Medical Marijuana Use in Nursing Homes: What’s the Risk of Exclusion?

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Twenty-three states and the District of Columbia have sanctioned the use and, in some states, the cultivation of medical marijuana.1 The efficacy of medical marijuana is still the subject of debate. Opinion polls and the barrage of new state laws legalizing medical marijuana show a definite shift at the state level. This trend creates a significant conflict between state and federal law, leaving long term care providers dazed and confused.

Marijuana remains a Schedule I drug under the federal Controlled Substances Act (CSA).2 The U.S. Department of Justice (DOJ) has said that it will not prosecute individual use, possession, or cultivation of marijuana where permitted under state law and will leave enforcement up to the states,3 but that message offers little comfort to long term care providers who could face exclusion from Medicare and Medicaid for violating the CSA.

This issue is of particular importance to skilled nursing facilities. Medicare and Medicaid are the primary payment source for residents. Medical marijuana use among the elderly population is growing.4 Moreover, several states have specifically identified Alzheimer’s disease, which affects many nursing home residents, as a condition that qualifies for the legal use of marijuana.5

So, what is the real risk of penalty or exclusion for permitting or facilitating a resident’s use of medical marijuana? It appears to be shrinking, but absent guidance from DOJ or the U.S. Department of Health and Human Services (HHS) that providers compliant with state law will not be prosecuted, the remote possibility of exclusion exists.

Background

The CSA establishes five schedules of controlled substances.6 To qualify as a Schedule I controlled substance, the drug must have a high potential for abuse and have no currently accepted medical use for treatment in the United States, and, as a result, cannot be prescribed.7 Marijuana (tetrahydrocannabinol) shares Schedule I classification with other well-known drugs such as heroin and LSD.8 Under the CSA, it is unlawful “to manufacture, distribute, or dispense” any Schedule I controlled substance.9 Tying the prohibitions in the CSA to Medicare and Medicaid, the Social Security Act (SSA) requires that any individual or entity that has been convicted of a felony offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance be excluded from participation in any federal health care programs.10

The Federal Government’s Position

Several federal agencies have weighed in on the clash between state and federal law. Unfortunately, HHS is not one of them. In 2009, DOJ’s Deputy Attorney General’s (DAG’s) Office issued the first of three memoranda providing guidance to prosecutors on federal enforcement priorities:11

The Department of Justice is committed to the enforcement of the Controlled Substances Act in all States. . . The Department is also committed to making efficient and rational use of its limited investigative and prosecutorial resources. As a general matter, pursuit of these priorities should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana. For example, prosecution of individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or those caregivers in clear and unambiguous compliance with existing state law who provide such individuals with marijuana, is unlikely to be an efficient use of limited federal resources.

The 2009 memorandum clearly explains that the stated priorities do not legalize medical marijuana and that compliance with state law does not create a legal defense to a CSA violation.12 In 2011, after DOJ noted an increase in scope in commercial cultivation, sale, distribution, and use of marijuana for purported medical purposes, the DAG issued a second memorandum to clarify that the 2009 memorandum was not intended to provide protection for such conduct.13 The 2011 memorandum further clarified that “caregiver” was intended to mean “individuals providing care to individuals with cancer or other serious illnesses, not commercial operations cultivating, selling or distributing marijuana.”14

The final memorandum came in August 2013, after the passage of laws in Colorado and Washington that permit the production, distribution, and possession of marijuana for personal use.15 The 2013 memorandum highlights the federal government’s priorities, including preventing drug trafficking, sale to minors, gang-related activity, violence in cultivation and distribution, and possession on federal property. In this supplemental guidance, the DAG informs prosecutors that they should focus on these priorities and leave state and local authorities to address enforcement of their drug laws so long as states have a strong and effective regulatory system such that federal priorities are not jeopardized.16
Despite DOJ’s recommendation that CSA violations by individuals not be prosecuted when the conduct complies with state law, the federal government remains opposed to the legalization of medical marijuana.17 One of the staunchest opponents of the legalization efforts is the U.S. Drug Enforcement Administration (DEA). In 2013, DEA, an enforcement arm of DOJ, said that:

> [t]he clear weight of the currently available evidence supports [the] classification [as a controlled substance], including evidence that smoked marijuana has a high potential for abuse, has no accepted medicinal value in treatment in the United States, and evidence that there is a general lack of accepted safety for its use even under medical supervision.18

In spite of DEA’s position and several attempts last year to thwart efforts to implement medical marijuana programs in states where it is permitted,19 the 2015 omnibus spending bill signed on December 16, 2014 prohibits DOJ and DEA from using any funding this Fiscal Year (FY) to prevent states that currently permit medical marijuana from implementing their laws.20

Notably, less than two weeks later, the U.S. Department of Housing and Urban Development (HUD) confirmed its position on strict compliance with the CSA. First in 2011 and again on December 29, 2014, HUD issued memoranda explaining that federal admissions standards for federal public and assisted housing, which prohibit the admission of an individual who uses a controlled substance, preempt any state law that permits the use of medical marijuana.21 The 2014 memorandum explicitly stated that “[b]ecause the CSA prohibits all forms of marijuana use, the use of ‘medical marijuana’ is illegal under federal law even if it is permitted under state law.”

In its January 2011 memorandum, HUD’s general counsel also explained that federal nondiscrimination laws do not require allowing the use of medical marijuana as a reasonable accommodation.22 First, both the Americans with Disabilities Act and Section 504 of the Rehabilitation Act disqualify illegal drug users from protection.24 Second, the general counsel concluded that under the Fair Housing Act, permitting the use of medical marijuana would constitute a fundamental alteration of a public housing authority’s or owner’s operation.25

Unlike other federal agencies, HHS and the Centers for Medicare & Medicaid Services (CMS) have been silent on the issue of medical marijuana, leaving Medicare and Medicaid participants in a precarious position. The lack of uniformity of positions within the federal government makes it difficult to anticipate HHS’ or CMS’ position on the subject. Guidance from either agency certainly has been sought, but there has been no response.26

Risk of Exclusion

For the reasons discussed below, the likelihood of exclusion from federal health care programs is remote. Mandatory exclusion under the SSA is required only after a felony conviction relating to the “unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.”27 DOJ would be the agency that would have to charge providers. Although its guidance does not address enforcement priorities with respect to institutional providers or caregivers, there have been no reported attempts by DOJ to charge them with a CSA violation. Further, there are no reported cases of exclusion or threats of exclusion of any provider.28 The fear of prosecution should be further diminished during the current FY by the omnibus spending bill, which prohibits DOJ and DEA from interfering with state implementation of medical marijuana programs. While the risk of exclusion may be low, providers should still be cautious as they could be violating federal law even if they are not convicted and excluded.

Also pertinent to this discussion is that the use of medical marijuana in nursing homes would be unlike the administration of other prescribed drugs. Generally, a physician writes a recommendation or certification (as opposed to a prescription) for use and the patient takes it to a dispensary or supplier or, in some states, the patient grows his own supply. Pharmacies do not carry or dispense medical marijuana. Not surprisingly, it is not covered by Medicare, Medicaid, or most private insurances.

Because medical marijuana is not accessed in the same way as traditionally prescribed drugs, it is foreseeable that the facility could be a passive participant in the process by merely providing the resident a place in which to use the medical marijuana. The facility could require that, in compliance with state law, a family member or outside caregiver obtain, deliver, and assist the resident with administration. While this model may seem attractive because providing a place to use the drug does not appear to rise to the level of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance, there is no guarantee that the government would adopt that interpretation.

Deciding Whether to Permit or Facilitate Use

Providers’ hesitation to take even a small risk when it comes to medical marijuana is understandable. Many providers have taken the conservative, and completely reasonable, position that they will not permit the use of medical marijuana in their facilities so long as it is prohibited by federal law.

On the other hand, in states where medical marijuana is legal, providers may wish to permit or facilitate medical marijuana use in accordance with state law. Importantly, counsel cannot advise providers that it is appropriate to violate the law. Rather, providers should be counseled on state law requirements, the conflict between state and federal law, and the consequences for violating those laws,
including the possibility of exclusion. In addition to the legal issues, a number of risk management issues exist, including drug diversion, the marijuana forms that will be permitted (smoke, vaporized, edible, pill), revision of no-smoking policies if necessary, interventions to protect impaired residents, and protecting the rights of other residents. These and other related issues should be addressed through adequate policies and procedures.

Like many issues in long term care, providers must walk the fine line between acting in the best interest of their residents and legal compliance. Without doubt, the federal government will be forced to address this issue head-on at some point in the future. For the sake of nursing homes and their residents, let’s hope that guidance comes sooner rather than later—but don’t hold your breath.


3 Memorandum from James M. Cole, Deputy Attorney General, U.S. Department of Justice (DOJ), to All United States Attorneys, Guidance Regarding Marijuana Enforceability (Aug. 29, 2013).


8 Id.; “Dispense” is defined as “to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling, or compounding necessary to prepare the substance for such delivery.” 21 U.S.C. § 802.


10 42 U.S.C. § 1320a-7(a)(4).

11 Memorandum from David W. Ogden, Deputy Attorney General, DOJ, to Selected United States Attorneys, Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana (Oct. 19, 2009) (emphasis added).

12 Id.

13 Memorandum from James M. Cole, Deputy Attorney General, DOJ, to All United States Attorneys, Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use (June 29, 2011).

14 Id.

15 Memorandum from James M. Cole, Deputy Attorney General, DOJ, to All United States Attorneys, Guidance Regarding Marijuana Enforcement (Aug. 29, 2013).

16 Id.

17 The Office of National Drug Control Policy (ONDCP), an executive agency authorized by the Anti-Drug Abuse Act of 1988, states the federal government’s position on medical marijuana use: It is the federal government’s position that marijuana be subjected to the same rigorous clinical trials and scientific scrutiny that the Food and Drug Administration (FDA) applies to all other new medications, a comprehensive process designed to ensure the highest standards of safety and efficacy. It is this rigorous FDA approval process, not popular vote, that should determine what is, and what is not medicine. Available at www.whitehouse.gov/ondcp/frequently-asked-questions-and-facts-about-marijuana.


21 Memorandum from Benjamin T. Metcalf, Deputy Ass’t Secretary for Multifamily Housing Programs, U.S. Dep’t of Housing and Urban Development (HUD), to Various HUD Directors, Use of Marijuana in Multifamily Assisted Properties (Dec. 29, 2014); Memorandum from Sandra Henriquez, Assistant Secretary for Public and Indian Housing, HUD, to All Field Offices and Public Housing Agencies, Medical Use of Marijuana in Public Housing and Housing Choice Voucher Programs (Feb. 10, 2011); Memorandum from Helen R. Kanovsky, General Counsel, HUD, to Assistant Secretaries within HUD, Medical Use of Marijuana and Reasonable Accommodation in Federal Public and Assisted Housing, (Jan. 1, 2011).”

22 Memorandum from Benjamin T. Metcalf, Deputy Ass’t Secretary for Multifamily Housing Programs, HUD, to Various HUD Directors, Use of Marijuana in Multifamily Assisted Properties (Dec. 29, 2014).


24 In two different injunction actions brought by physicians against ONDCP, the plaintiffs alleged threatened exclusion from Medicare and Medicaid if they discussed the risks and benefits of medical marijuana with their patients. Pearson v. McCaffrey, 139 F. Supp. 2d 113 (D.C. 2001); Conant v. McCaffrey, No. C-97-00139 WHA, 2000 U.S. Dist. LEXIS 13024 (N.D. Calif. Sept. 7, 2000) aff’d, 309 F.3d 629 (9th Cir. 2002). In both cases, the court dismissed the claims about exclusion from Medicare and Medicaid as there was a lack of immediate threat of exclusion. The claims were based on a 1996 statement from then-director of ONDCP, Barry McCaffrey, in which he stated that a letter will be sent: to national, state and local practitioner associations and licensing boards which states unequivocally that DEA will seek to revoke the DEA registrations of physicians who recommend or prescribe Schedule I controlled substances. This letter will outline the authority of the Inspector General for HHS to exclude specified individuals or entities from participation in the Medicare and Medicaid programs. Statement Released by Barry R. McCaffrey, Director of Office of National Drug Control Policy, December 30, 1996, available at www.ncjrs.gov/txtfiles/215rel.txt. No such letter was ever sent. Conant, 2000 U.S. Dist. LEXIS at *24.