance shall preserve appropriate restrictions for safety-sensitive duties while requiring individualized assessment where applicable.

APPROPRIATIONS SUBCOMMITTEE: DEPARTMENT OF DEFENSE

For the millions of Americans who serve or have served in the armed forces, the discipline and sacrifice of military life come with strict rules. One of the most unyielding is the blanket prohibition on cannabis use for active-duty service members — even when that use is legal under state law and medically recommended by a doctor.

This isn't just about recreational use. It means that service members with chronic pain, PTSD, traumatic brain injuries, or other service-related medical conditions are barred from using medical cannabis, even if it is the most effective treatment available to them.



For active-duty military members, cannabis use is prohibited under Article 112a of the Uniform Code of Military Justice (UCMJ), which forbids:

"the knowing use, possession, or distribution of marijuana and marijuana-derived products, including CBD. This prohibition applies at all times and in all locations. Violations are punishable under Article 92 of the UCMJ."

Each branch enforces this policy as follows:

Army: AR600-85, section 4-2p
Air Force: AFMAN 44-197, Paragraph 1.2.2.1
Navy & Marines: ALNAV 057/19, Paragraph 3
Coast Guard: COMDTINST M1000.10A, Chapter 5, Section D.1

Congress should direct DOD to review Department-wide and branch-specific policies governing cannabis, hemp-derived cannabinoids, cannabidiol products, and state-authorized medical cannabis use.

Purpose: The military has unique readiness, discipline, deployment, and safety requirements, but current policies provide no responsible pathway for medical disclosure, clinical review, transition planning, disability evaluation, or continuity-of-care planning.

SAMPLE BILL LANGUAGE:

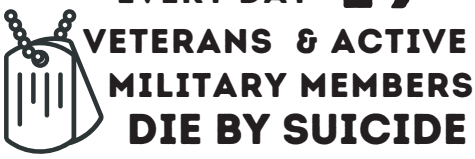
SEC. __. DEPARTMENT OF DEFENSE MEDICAL CANNABIS POLICY REVIEW.
Not later than 30 days after the date of enactment of this Act, the Secretary of Defense shall review Department-wide and branch-specific policies governing cannabis, hemp-derived cannabinoids, cannabidiol products, and state-authorized medical cannabis use. The review shall identify duty assignments, deployment contexts, weapons-related duties, aviation roles, and safety-sensitive activities where restrictions remain necessary, while also establishing a responsible pathway for medical disclosure, clinical review, transition planning, disability evaluation, and continuity-of-care planning. The Secretary shall issue guidance to ensure that disclosure of state-authorized medical cannabis use for purposes of seeking medical guidance, transition planning, disability evaluation, or continuity of veteran healthcare is evaluated through clinical and readiness-based review rather than through automatic punitive action.

APPROPRIATIONS SUBCOMMITTEE: MILITARY CONSTRUCTION & VETERANS AFFAIRS

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.

A. VA CLINICAL SUPPORT FOR VETERANS PARTICIPATING IN STATE MEDICAL CANNABIS PROGRAMS

"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)



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 FY2026.

Direct VA to replace VHA Directive 1315 and allow VA clinicians to support veterans participating in state medical cannabis programs, including by discussing medical cannabis, documenting therapeutic use, making referrals, completing state forms, and assisting with registration where consistent with state law and clinical judgment.

Purpose: Veterans who rely on VA healthcare are forced to seek medical cannabis guidance outside the VA system, often from clinicians without access to their full medical history, medication list, disability profile, or treatment plan.

SAMPLE BILL LANGUAGE:

SEC. __. VA CLINICAL SUPPORT FOR STATE MEDICAL CANNABIS PROGRAM PARTICIPATION.
Not later than 30 days after the date of enactment of this Act, the Secretary of Veterans Affairs shall issue guidance permitting Department of Veterans Affairs healthcare providers to discuss medical cannabis with veterans and, where consistent with state law and clinical judgment, recommend medical cannabis, make referrals, complete state medical cannabis program forms, assist veterans in registering for state-authorized medical cannabis programs, document therapeutic medical cannabis use, evaluate potential drug interactions, and coordinate care.

B. VA ELECTRONIC MEDICAL RECORD CODE FOR THERAPUTIC USE OF CANNABIS

Direct VA to update its electronic medical record systems to include a distinct code or field for therapeutic medical cannabis use.

Purpose: Medical cannabis use should be documented as therapeutic medication use when appropriate, not automatically recorded as non-medical use, illicit drug use, or substance-use-disorder-related history.

22% OF VETERANS CURRENTLY USE CANNABIS TO TREAT MEDICAL CONDITIONS

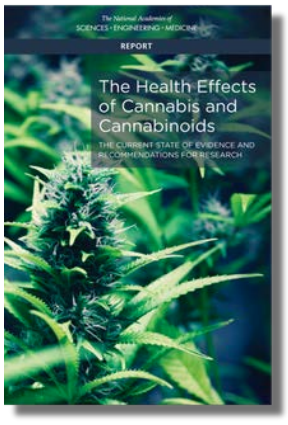
SAMPLE COMMITTEE REPORT LANGUAGE:

VHA Medical Cannabis Documentation and Report.
The Committee directs VA to report on potential cost savings, clinical protocols, patient safety guidance, education needs, and implementation requirements associated with allowing VHA clinicians to support veterans participating in state medical cannabis programs.

SAMPLE BILL LANGUAGE:

SEC. __. VHA MEDICAL CANNABIS DOCUMENTATION & REPORT.
The Secretary of Veterans Affairs shall update Department electronic medical record systems to include a distinct code or field for therapeutic medical cannabis use, separate from non-medical cannabis use, illicit drug use, or substance-use-disorder-related documentation. Such documentation shall include, where known, the route of administration, cannabinoid content, dose, frequency of use, participation in a state medical cannabis program, the certifying healthcare professional, where applicable, possible drug interactions, contraindications, and care-coordination needs.

Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the Committees on Appropriations a report evaluating cost savings, clinical protocols, education requirements, and implementation needs for VHA medical cannabis clinical support.



"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"

KEY TAKEAWAYS

Need for an HHS-led, healthcare-centered national medical cannabis program.

Creation of the Office of Medical Cannabis and Cannabinoid Control and a new Schedule VI.

Recognition of cannabis as a botanical medicine with a unique therapeutic and regulatory profile.

Federal-state coordination, national product safety standards, research access, and healthcare integration.

Durable federal framework for safe, legal, reliable therapeutic access and patient protections.

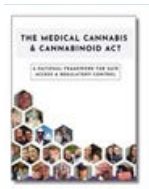
AG Order No. 6754-2026 marks a major federal shift, but it is not a substitute for a national medical cannabis program. The Order demonstrates that medical cannabis can operate within a lawful federal framework, that federal policies can build on existing state medical cannabis systems, state-licensed medical cannabis businesses can be brought into a federal registration structure, and these programs can be integrated into the U.S. healthcare landscape.

That is a significant first step, but it also reveals the limit of the powers granted to the Office of the Attorney General under U.S.C. 811 (d). AG Order No. 6754-2026 aligns the U.S. federal cannabis policy with the obligations set forth in international treaties, namely the scheduling of cannabis and federal control over the medical supply to both ensure access and prevent diversion. Neither the Attorney General nor the Executive Branch alone can create a functioning program that anticipates and meets the needs of both the current and future patient populations.

ASA's Medical Cannabis & Cannabinoid Act (MCCA) was drafted to address the gaps that administrative scheduling alone cannot resolve. Like the DOJ Order, the MCCA was designed to comply with international drug treaties and create a federal pathway for medical cannabis. Unlike the DOJ Order, the MCCA places federal oversight within the Department of Health and Human Services through a new Office of Medical Cannabis and Cannabinoid Control staffed with experts on cannabis medicines. The DOJ Order depends on existing state medical cannabis systems for oversight and access and the DEA for enforcement.

The MCCA would serve patients nationwide, fully integrate medical cannabis into U.S. healthcare systems, and coordinate medical cannabis policy implementation across federal agencies. By contrast, AG Order No. 6754-2026 serves only patients registered in state medical cannabis programs and primarily provides implementation guidance to the DEA and the Treasury. The Order represents the outer limit of what the Executive Branch and the Attorney General can do to address access to controlled substances. The ball once again rests with Congress.

MCCA vs AG Order No. 6754-2026



		SCHEDULE VI			REGULATONS FOR ALL CANNABINOID PRODUCTS	INTERSTATE COMMERCE	
		SCHEDULE III			?	?	?

The Medical Cannabis & Cannabinoid Act creates a national medical cannabis program through two primary functions: establishing an Office of Medical Cannabis and Cannabinoid Control within HHS and moving cannabis into a newly created Schedule VI. Schedule VI recognizes cannabis as a botanical medicine with a unique profile and allows regulations tailored to its properties and therapeutic use.

- The OMC mission should be to facilitate access to medical cannabis and cannabinoids for therapeutic use and research, regulate production and product safety, facilitate public-private partnerships for product development and research, and oversee Schedule VI.
- A national medical cannabis program should protect patients, standardize product safety and terminology, support research, create healthcare integration tools, protect civil rights, and provide a clear federal-state coordination structure.

Recent cannabis reform bills have focused primarily on decriminalization, criminal justice reform, and commercial access. Those goals matter, but they do not solve the specific problems faced by medical cannabis patients. Adult-use markets do not serve patients, and FDA-only or tobacco-style regulatory models risk treating cannabis as a consumer product category rather than a medical therapy requiring patient protections, data infrastructure, product standards, and healthcare integration.

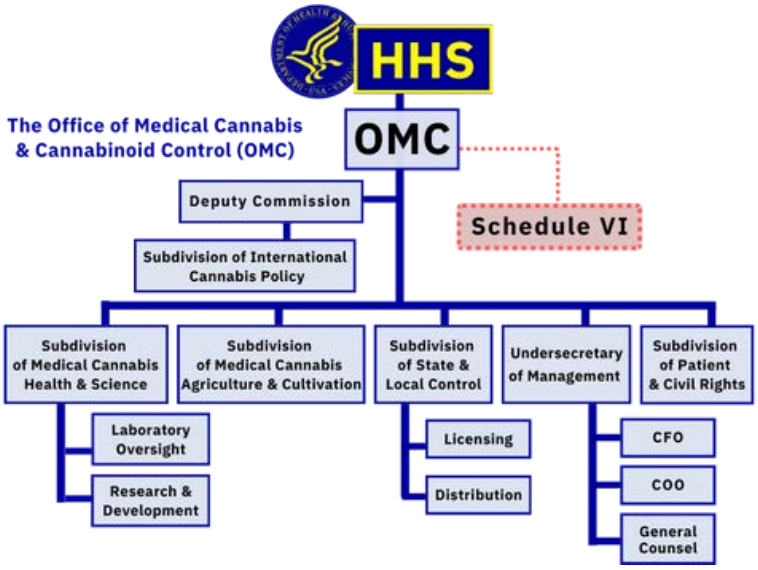
Medical cannabis represents a distinct product type whose supply chain crosses healthcare, agriculture, public health, research, state licensing, product safety, and civil rights systems. Efficiently implementing a federal medical cannabis program requires an agency structure with clear authority and patient-centered expertise.

AG Order No. 6754-2026 took an important step by recognizing the access infrastructure built through state statutes that would not have occurred through the rescheduling of cannabis alone. **However, it exposes the limitations of the Executive branch in addressing nationwide access issues, as well as the limitations of a framework housed primarily within the DEA. Medical cannabis policy should be led by healthcare expertise, with a national program housed in HHS, an Office of Medical Cannabis and Cannabinoid Control, standardized product safety and data systems, civil rights coordination, and a medical cannabis schedule designed for whole-plant and cannabinoid medicines.**

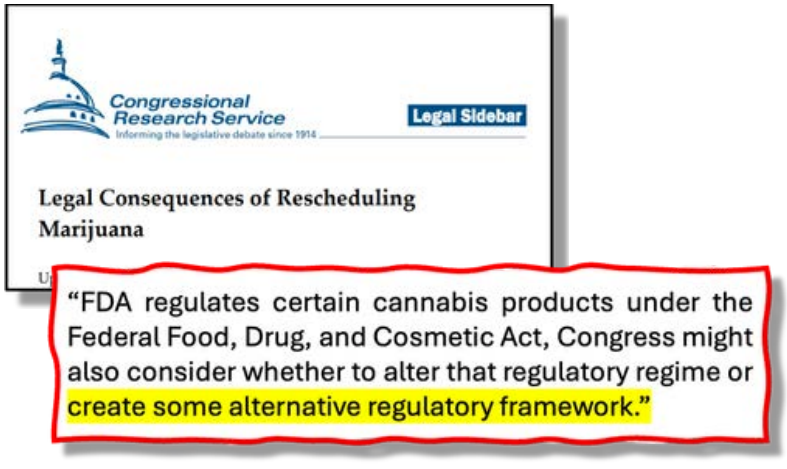
MEDICAL CANNABIS & CANNABINOID ACT (MCCA)

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).**



A NEW AGENCY: OMC



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

Download Full Text: SafeAccess4All.org

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.


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

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

"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."

MEETS 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 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.

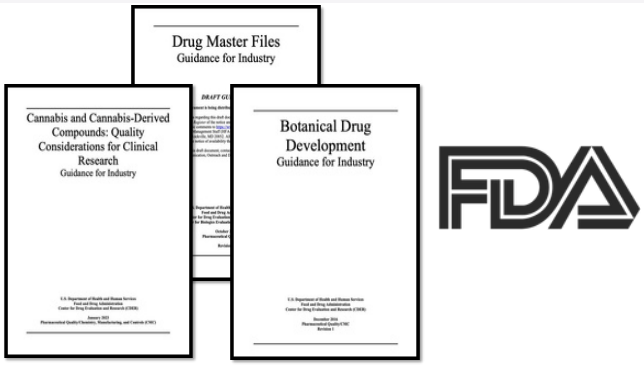
WHY NOT PUT OVERSIGHT IN THE FDA?

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.



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.

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.

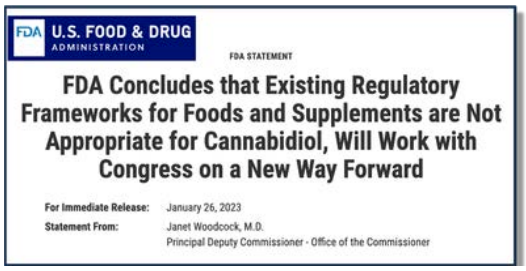
A Schedule VI classification would resolve the issues of regulating "hemp-derived" cannabinoid products by formally codifying cannabis as medicine and extending protections for patients under the Americans with Disabilities Act. This approach would prioritize patient rights alongside business interests,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

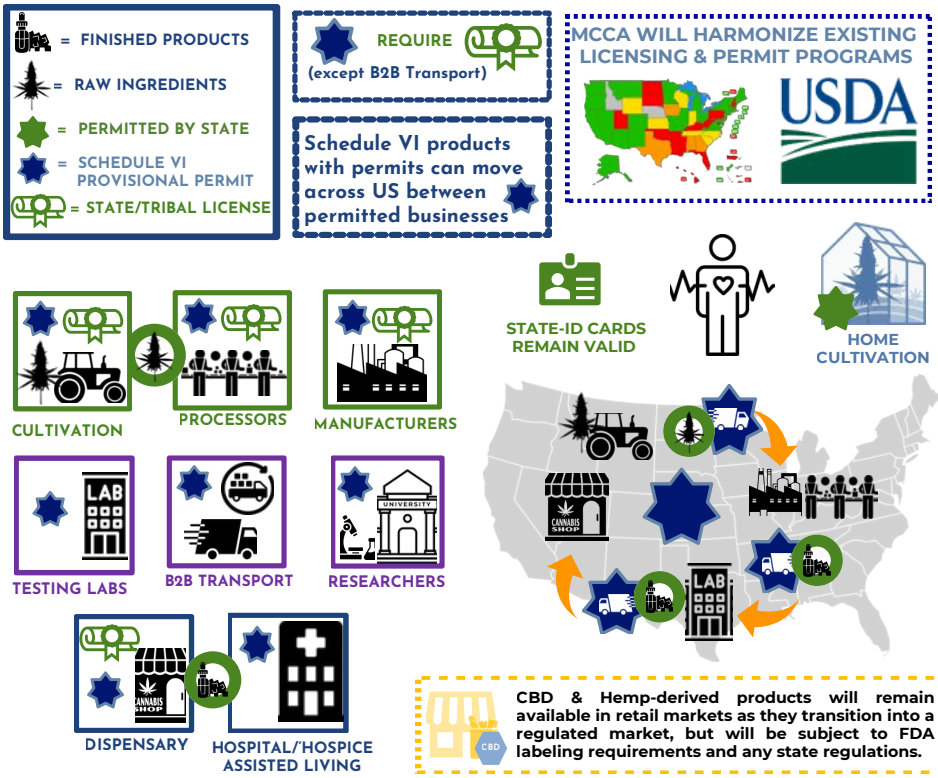
Statement From: Janet Woodcock, M.D.
Principal Deputy Commissioner - Office of the Commissioner

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- FIRST 60 DAYS



Title I- Office of Medical Cannabis & Cannabinoid Control

Sec. 801- Amend Controlled Substance Act
Sec. 802- Amend Hemp Authorization Act.

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

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.

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.

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.

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

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.

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.

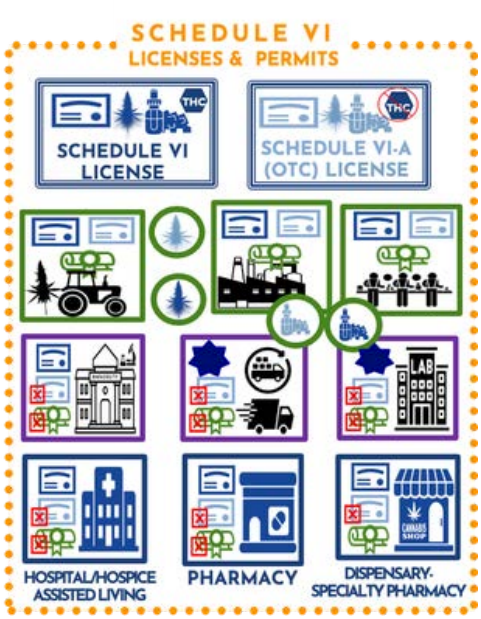
FOOD & DRUG ADMINISTRATION- Issue requirements for products containing cannabinoids to include 1) source of the cannabinoid, 2) "The safety of this product has not been evaluated by the FDA," 3) "This product has not been tested for contaminants," or a QR code to Certificate of Analysis, and 4) Batch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

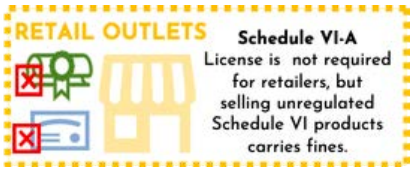
TRANSPORTATION SECURITY ADMINISTRATION- Cannabis does not need to be confiscated.

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- FIRST 12 MONTHS





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

- 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

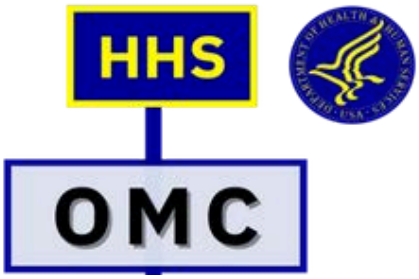
NATIONAL MEDICAL CANNABIS PROGRAM ROLE OUT-PHASE III- FIRST 24 MONTHS

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

- 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.

- 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

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

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

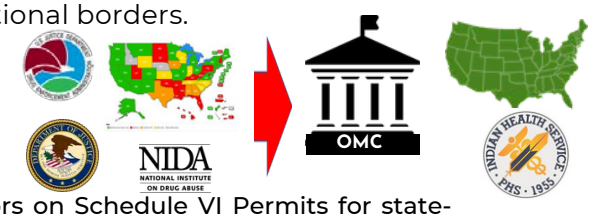
SEC. 404- SUBDIVISION OF PATIENT & CIVIL RIGHTS

- 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

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.

MEDICAL CANNABIS POLICY TALKING POINTS

NEED FOR LEADERSHIP

"HHS should lead implementation because the central question is healthcare: patient safety, clinical evidence, data standards, coverage research, product safety, and therapeutic use."

"AG Order No. 6754-2026 changed the legal posture of qualifying medical cannabis, but patients will not benefit unless agencies update policies and Congress oversees implementation."

"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."

"Congress should introduce and pass the Medical Cannabis and Cannabinoid Act to finish the job that AG Order No. 6754-2026 started."

"This is about patients, not adult-use legalization. Congress should use our power of the purse to ensure AG Order No. 6754-2026 implementation means healthcare integration, civil rights, housing stability, veterans' care, research, and product safety."

RESTORING PATIENT RIGHTS

"The DOJ order proves a federal medical cannabis pathway is possible, but it leaves too much authority in DEA and too many patient protections dependent on agency guidance."

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

"Federal policy must move from blanket exclusion to individualized assessment, reasonable accommodation, actual impairment, documented safety risk, and clinical judgment."

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."

"The MCCA would create a healthcare-centered national framework through HHS, including an Office of Medical Cannabis and Cannabinoid Control, a new medical cannabis schedule, product safety standards, healthcare integration, and coordination with state programs."

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

Headquarters:
1629 K Street Northwest Suite 300
Washington, DC 20006-1631