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Medical Marijuana in Seniors Housing and Senior Care Communities

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TABLE OF CONTENTS

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In only a few short years, we have seen a dramatic transformation in the public's opinion toward medical marijuana. These days, medical marijuana is increasingly viewed as a legitimate alternative treatment for medical conditions such as chronic pain, seizure disorders, cancer, glaucoma, and Alzheimer's-related agitation. In fact, as of the publication of this *Special Issue Brief*, more states in the U.S. allow medical marijuana than prohibit it.

The history of legalized medical marijuana spans only 20 years. It was first legalized by California voters in 1996. Ten years later, 11 states had some form of medical marijuana laws on the books. Fast-forward another ten years to 2016, and we find that medical marijuana is legal in 26 states, the District of Columbia, and the territory of Guam, with several more states considering similar laws. Looking to the next ten years, it is very possible that every state in the nation will have some form of medical marijuana law on the books.

But isn't marijuana illegal under federal law? The short answer is "yes." Under the federal Controlled Substances Act, marijuana is classified as a Schedule I drug, meaning it has no currently accepted medical use under federal law. However, in recent years, the federal government has given states progressively more autonomy in regulating and enforcing their marijuana laws despite federal law to the contrary. In 2009 and 2013 President Obama issued guidelines to federal prosecutors advising them not to focus on medical marijuana use, and to defer instead to state authorities to address and enforce these laws. More recently, federal budgets passed by Congress for fiscal years 2015 and 2016 specifically prohibited the Department of Justice from using federal funds to prosecute individuals and businesses otherwise operating in compliance with state medical marijuana laws.

In addition, recent studies have found that the medical marijuana market is a decidedly more senior crowd than one might have anticipated. A study published in the journal *Drug and Alcohol Dependence* this year found that medical marijuana users tend to be in their 50s or older, and that medical marijuana use has increased sharply across all age brackets since 2009.[1] Another study published in *Health Affairs* in 2013 found that Medicare Part D utilization of certain drug categories (such as pain medication and antidepressants) was significantly lower in states with medical marijuana laws than those without, suggesting that some Medicare beneficiaries were using medical marijuana as an alternative to prescription drugs covered by Part D. [2] And although the social stigma of medical marijuana use has not completely been eliminated, its use has become acceptable enough that "medical marijuana clubs" have begun to spring up at some seniors housing communities.[3]

What do these changes mean for seniors housing providers? It is safe to say that that medical marijuana is here to stay, and it is likely to increase as baby boomers begin to enter seniors housing. The question for the prudent provider is not if it should adopt a medical marijuana policy, but when.

Part I of this *Special Issue Brief* summarizes current medical marijuana laws among the states, focusing on eight state programs. In Part II, we address some of the most frequently asked questions regarding medical marijuana use in seniors housing and senior care communities.

[1] "Trends in Registered Medical Marijuana Participation Across 13 US States and District of Columbia," Fairman, Brian J. *Drug & Alcohol Dependence*, Vol. 159, 72 – 79 (2016).

[2] "Medical Marijuana Laws Reduce Prescription Medication Use in Medicare Part D," Bradford, Ashley C. and Bradford, W. David, Health Affairs, Vol. 35, 1230 – 1236 (2016).

[3] Two well-publicized examples of such clubs in California are at Rossmoor, in Walnut Creek, CA, and at Laguna Woods Village, in Laguna Woods, CA.

I. STATE MEDICAL MARIJUANA LAWS

Currently, medical marijuana laws have been enacted in 26 states, the District of Columbia, and the territory of Guam, as summarized in the table below:

	State	Year Passed	State Statutes and Regulations	Quantity Permitted for Personal Use	State Agency Website
1	Alaska	1998	Alaska Stat. §§ 17.37.10 to 17.37.80	1 oz.	https://www.commerce.alaska.gov/web/amco/
2	Arizona	2010	Ariz. Rev. Stat. Ann. §§ 36-2801 to 36-2819	2.5 oz.	http://azdhs.gov/licensing/medical-marijuana/index.php
3	California	1996	Cal. Health & Safety Code §§ 11362.7 to 11362.83	8 oz.	https://www.cdph.ca.gov/programs/MMP/Pages/default.aspx
4	Colorado	2000	Colo. Rev. Stat. §§ 12-43.3-101 to 12-43.3-106, 18-18-406.3 and 25-1.5-106; 5 Colo. Code Regs. §§ 1006-2:1 to 1006-2:13.	2 oz.	https://www.colorado.gov/pacific/enforcement/marijuanaenforcement
5	Connecticut	2012	Conn. Gen. Stat. §§ 21a-408 to 21a-408p; Conn. Regs. §§ 21a-408-1 to 21a-408-70.	2.5 oz.	www.ct.gov/dcp/mmp
6	Delaware	2011	16 Del. Code §§ 4901A to 4926A.	6 oz.	http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html
7	District of Columbia	2010	D.C. Code §§ 7-1671.01 to 7-1671.13; D.C. Mun. Regs. Tit. 22-C	2 oz.	http://doh.dc.gov/service/medical-marijuana-program
8	Guam	2015	Title 10 Guam Code Ann. § 122407	3-month supply	http://dphss.guam.gov/article/2015/07/15/draft-guam-rules-governing-medical-marijuana
9	Hawaii	2000	Haw. Rev. Stat. §§ 329-121 to 329-131; Haw. Code R. § 23-202-1 to 23 202-15	4 oz.	http://health.hawaii.gov/medicalmarijuana/
10	Illinois	2013	410 Ill. Comp. Stat. 130/1 - 130/999; Ill. Admin. Code tit. 77, § 946	2.5 oz.	http://www.illinois.gov/gov/mcpp/Pages/default.aspx
11	Louisiana	2016	La. Rev. Stat. §§ 40:1046 to 40:1047	30-day supply	[Program pending]
12	Maine	1999	Me. Rev. Stat. Tit. 22 §§ 2421 - 2430-B; 10-144 Me. Code R. ch. 122, § 1-11.	2.5 oz.	www.maine.gov/dhhs/dlrs/mmm/
13	Maryland	2014	Md. Code Ann. Health-Gen. § 13-3301 to 13-3311	120 g	http://mmcc.maryland.gov/default.aspx

	State	Year Passed	State Statutes and Regulations	Quantity Permitted for Personal Use	State Agency Website
14	Massachusetts	2012	Mass. Gen. Laws Ann. ch. 94C App., §§ 1-1 to 1–17; 105 Mass. Code Regs. 725.001 to 725.800	60-day supply up to 10 oz.	http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/medical-marijuana/
15	Michigan	2008	Mich. Comp. Laws §§ 333.26421 to 333.26430; Mich. Admin. Code R. §§ 333.101 to 333.133	2.5 oz.	http://www.michigan.gov/lara/0,4601,7-154-72600_72603_51869---,00.html
16	Minnesota	2014	Minn. Stat. §§ 152.21 to 152.37	30-day supply, non-smokable only	http://www.health.state.mn.us/topics/cannabis/
17	Montana	2004	Mont. Code Ann §§ 50-46-301 to 50-46-344	1 oz.	https://dphhs.mt.gov/marijuana.aspx
18	Nevada	2000	Nev. Const. Art. 4, § 38; Nev. Rev. Stat. 453A; Nev. Admin. Code §§ 453A.010-453A.240	2.5 oz.	http://dpbh.nv.gov/Reg/Medical_Marijuana/
19	New Hampshire	2013	N.H. Rev. Stat. Ann. §§ 126-X:1 to 126-X:11	2 oz.	http://www.dhhs.nh.gov/oos/tcp/
20	New Jersey	2010	N.J. Stat. Ann. §§ 24:6i-1 to 24:6i-16; N.J. Admin. Code §§ 8:64-1.1 - 8:64-13.11	2 oz.	http://www.nj.gov/health/medicalmarijuana/
21	New Mexico	2007	N.M. Stat. Ann. §§ 26-2b-1 to 26-2b-7; N.M. Admin. Code §§ 7.34.2	230 g	https://nmhealth.org/about/mcp/svcs/
22	New York	2014	N.Y. Pub. Health Law, Art. 33, Title 5-A §§ 3360 to 3366	30-day supply, non-smokable only	https://www.health.ny.gov/regulations/medical_marijuana/
23	Ohio	2016	House Bill 523 (71-26 H; 18-15 S)	90-day supply	http://www.medicalmarijuana.ohio.gov/faqs
24	Oregon	1998	Or. Rev. Stat. §§ 475.300 to 475.346; Or. Admin. R. 333-008-0000	24 oz.	http://www.oregon.gov/oha/mmj/Pages/index.aspx
25	Pennsylvania	2016	P.L. 84, No. 16 (Apr. 17, 2016)	30-day supply	http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/MedicalMarijuana/Pages/default.aspx
26	Rhode Island	2006	R. I. Gen. Laws §§ 21-28.6-1 to 21-28.6-13; R.I. Admin. Code 31-2-7:1.0 to 31-2-7:11.0	2.5 oz.	http://www.health.ri.gov/healthcare/medicalmarijuana/
27	Vermont	2004	Vt. Stat. Ann. tit. 18, §§ 4471 to 4474l; Vt. Admin. Code 17-2-3:1 to 17-2-3:12	2 oz.	http://vcic.vermont.gov/marijuana-registry
28	Washington	1998	Wash. Rev. Code §§ 69.51A.010 to 69.51A.903	24 oz.	http://www.doh.wa.gov/YouandYourFamily/Marijuana/MedicalMarijuana

In this *Special Issue Brief*, we focus on eight states — Arizona, California, Colorado, Illinois, Massachusetts, New York, Oregon, and Washington — to illustrate some of the issues seniors housing providers are likely to encounter from one state to another.

In general, medical marijuana laws in all states share certain common features. They each set forth the conditions for an individual to possess, use, and sometimes grow marijuana at home. Specifically, an individual must be deemed to be a "qualified" or a "qualifying" patient, meaning the individual is diagnosed with a medical condition set forth in the statute and obtains a doctor's written recommendation[4] to use medical marijuana to treat the condition. In addition, most states require patients to be listed on a confidential state registry or carry a special medical marijuana identification card. Other provisions will vary from state to state, such as the medical conditions covered, the quantity of medical marijuana an individual may possess, and the types of medical marijuana permitted under state law. Additionally, some state laws contain anti-discrimination provisions that attempt to limit whether landlords can refuse to lease or evict residents solely based on their medical marijuana use.

A. ARIZONA

Arizona enacted the Arizona Medical Marijuana Act in 2010. Qualifying medical conditions include Alzheimer's disease, ALS, cachexia/wasting syndrome, cancer, chronic pain, Crohn's disease, glaucoma, hepatitis C, HIV/AIDS, severe nausea, persistent muscle spasms, and seizures.[5]

Arizona has seen a steady increase in medical marijuana users both in the general public and among seniors. An April 2012 report by the Arizona Department of Health Services noted that of the state's 22,200 registered medical marijuana patients, 7,846 (35%) were over the age of 51, and of those, 2,886 were over the age of 61. In April 2016, the same report noted that the state's registered medical marijuana patients had increased to approximately 98,000, of which 37,889 (39%) were over the age of 51. Of those, 19,831 were over the age of 61.[6]

[4] Physicians cannot write actual prescriptions for marijuana because it is not FDA approved and is classified as a Schedule I drug by the DEA, meaning it has no currently accepted medical use.

[5] Ariz. Rev. Stat. § 36-2801(3).

[6] Application Monthly Report – Arizona Medical Marijuana Program: April 24, 2011 – February 28, 2012"; See also "Arizona Medical Marijuana Program Annual Report – 2012"; "Arizona Medical Marijuana Program April 2016 Monthly Report" (http://azdhs.gov/licensing/medical-marijuana/index.php#reports)

The Arizona law contains one of the more expansive antidiscrimination provisions protecting qualified patients — landlords and licensed facilities cannot "unreasonably restrict" access to medical marijuana or refuse to lease to individuals based solely on their medical marijuana status, unless the landlord/facility stands to lose a monetary or licensing-related benefit under federal law or regulations.[7] This restriction has not yet been tested in the courts, so it is unclear whether a state court would find that an across-the-board policy against medical marijuana use is an "unreasonable restriction," though it is clear that for those providers that participate in federal programs such as Medicare, Medicaid, or HUD affordable housing, such prohibitions are permissible as long as marijuana remains illegal under federal law.

In addition, Arizona allows licensed facilities to restrict the type of marijuana that may be used onsite and to refuse to centrally store or assist with providing medical marijuana to qualifying patients.[8] Further, if a facility would jeopardize a federal monetary or licensing benefit by permitting medical marijuana use, the facility may prohibit medical marijuana use altogether.

B. CALIFORNIA

Medical marijuana became legal in California when voters passed Proposition 215, also known as the Compassionate Use Act of 1996. Qualifying medical conditions under California law include anorexia, arthritis, cachexia/wasting syndrome, cancer, chronic pain, HIV/AIDS, glaucoma, migraines, persistent muscle spasms, severe nausea, seizures, and any other chronic or persistent medical symptom that substantially limits the person's ability to conduct one or more major life activities or that may cause serious harm to the person's safety, physical, or mental health.[9] California does not require qualified patients to register with the state, but does have a voluntary medical marijuana identification card program. Unlike Arizona, California law does not contain anti-discrimination provisions that restrict landlords from limiting or prohibiting the use of medical marijuana on their premises.

[7] Ariz. Rev. Stat. § 36-2813.

[8] ARS § 36-2805.

[9] Cal. Health & Safety Code § 11362.7(h).

The Community Care Licensing Division of the California Department of Social Services ("CCLD"), which licenses assisted living providers in the state, recently issued a policy guidance on medical marijuana and updated its Evaluator Manual for state surveyors.[10] The Evaluator Manual explains that "[i]f a resident possesses marijuana which has been recommended by a licensed physician for medicinal use and the facility complies with applicable regulations regarding the storage, administration and documentation of such medication, then there is no violation with regard to such possession, storage, and use of marijuana by the patient-resident."[11] However, the manual also notes that "[t]he determination of acceptance and retention of a resident is based on the licensee's ability to ensure the health and safety of the individual resident and the other residents in care. Licensees continue to have discretion in evaluating a resident's suitability for acceptance and retention and to stipulate conditions in the admission agreements." This guidance clarifies that providers may choose to store or assist residents with medical marijuana, but are not required to do so.

Some licensed facilities in California's Sonoma County have begun implementing a medical marijuana program for residents with dementia and Alzheimer's disease.[12] It remains to be seen if the practice becomes more widespread as more physicians and psychiatrists express a preference for medical marijuana over other psychoactive medications, and more risk-averse providers wait and see how these projects turn out in other communities.

C. COLORADO

Colorado adopted the Medical Use of Marijuana Initiative in 2000 and established the Medical Marijuana Registry Program, which issues identification cards and maintains a state registry of medical marijuana patients. Qualifying medical conditions are cancer, glaucoma, HIV/AIDS, cachexia/wasting syndrome, chronic pain, severe nausea, seizures, and any other medical condition approved by the state health agency.[13] In addition, Colorado legalized

[10] *Quarterly Update: Adult/Senior Care Update*, California Department of Social Services ("CDSS"), Community Care Licensing Division, Summer 2016, available at: http://ccld.ca.gov/res/pdf/ASCSummer2016.pdf.

[11] *Regulation Interpretations and Procedures for Residential Care Facilities for the Elderly*, CDSS, pp. 93.1 – 93.2, April 2016 (interpreting 22 Cal. Code Regs. § 87458).

[12] "Marijuana Aids Sonoma County Alzheimer's Patients," Kovner, Guy, The Press Democrat, July 25, 2016, available at: http://www.pressdemocrat.com/news/5816089-181/marijuana-aids-sonoma-county-alzheimers.

[13] 5 Colo. Code Regs. § 1006-2.

recreational marijuana use in 2014. The recreational marijuana laws are in addition to existing medical marijuana laws, which remain intact and provide enhanced rights to medical marijuana users, such as a lower taxation rate, higher possession limits, and higher potency for some medical marijuana products.

Seniors housing providers are taking different approaches to medical marijuana use within the communities. Some licensed communities in Colorado allow residents to store and maintain medical marijuana in appropriately locked receptacles in their rooms, provided the resident has a valid doctor's recommendation and follows state-specific regulations, but will not centrally store medications for their residents.[14] For residents unable to handle their own medications, these communities require that outside caregivers visit the resident and assist with taking medical marijuana if necessary, then take the remaining medical marijuana product off campus. The Colorado Department of Public Health has issued some limited guidance regarding medical marijuana use in assisted living residences,[15] identifying several of the questions providers will need to address if they choose to permit medical marijuana in their communities.

D. ILLINOIS

Illinois adopted the Compassionate Use of Medical Cannabis Pilot Program Act in 2013. The law contains an extensive list of conditions, including cancer, glaucoma, HIV/AIDS, hepatitis C, Crohn's disease, Alzheimer's-related agitation, cachexia/wasting syndrome, muscular dystrophy, severe fibromyalgia, spinal cord disease, rheumatoid arthritis, spinal cord injury, traumatic brain injury, post-concussion syndrome, multiple sclerosis, Parkinson's disease, Tourette's syndrome, lupus, residual limb pain, seizures, post-traumatic stress disorder, and several other conditions.[16]

Illinois law contains antidiscrimination language that prohibits landlords from refusing to lease to or otherwise penalize an individual solely because of the individual's status as a

[14] "Marijuana Laws Put Senior Living Between a Bud and a Hard Place," Dowell, Cassandra, Senior Housing News, Jun 15, 2014, available at: http://seniorhousingnews.com/2014/06/15/marijuana-laws-put-senior-living-bud-hard-place/.

[15] See https://www.colorado.gov/pacific/sites/default/files/HF_Medical-Marijuana-Use-in-Assisted-Living-Residences-Working-Draft-2-02-10.pdf; https://www.colorado.gov/pacific/sites/default/files/HFREPV_Marijuana%20Laws%20that%20Impact%20Health%20Care%20Institutions%20_081715.pdf.

[16] 410 Ill. Comp. Stat. § 130/7(h)

qualifying patient, unless failing to do so would cause the landlord to violate federal law or lose a monetary or licensing-related benefit under federal law or rules.[17] Since marijuana remains illegal under federal law, Illinois landlords will generally have discretion to allow or prohibit medical marijuana use in their communities, provided they have policies in place and carry out those policies uniformly.

E. MASSACHUSETTS

Massachusetts adopted the Massachusetts Act for the Humanitarian Medical Use of Marijuana in 2013. Subsequently, the Massachusetts Department of Health issued over 50 pages of regulations regarding the use of medical marijuana. Qualifying conditions include cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Crohn's disease, Parkinson's disease, multiple sclerosis, and "other debilitating conditions as determined in writing by a qualifying patient's certifying physician."[18] The regulations also refer to medical marijuana use in licensed settings. Under the regulations, an employee of a hospice provider, nursing facility, medical facility, visiting nurse service, home healthcare provider or personal care service may serve as a caregiver for more than one qualified patient at any time. In addition, caregivers may transport a qualified patient to and from a registered dispensary and assist with preparing and administering the medical marijuana.[19]

F. NEW YORK

New York adopted the Compassionate Care Act in 2014. Qualifying conditions include amyotrophic lateral sclerosis, cancer, epilepsy, HIV/AIDS, Huntington's disease, inflammatory bowel disease, Parkinson's disease, multiple sclerosis, neuropathy, and spinal cord injury with spasticity. In addition, the patient must suffer one of the following "complicating conditions" to qualify: cachexia/wasting syndrome, severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms.[20] Under current New York law, medical marijuana may not be smoked. Additionally, both eligible patients and their referring physicians must

[17] 410 Ill. Comp. Stat. § 130/40.

[18] 105 Mass. Code Regs § 725.004

[19] 105 Mass. Code Regs § 725.020.

[20] N.Y. Pub. Health Law § 3360(7).

register with the state. However, New York currently permits only 20 dispensaries statewide despite having a population of nearly 20 million.[21] Because of these and other restrictions, the medical marijuana program has not been widely accessed: as of August 2016, only 677 physicians and 7,005 patients have registered with the program statewide.[22]

G. OREGON

Oregon adopted the Medical Marijuana Act in 1998. Qualifying conditions include Alzheimer's disease, cachexia/wasting syndrome, cancer, chronic pain, glaucoma, HIV/AIDS, nausea, persistent muscle spasms, post-traumatic stress disorder, and seizures.[23] In 2015, Oregon legalized recreational marijuana use as well, allowing any adult 21 years of age or older to purchase limited quantities of marijuana at state dispensaries. The recreational laws do not "undo" the medical marijuana program, however, as medical marijuana patients have certain additional rights that do not extend to recreational users, such as a 0% sale tax rate (as opposed to 17% for recreational sales), higher possession limits (24 oz. for patients versus one ounce for recreational users), and access to higher potency medical marijuana products.

In contrast to New York's relatively small program, Oregon's medical marijuana program is more widely utilized: as of July 1, 2016, Oregon had 66,880 registered medical marijuana patients, nearly 30,000 registered caregivers, and 1,692 registered physicians.[24] According to a 2016 Portland State University survey prepared in collaboration with the Oregon Department of Human Services, of the 253 licensed senior care communities surveyed (assisted living, residential care, and memory care), 27% of providers have written policies permitting medical marijuana use and 14% of providers have policies permitting recreational use.[25]

[21] "Medical Marijuana Program Applications," New York State Department of Health website, at: (https://www.health.ny.gov/regulations/medical_marijuana/application/applications.htm)

[22] "About the Medical Marijuana Program," New York State Department of Health website, at: https://www.health.ny.gov/regulations/medical_marijuana/.

[23] Or. Rev. Stat. § 475B.410(6).

[24] "Oregon Medical Marijuana Program Statistics," Oregon Health Authority website, at: https://public.health.oregon.gov/diseasesconditions/chronicdisease/medicalmarijuanaprogram/pages/data.aspx.

[25] Carder, P., Kohon, J., Limburg, A., Zimam, A., Rushkin, M., & Neal, M. (June, 2016). *Oregon Community-Based Care Survey: Assisted Living, Residential Care, and Memory Care*, available at: https://www.pdx.edu/ioa/sites/www.pdx.edu.ioa/files/Resident%20and%20Community%20Characteristics%20Report%202016%20-%20Assisted%20Living,%20Residential%20Care,%20Memory%20Care.pdf.

H. WASHINGTON

Washington legalized medical marijuana in 1998 when it enacted the Cannabis Patient Protection Act, and legalized recreational marijuana use in 2014. Qualifying conditions under the medical marijuana laws include chronic pain, cancer, epilepsy, HIV/AIDS, anorexia, glaucoma, Crohn's disease, multiple sclerosis, persistent muscle spasms, post-traumatic stress disorder, traumatic brain injury, and hepatitis C.[26] As in other states with both medical and recreational marijuana laws, medical marijuana patients have additional rights and benefits over recreational users, which are accessed by registering with the state's medical marijuana database. Registration is optional, but patients who register are entitled to tax-free purchases of medical marijuana, higher limits on purchasing and possession, and access to high-THC products not otherwise available to unregistered patients and recreational users.

II. CONSIDERATIONS FOR PROVIDERS – QUESTIONS AND ANSWERS

Senior living communities operating in a state that has legalized medical marijuana are confronted with a number of issues as they consider whether to accommodate medical marijuana use in their communities. In this section, we address some of the questions most frequently asked by seniors housing and senior care providers. Because medical marijuana laws vary by state, our responses to these questions should be taken as general guidelines to be cross-referenced against state and local laws and regulations.

1. Can seniors housing and senior care providers prohibit all medical marijuana use at their communities?

Usually, yes. Because marijuana remains illegal under federal law, providers can typically prohibit medical marijuana use on their campuses, even in states that have legalized the practice. However, specific state laws should be consulted to confirm this is the case. In some states, such as Arizona, medical marijuana laws provide that assisted living facilities and certain other licensed facilities "may adopt reasonable restrictions on the use of marijuana

[26] Wash. Rev. Code § 69.51A.010(24).

by their residents" including restricting the mode of consumption (e.g., smoking, edibles, vaporizers, topical preparations) and refusing to centrally store medical marijuana. In addition, Arizona law allows both licensed and unlicensed providers to restrict medical marijuana use if "failing to do so would cause the facility to lose a monetary or licensing-related benefit under federal law or regulations."[27] In other words, communities that participate in federal Medicare, Medicaid, or affordable housing programs can prohibit all medical marijuana use because it is illegal under federal law and permitting such use may jeopardize the facilities' reimbursement by or enrollment in these federal programs.

Alternatively, providers may choose to prohibit all forms of medical marijuana, but permit the use of FDA-approved drugs, such as Marinol, that contain synthetically derived cannabinoids (the pain-relieving compounds present in marijuana). However, some advocates argue that because these drugs do not contain all of the active compounds that naturally occur in marijuana, their ability to treat pain, nausea, depression, and other symptoms is limited. Nevertheless, many providers have historically opted for this approach. As medical marijuana use proliferates, however, providers may find they need to revisit these policies to meet the demands of their resident populations.

2. Can residents be evicted from a community for consuming medical marijuana despite the provider's prohibition against its use?

The answer to this question will depend on the state, and may vary between licensed and unlicensed communities. In licensed communities that prohibit medical marijuana, some state regulations may permit evictions when a resident violates federal drug laws. Others may permit evictions when the resident does not comply with the written policies of the community. Accordingly, if the community has written rules against (a) smoking, (b) using marijuana, or (c) violating federal drug laws generally, it could evict a medical marijuana user for violation of the policies, but its policies should be clearly drafted and uniformly enforced.

In unlicensed senior communities, landlord-tenant law will usually apply. Ironically, it may be more difficult to evict a resident from an unlicensed community for consuming medical marijuana if the state's marijuana law contains anti-discrimination or eviction protections.

[27] Ariz. Rev. Stat. §§36-2805; 36-2813.

However, the anti-discrimination provisions are not absolute, and usually contain a number of exceptions that may apply in many seniors housing settings. In addition, unlicensed providers that participate in federal affordable housing programs under HUD may have separate grounds for prohibiting medical marijuana use, since federal programs prohibit providers from leasing to tenants who violate federal drug law regardless of whether states permit the practice.[28] Providers also need to be aware of quirks in their states' laws to ensure they comply with state law when enforcing federal prohibitions. For example, in California, the landlord-tenant statutes permit evictions based on violation of state or local laws, but do not mention violation of federal law as grounds for eviction. In these cases, admission / residency agreements should be drafted to contemplate that a resident's violation of federal law is a material breach of the agreement.

3. If a provider decides to allow medical marijuana use at the community, can the provider limit what forms of medical marijuana are permitted?

Yes. Many providers have strict no-smoking policies and would not want to undermine such policies with an exception for medical marijuana smoking. In keeping with their policies, providers may choose to prohibit smoking while permitting other forms of marijuana consumption, such as edibles, topical preparations, or "vaping" devices that vaporize marijuana concentrates. The vapor from such devices is not as pervasive as marijuana smoke, and because these devices do not burn the vaporizing medium, there is less risk of fire.

4. Can providers centrally store medical marijuana and assist residents with taking the drug?

If an assisted living provider wishes to centrally store medical marijuana for its residents, the provider will need to consider whether the state's assisted living laws regarding central storage of medications can be satisfied in the context of medical marijuana. For example, in California, assisted living regulations governing prescription and nonprescription PRN medications (i.e., to be taken as needed) require a physician's order, dated and written on a prescription blank to be maintained in the resident's file.[29] However, California physicians

[28] A 2014 HUD memorandum notes that HUD providers cannot establish policies authorizing medical marijuana use in their communities or admit residents to housing programs who illegally use controlled substances such as marijuana. See http://portal.hud.gov/hudportal/documents/huddoc?id=useofmarijinmfassistpropty.pdf.

[29] 22 Cal. Code Regs. §87465(e).

cannot "prescribe" medical marijuana or write orders for marijuana onto prescription blanks due to current federal restrictions; they may only "approve" or "recommend" the medical use of marijuana, which they then document in the patient's medical record.[30] In addition, centrally stored medications in California assisted living facilities must be kept in their original containers and labeled with all necessary prescription information, such as the prescriber's name, drug name, strength, quantity, expiration date, and number of refills.[31] Containers distributed by marijuana dispensaries would meet few if any of these requirements. And if the marijuana is sold as edibles such as brownies, cookies, or lollipops, the central storage question becomes increasingly problematic.

On a promising note, CCLD has issued a policy memo explaining that if a facility "complies with applicable regulations regarding the storage, administration and documentation of such medication, then there is no violation with regard to such possession, storage, and use of marijuana by the patient-resident."[32] Although the memo reflects an acceptance of medical marijuana in the assisted living context, it does not necessarily clarify how a provider is to comply with applicable regulations regarding storage and administration at the facility. For the time being, the best approach is for providers to work with their state licensing agency and, if necessary, to request an exception from central storage requirements if those requirements do not fit well with how medical marijuana is distributed, stored, and used.

5. Can an assisted living provider allow medical marijuana to be stored by residents who handle their own medications, but not by residents who require assistance with their medications?

This will depend on state laws and regulations, but the answer will likely be "yes." Some senior care providers have adopted policies that allow medical marijuana to be kept by a resident who is able to handle his or her own medications, as long as the marijuana is stored in a locked container in the resident's unit.

At the same time, providers' policies may state that they will not centrally store medical marijuana for residents unable to handle their own medications. In such cases, the providers

[30] Cal. Health & Safety Code 11362.5(d).

[31] 22 Cal. Code Regs. §87465(g).

[32] *Quarterly Update: Adult/Senior Care Update, California Department of Social Services* ("CDSS"), Community Care Licensing Division, Summer 2016, available at: http://ccld.ca.gov/res/pdf/ASCSummer2016.pdf

have allowed designated caregivers to bring medical marijuana to the resident, assist the resident with administration, and then take the unused portion off campus when the caregiver leaves. Such policies are workable when residents need scheduled or infrequent doses of the drug, but may become burdensome if a resident needs to take multiple doses of marijuana throughout the day, or if the symptoms being treated arise without warning.

6. What additional steps should providers take regarding residents who consume medical marijuana at the community?

Marijuana acts as an intoxicant, and can affect judgment, balance, reaction time, and heart rate. Among seniors, these side effects can increase the already heightened risk of falls and other injuries. Licensed providers should evaluate a resident's care plan to determine how to best address the possible side effect of medical marijuana use. For example, residents who take medical marijuana before meals to improve appetite or reduce nausea may need to be escorted to and from the dining area or other common areas to prevent falls and disorientation. Other adjustments to a resident's care plan may also be necessary depending on the circumstances.

7. How do recreational marijuana laws change our perspective of marijuana use in seniors housing?

Given how quickly medical marijuana laws have spread across the country in the past twenty years, can we expect a similar wave of recreational marijuana laws to follow in the near future? Washington, Colorado, Alaska, and Oregon have already passed recreational marijuana laws. In November, California and Arizona residents will vote on similar laws to legalize adult recreational marijuana use. Will recreational marijuana laws change how seniors housing providers approach marijuana use in their communities? Possibly. However, recreational marijuana use will not come with the same types of patients' access rights and nondiscrimination provisions that some states have written into their medical marijuana laws. Therefore, it is possible that a community's recreational marijuana policies may look very similar to its overall smoking policies. However, providers will also want to consider how their policies will address other forms of marijuana consumption at their communities, such as edible products, vaporizers, extracts, and oils.

III. CONCLUSION

Not long ago, the question of medical marijuana in seniors housing was not on the radar for most providers. Today, more than half the states in the U.S. have enacted medical marijuana laws, with more states poised to join the ranks in the near future. Seniors account for a large and growing proportion of the medical marijuana market, and they have begun seeking out states with friendly marijuana laws to spend their retirements.[33] For seniors who are considering a move to a seniors housing community, a provider's medical marijuana policies may factor into their decision-making, as well. Whether or not providers choose to allow medical marijuana on their campuses, they should take the opportunity now to draft clear and comprehensive marijuana policies that reflect the providers' values, comply with state laws and regulations, and thoughtfully respond to prospective residents' questions about medical and recreational marijuana use at the community.

[34] "More Retirees Flock to U.S. States for Legal Pot," Taylor, Chris, Reuters, Jul. 22, 2015; "Seniors in Laguna Woods Village are Craving Medical Marijuana," Foxhall, Emily, Los Angeles Times, Oct. 22, 2014.

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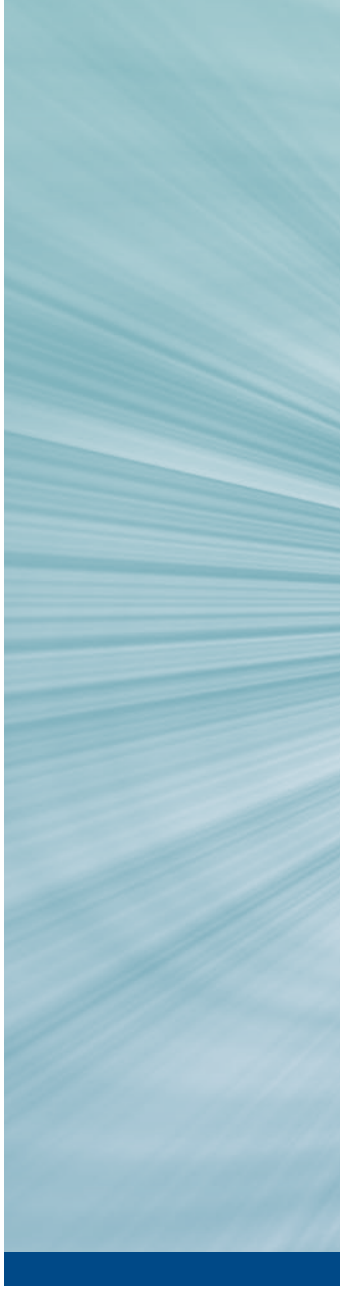

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