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Issued Via E-Mail

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Re: Public Comments in MCP Rulemaking

Dear Mr. Erickson:

This letter is written on behalf of the New Mexico Department of Health, Medical Cannabis Program (“Department”, “NMDOH”) to address public comments received in the course of the ongoing rulemaking concerning the proposed amendments to 7.34.2.7 NMAC, 7.34.4.28 NMAC, and various sections of 7.34.3 NMAC.

The Department of Health received public comments from Kristina Caffrey, Duke Rodriguez, and Kylie Safa on behalf of the cannabis producer Ultra Health. The Department also received public comment from T.J. Trujillo, an attorney for another cannabis producer, Pecos Valley Production, who summarily endorsed Ultra Health’s comments in his statements at the public rule hearing. For purposes of this letter, I refer to these public comments as Ultra Health’s comments.

Ultra Health’s comments relate to a legal dispute in the ongoing lawsuit *Jason Barker v. New Mexico Dept. of Health et al.*, case no. D-202-CV-2021-04058. A hearing was held in that case on November 2, 2021, and the parties anticipate that a decision will be issued by Judge Baca soon. While the outcome of that case, and the outcome of any subsequent appeal therefrom, may ultimately impact the ability of the Department to adopt or enforce portions of the proposed rule amendments, the Department has not been divested of rulemaking jurisdiction by the suit, and the Department has not been enjoined from pursuing any rule amendments concerning the Medical Cannabis Program.

Ultra Health’s comments center on the claim that NMDOH lacks authority to set regulatory standards concerning the “adequate supply” limit. Ultra Health’s interpretation of the law relies on select passages of the Cannabis Regulation Act (CRA), which was passed via House Bill 2 in the 2021 Special Legislative Session, and which took effect on June 29, 2021. Ultra Health argues that the CRA at NMSA 1978, § 26-2C-5, “transferred the vast majority of the medical cannabis program from DOH to the Cannabis Control Division”. It emphasizes that, pursuant to the CRA at NMSA 1978, § 26-2C-25(A)(1), it became lawful for any person 21 years of age or older to purchase or possess cannabis. It further notes that there is now a 2-ounce purchase limit per

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transaction under the CRA, and that there is no overall limit concerning the amount of cannabis that a person 21 years of age or older can purchase. *See* NMSA 1978, § 26-2C-3(B)(4(a)).

The fundamental error in Ultra Health’s legal arguments, and the critical fact which Ultra Health has failed to acknowledge in this rulemaking, is that the “adequate supply” limit remains in statute. This is an extraordinary omission. Despite the fact that the CRA made various amendments to the Lynn and Erin Compassionate Use Act (“LECUA”), including numerous amendments to the definitions at NMSA 1978, § 26-2B-3, the definition of adequate supply remained in the law. In fact, the expression “adequate supply” is used in several places in the LECUA, including Sections 26-2B-3, 26-2B-4, 26-2B-6, and 26-2B-7. This cannot be interpreted as a “mistake”, akin to a typo or a scrivener’s error: the CRA kept the adequate supply limit in the law, and the Department of Health is obligated to apply it. As a general matter, laws are not interpreted to be meaningless; and yet that is what Ultra Health asks the Hearing Officer and the Department to do. *See* NMSA 1978 § 12-2A-18 (“A statute or rule is construed, if possible, to: ... give effect to its entire text”); *see also* NMSA 1978, § 12-2A-10 (“If statutes appear to conflict, they must be construed, if possible, to give effect to each.”).

Again, the bill that enacted the Cannabis Regulation Act and which made various amendments to the Lynn and Erin Compassionate Use Act included several amendments to the definitions section of the LECUA at NMSA 1978, § 26-2B-3, but did not delete or modify the “adequate supply” definition that is contained in that section. The bill also amended the civil and criminal immunities section of the LECUA at NMSA 1978, § 26-2B-4, as well as the duties of the Department of Health with respect to the Medical Cannabis Program that are identified at NMSA 1978, § 26-2B-7, but did not remove any of the references to “adequate supply” contained in those sections. The inclusion of “adequate supply” in House Bill 2 demonstrates that it was included deliberately, and that the references to adequate supply were intended to be read in conjunction with the contemporaneously created CRA text.

As noted, a reference to “adequate supply” remains in the LECUA at NMSA 1978, § 26-2B-6. That section identifies the duties of the Medical Cannabis Advisory Board, which is charged with “recommend[ing] quantities of cannabis that are necessary to constitute an adequate supply for qualified patients and primary caregivers”. *Id.* The Advisory Board is appointed by the Cabinet Secretary of the Department of Health, and makes recommendations to the Department of Health. *Id.* There would be no reason for the Legislature to require the Medical Cannabis Advisory Board to make recommendations to the Department of Health about the adequate supply limit if the Department of Health had no authority to set the adequate supply limit. Thus, to interpret the LECUA in this manner would effectuate an absurd result. *See Provisional Gov’t of Santa Teresa v. Dona Ana County Bd. of County Commissioners*, 2018-NMCA-070, ¶ 27, 429 P.3d 981, 989 (holding that “[c]ourts will not construe a statute in a manner that leads to an absurd result”, and that this is a basis “for insisting on application of the words’ plain meaning to avoid an absurdity.”) (internal citations omitted).

The LECUA at NMSA 1978, § 26-2B-7(A)(2) requires that the Department of Health “define the amount of cannabis that is necessary to constitute an adequate supply, including amounts for topical treatments”. The LECUA at NMSA 1978, § 26-2B-3(A) defines “adequate supply” as:

an amount of cannabis, in any form approved by the department, possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver that is determined by rule of the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months and that is derived solely from an intrastate source[.]

“Department” is defined to mean the Department of Health. NMSA 1978, § 26-2B-3(G).

Due to the enactment of the CRA and the coming of commercial cannabis sales (which will begin no later than April 1, 2022, per NMSA 1978, §§ 26-2C-6(K) and NMSA 26-2C-7(B)(5)), the legal significance of adequate supply is changing. As noted, the definition of adequate supply describes it as a possession limit, and the civil and criminal immunities section of the LECUA, at NMSA 1978, § 26-2B-4(A), also describes it as a usage limit. However, given that the CRA at NMSA 26-2C-25(A)(2) has authorized any person 21 years of age and older to possess unlimited quantities of cannabis within the person’s residence, and given that that section of the CRA has broadly authorized the use of cannabis by persons 21 years of age and older without a usage limit, adequate supply will now function primarily as a purchase limit for what are deemed “medical” purchases. Purchases beyond the adequate supply limit will be taxed as “commercial” sales. Adequate supply may also function as a possession limit for patients, and as a collective possession limit for qualified patients and primary caregivers, for amounts of cannabis possessed outside the person’s residence.<sup>1</sup> The adequate supply limit will also continue to operate fully as a use and possession limit for qualified patients and primary caregivers who are under the age of 21, given that the immunities of the CRA at NMSA 1978, § 26-2C-25 apply only to persons 21 years of age and older, whereas any person (including a minor) can be enrolled in the Medical Cannabis Program, and any person 18 and older can be enrolled as a primary caregiver. NMSA 1978, § 26-2B-4(D) (specifying enrollment requirements for qualified patients under the age of 18); NMSA 1978, § 26-2B-3(M) (defining “primary caregiver”).

The fact that the CRA applies the two-ounce transactional limit to sales to “persons”, and that the CRA immunizes “persons” for the purchase and possession of cannabis, is irrelevant. The Department does not dispute that qualified patients and primary caregivers are bound to the two-ounce per-transaction purchase limit, as are all persons who make commercial cannabis purchases; and the Department does not dispute that persons 21 years of age and older are generally immunized for possession of two ounces of cannabis outside their residence.

Reading the LECUA and the CRA together, it is evident that the New Mexico Legislature created a two-tiered framework for “medical” purchases and “commercial” (i.e., “recreational”) purchases, with the primary distinction being whether revenue from a given sale will be subject to taxes under New Mexico tax laws. *See* NMSA 1978, § 7-9-73.2 (exempting from gross receipts tax “cannabis products that are sold in accordance with the Lynn and Erin Compassionate Use Act”, as well as “receipts from the sale of prescription drugs”); NMSA 1978, § 7-42-3 (imposing

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<sup>1</sup> This is due to the fact that 1) the adequate supply limit is greater than the ordinary two-ounce possession limit of the CRA; 2) the LECUA at NMSA 1978, § 26-2B-4 continues to immunize patients and primary caregivers for the possession of cannabis up to the adequate supply limit; and 3) the CRA at NMSA 1978, § 26-2C-25(A)(1) acknowledges that the possession limits for qualified patients may differ from those that apply to the general public.

cannabis excise taxes on cannabis retailers that sell cannabis products in New Mexico). This two-tiered system is closely analogous to other drug sales in New Mexico. Take for example, the drug Ibuprofen: Ibuprofen is both a prescription pharmaceutical and an over-the-counter drug. If a person has a prescription for Ibuprofen, they can purchase up to the quantity of Ibuprofen that is specified in their prescription, and those sales are not subject to gross receipt tax, because they are deemed prescription sales and therefore exempt under the state's Tax Code. *Id.* However, if a person purchases Ibuprofen over-the-counter, that sale is subject to gross receipts tax, because it is not deemed to be the sale of a prescription drug.<sup>2</sup> When the Medical Cannabis Program was created, the NM Legislature opted not to authorize prescriptions for cannabis in the LECUA. Upon information and belief, this decision was made based on concerns that, because marijuana remains illegal under federal law, the issuance of prescriptions for cannabis could pose risks to physicians' DEA licenses. Instead of a prescription model, the New Mexico Legislature instituted an "adequate supply" limit, a three-month limit to be set by the Department of Health. Once commercial cannabis sales begin, the adequate supply limit will operate to limit the amount of cannabis that is deemed exempt from taxes, just as a prescription effectively limits the quantity of Ibuprofen that is deemed exempt from gross receipts tax.

Section 26-2C-5 of the CRA states, "Except for administration of the medical cannabis registry, the power, duty and authority of the department of health related to the medical cannabis program shall be transferred to the [cannabis control] division on the effective date of the Cannabis Regulation Act." Ultra Health relies primarily on this passage, arguing that this section of the CRA transferred DOH's authority regarding the adequate supply limit to the CCD. Implicit in this argument is the notion that Section 26-2C-5 of the CRA "nullified" all of the many references to "adequate supply" that remain in the LECUA. However, the title of Section 26-2C-5 refutes Ultra Health's claim. Section 26-2C-5 is entitled, "Department of health; duties; **transfer of licensing duties**".<sup>3</sup> (Emphasis added.) This proves that the Legislature did not intend that the powers to be transferred to the CCD would include the setting of the adequate supply limit. *See Tri-State Generation & Transmission Ass'n, Inc. v. D'Antonio*, 2012-NMSC-039, ¶ 18, 289 P.3d 1232, 1238 ("For the purpose of determining the legislative intent we may look to the title, and ordinarily it may be considered as a part of the act if necessary to its construction.") (internal quotation marks and cited authority omitted). The setting of the adequate supply limit is not a licensing duty, because it does not pertain to the licensing that was done previously under the LECUA. The only medical cannabis "licensing" that was ever done under the LECUA was the licensing of commercial cannabis establishments, and the issuance of (now extinct) personal production licenses to qualified patients,<sup>4</sup> in accordance with the prior version of NMSA 1978, § 26-2B-7 and

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<sup>2</sup> In its written comment, Ultra Health claims that, because there is no volume limit on medical cannabis sales specified in the gross receipts tax exemption at NMSA 1978, § 7-9-73.2, all cannabis sales to qualified patients and primary caregivers are tax-free, irrespective of whether the volume purchased is within the three-month adequate supply limit. By his argument, all receipts from the sale of Ibuprofen would likewise be deemed tax-free, because no volume limit on Ibuprofen is specified in that section of the tax law. Ultra Health's argument, and its persistent refusal to acknowledge the existence of the adequate supply limit in statute, defy reason.

<sup>3</sup> The caption on the first page of House Bill 2 from the 2021 Legislative session describes the bill in similar terms, as "TRANSFERRING LICENSING AUTHORITY UNDER THE LYNN AND ERIN COMPASSIONATE USE ACT TO THE CANNABIS CONTROL DIVISION".

<sup>4</sup> "Personal production licenses" ("PPLs") were struck from the LECUA via House Bill of the 2021 Special Session. Upon information and belief, the Legislature opted to eliminate PPLs due to the fact that all persons 21 years

pursuant to Department rule 7.34.4 NMAC (“Licensing Requirements for Producers, Couriers, Manufacturers and Laboratories”). Only commercial licensing duties have been transferred to the CCD. *See* NMSA 1978 § 26-2C-3 (creating the Cannabis Control Division within the Regulation and Licensing Department “to administer the Cannabis Regulation Act and the licensing provisions of the Lynn and Erin Compassionate Use Act and rules promulgated in accordance with those acts”); *see also* NMSA 1978, § 26-2C-6(B) (identifying all of the persons and entities to be licensed by the Cannabis Control Division of RLD, all of which are commercial license designations). At no time have the LECUA or NMDOH rule ever described qualified patients or primary caregivers as being “licensed” for those designations.<sup>5</sup> Instead, qualified patients and primary caregivers are deemed “enrolled”, their names are included in the Medical Cannabis Registry, and they are issued Registry identification cards on that basis.

Because the Legislature transferred only licensing duties to the CCD within RLD, which duties do not include the setting of the adequate supply limit; because the Legislature reserved to NMDOH the “administration of the medical cannabis registry”; and because the LECUA contains numerous references to the adequate supply limit and the Department of Health’s role in setting it, it is apparent that the Legislature considered the setting of the adequate supply limit to be a responsibility associated with the administration of the Medical Cannabis Registry. The fundamental purpose of statutory construction is to ascertain and effectuate legislative intent, using the plain language of the statute as the primary indicator of that intent. *See, e.g., State v. Nelson*, 1996-NMCA-012, ¶ 6, 121 N.M. 301. A court does not give effect to or embrace legislative intent if it reads a statute in a way that would render it meaningless. *See City of Deming v. Deming Firefighters Local 4521*, 2007-NMCA-069, ¶ 23, 141 N.M. 686, 692. Unlike Ultra Health’s argument, the Department of Health’s interpretation of the LECUA and the CRA relies on the plain text of the statutes and gives effect to both statutes.

Ultra Health’s argument concerning the reciprocal participation limit is unavailing, for similar reasons. References to a “limit identified by department rule” for reciprocal participants remain in the LECUA at NMSA 1978, § 26-2B-4(B), (C)(1) and (C)(2). Again, that section of the statute was amended by House Bill 2 of the 2021 Special Legislative Session, the bill which created the CRA, and yet those references remained unchanged. As in the case of “adequate supply”, the Medical Cannabis Advisory Board is tasked in the LECUA with making recommendations to the Department of Health concerning the reciprocal participation limit. NMSA 1978, § 26-2B-6(G). There would be no purpose for requiring this unless the Department of Health was, as the plain text of the LECUA states, responsible for setting the reciprocal participation limit by rule. Also,

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and older can now possess up to 6 mature cannabis plants and 6 immature cannabis plants at any one time. *See* NMSA 1978, § 26-2C-25(A)(9) (“Personal use of cannabis”).

<sup>5</sup> The distinction between a qualified patient and a “licensee” was reflected in various passages within the previous version of the LECUA, including the prior version of NMSA 1978, § 26-2B-4 (effective June 29, 2019), which established civil and criminal immunities for qualified patients, primary caregivers, reciprocal participants, and licensees. That section stated at subsection “G” that “[a] licensee or licensee representative shall not be subject to arrest, prosecution or penalty, in any manner, for the production, possession, manufacture, distribution, dispensing or testing of cannabis pursuant to the Lynn and Erin Compassionate Use Act.” Here again, all references to a “license” within the LECUA, apart from references to personal production licenses, concerned the licensing of commercial establishments.

for the same reasons described above, the setting of the reciprocal participation limit is not a licensing duty under the LECUA and was therefore not transferred to the CCD under the CRA.

At page 5 of the November 9, 2021 letter from its Chief Legal Officer, Kristina Caffrey, Ultra Health complains that the proposed 425-unit adequate supply limit “is unsupported by substantial evidence”. Ultra Health argues that “[t]he DOH has provided no evidence at all, let alone substantial evidence, to support its 425-units-over-90-days ‘adequate supply’ figure.” The letter states that “the DOH has provided no studies, no surveys, no supporting documents, no comparisons to other states. In short, DOH has provided no evidence whatsoever.” These statements are outrageously hypocritical and demonstrate bad faith on the part of Ultra Health and its representatives. **The 15-ounce adequate supply limit that the Department of Health is now proposing is a direct result of Ultra Health’s petition to the Medical Cannabis Advisory Board in which Ultra Health requested adoption of a 15-ounce limit.** On March 29, 2020, Ultra Health petitioned the Medical Cannabis Advisory Board for the adequate supply limit to be increased. That petition is referenced at page 4 of the Decision by Acting Cabinet Secretary Dr. David Scrase on the Medical Cannabis Advisory Board’s recommendations, which is contained at Exhibit 8 from the rule hearing in this matter. In Ultra Health’s petition, attached hereto as Exhibit “A”, Ultra Health’s Chief Operating Officer, Kylie Safa, requested that the adequate supply limit be increased to “a minimum of 15 ounces (420 units) of usable cannabis for a period of three months.” Ex. A at 4. Ultra Health’s petition described this as a “common conservative industry standard”, and stated that Ultra Health had previously petitioned for the same adequate supply limit on March 25, 2019. Ex. A at 2. The petition detailed how New Mexico’s adequate supply limit compared with those of other states, stating that Arizona, Arkansas, Illinois, Maine, and Nevada all had 15-ounce limits for a three-month period. Ex. A at 5-6. The petition stated, “These examples also show that Ultra Health’s recommended 15 ounces per any 3-month period is in keeping with the industry practice.” Ex. A at 7. The petition stated:

Again, the most commonly accepted, conservative industry standard for patient purchase limits equates to 15 ounces in a 90-day period. The advisory board should recommend to the Department an increase in patient purchase limits to no less than 15 ounces over 90 days to ensure patients can purchase back-stock medicine allowing them to meet the CDC’s recommendation to have a 30-day supply of medicine on hand.

Ex. A at 9. The petition concluded, “We respectfully request the Medical Cannabis Advisory Board increase adequate supply to a minimum of the conservative industry standard of 15 ounces (or 420 units) for a three-month period.” Ex. A at 11.

Previously, on March 25, 2019, Kylie Safa, who at that time held the title of Project Manager for Ultra Health, sent a letter to then Cabinet Secretary Kathyleen M. Kunkel to request that the Department of Health initiate a rulemaking process to amend Department rule 7.34.3.9 NMAC. A copy of that letter is attached hereto as Exhibit “B”. In its March 2019 letter, Ultra Health requested that NMDOH increase the adequate supply limit to 15 ounces. Ex. B at 2, 5. The letter stated, “Ultra Health believes patients should be allowed 15 ounces over a 90-day timeframe, which is in line with the amount patients can buy in other medical markets.” Ex. B at 4. As in its 3/29/20 petition to the Medical Cannabis Advisory Board, Ultra Health claimed that

other states had adopted a 15-ounce limit for a 3-month supply, including Arizona, Illinois, and Nevada. Ex. B at 5. “These examples”, it claimed, “also show that Ultra Health’s recommended 15 ounces per any 3-month period is in keeping with the industry practice.” *Id.*

For years, Ultra Health has pushed for the adoption of a 15-ounce adequate supply limit. Now that the Department has proposed to adopt Ultra Health’s limit, Ultra Health’s representatives attempt a cynical bait-&-switch, insisting that there’s no evidence to support it. Ultra Health’s arguments are disingenuous and without merit.

The proposed 15-ounce adequate supply limit nearly doubles the current 8-ounce limit, was unanimously endorsed by the Medical Cannabis Advisory Board, and is (by Ultra Health’s own repeated representations) an “industry standard” that is applied in several states. A review of the Medical Cannabis Program’s records shows that, out of approximately 127,000 currently enrolled qualified patients, only about 905 (about 7/10ths of 1 percent of all enrolled qualified patients) have sought a “medical exception”. That exception, at 7.34.3.9(C) NMAC, allows a patient to access an additional 115 units/grams, up to a total of 345 units/grams, or approximately 12 ounces of dried usable cannabis. Further, as expressed above, soon the adequate supply limit will no longer function as an acquisition limit for patients 21 years of age and older. With the arrival of “commercial” cannabis sales, those patients will be able to purchase quantities of cannabis above the 90-day adequate supply limit, provided that taxes are applied to those additional purchases. Since June 29, 2021, qualified patients and all other persons 21 years old and older have been allowed to lawfully grow and cultivate up to six mature cannabis plants and six immature (i.e., non-flowering) plants, and they are able to gift cannabis to one another. NMSA 1978, § 26-2C-25(A)(3), (9). The 6-mature plant limit represents a 50% increase in the number of mature plants that qualified patients can grow, compared to the 4-mature plant limit that previously applied to personal production license holders. There is no legitimate argument to say that the adequate supply limit prevents qualified patients from obtaining needed medicine.

Thank you for this opportunity to discuss the issues raised in public comments. Please feel free to contact me if you have any questions.

Sincerely,

Chris D. Woodward 12-3-21

Chris D. Woodward

Assistant General Counsel



Ultra Health®

March 29, 2020

**VIA Email and Hand Delivery**

Medical Cannabis Advisory Board  
Department of Health  
Medical Cannabis Program  
1474 Rodeo Road Suite 200  
Santa Fe, NM 87502

**Petitioner**

Ultra Health  
255 Camino Don Tomas  
Bernalillo, NM 87004  
415-250-8564

**Re: Petition to recommend quantities of cannabis that are necessary to constitute an adequate supply for qualified patients and primary caregivers**

Dear Medical Cannabis Advisory Board Member,

On behalf of the petitioner, Ultra Health, 255 Camino Don Tomas, Bernalillo, N.M., 87004, we respectfully submit the following petition for your consideration. This submission includes all required sections defined by the Department of Health, to the extent that it does not include material specifically required for a petition related to a newly requested qualifying medical condition. The petition is submitted in accordance with NMSA 1978 §26-2B-6(E). The



index of materials are as follows (due to the number of attachments and size of files, I have attached three files electronically and have provided links for other referenced materials):

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### **Introduction**

Pursuant to Rule 1.24.25.10 NMAC, New Mexico Top Organics-Ultra Health, Inc. (Ultra Health) previously petitioned the Department of Health to initiate a rulemaking regarding patient purchase and possession limitations, specifically to raise the patient purchase and possession limitation to the common conservative industry standard of 15 ounces (or 420 units if continuing current methodology of tracking) in any three-month period.

In connection with that written petition submitted on March 25, 2019, over one year ago, Ultra Health provided extensive objective data and evidence to the Department of Health Secretary Kathy Kunkel to increase patient purchase and possession limitations to a more reasonable and conservative industry standard of no less than 15 ounces (or 420 units if

continuing current methodology of tracking) in any three-month period. Secretary Kathy Kunkel responded to the aforementioned petition indicating that the DOH intended to revisit adequate supply in the then upcoming rulemaking regarding plant limits.

Unfortunately, this gaping issue in our Medical Cannabis Program has still not been addressed, despite Secretary Kunkel's response; despite two extensive rulemaking processes being initiated; and despite patient surveys conducted by Research and Polling, Inc., on behalf of the NMDOH, indicating the need for an increase in the allowed purchase limits. The Secretary's response indicated a willingness to review the matter, conditional on accomplishing the survey and the survey results (response attached). Sufficient time has expired and it is incumbent on the Medical Cannabis Advisory Board to properly consider the matter.

Governor Lujan Grisham has stated time and time again that she is committed to the need for a more robust medical cannabis program. Ultra Health provides sufficient evidence in this petition to support that an increase in the amount currently determined to what constitutes adequate supply will better the health and quality of life for the 82,000+ New Mexicans currently enrolled in the medical cannabis program and create the robust medical cannabis program the Governor has pledged.

Comparatively, the record is very clear on how reasonable other states have been in establishing their purchase and possession limits for medical cannabis patients. Of the 33 states with medical cannabis programs, only Ohio comes close to matching New Mexico's 230 units per 90 days, but even the Ohio model has broken it further into tiers and a possession limit on the amount of THC (dry weight) at any one time which potentially could provide amounts greater than New Mexico, particularly when applying to purchases of concentrates and edibles. Thus, New Mexico clearly falls to last in the country for those medical cannabis programs allowing for THC above 0.5%, and is not consistent with the Governor's expectation of a industry leading robust medical cannabis program.

The disparity is even more glaring when compared regionally with surrounding states. New Mexico's purchase and possession limit as determined for an adequate supply clearly needs an immediate increase. By example, Oklahoma has the most generous program allowing 270 ounces over 90 days, followed by Colorado at 180 ounces over 90 days, and then Arizona and Nevada both at 15 ounces over 90 days. Interestingly, one of the more conservative states in the region is Utah and their program officially initiated dispensing activities on March 1, 2020. Just weeks old, Utah became the most recently launched program in the U.S., and is allowing patients to possess 12 ounces in a 90-day period, which is 50% higher than what New Mexico patients are legally allowed to access. New Mexico must immediately update the amount deemed to be an adequate supply.

### Advisory Board Statutory Duty to Recommend Quantities Regarding Adequate Supply

NMSA 1978 §26-2B-3(A) explicitly defines “adequate supply” as “an amount of cannabis, in any form approved by the department, possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver that is determined by rule of the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months and that is derived solely from an intrastate source”.

The medical cannabis advisory board has the statutory authority and the duty to recommend amounts of cannabis qualified patients may purchase and possess. The Lynn and Erin Compassionate Use Act explicitly lists advisory board duties. NMSA 1978 §26-2B-6(E) states, “The advisory board shall: (...) E. **recommend quantities of cannabis that are necessary to constitute an adequate supply for qualified patients and primary caregivers**” (emphasis added).

Ultra Health respectfully requests that the advisory board uphold their statutory duty to recommend quantities of cannabis to constitute an adequate supply and, for the reasons stated within this petition, recommend a minimum of 15 ounces (420 units) of usable cannabis for a period of three months.

### Existing Rule Regarding Adequate Supply

The current rule regarding patient possession and adequate supply is Rule 7.34.3.9 NMAC, which states, “A qualified patient and a qualified patient’s primary caregiver may collectively possess within any three-month period a quantity of usable cannabis no greater than 230 total units. For purposes of department rules, this quantity is deemed an adequate supply.” This roughly translates to 8 ounces, or 230 grams, per 90 days.

To calculate a unit, “one unit of usable cannabis shall consist of one gram of dried leaves and flowers of the female cannabis plant, or 0.2 grams (200 milligrams) of THC for cannabis derived products.” Rule 7.34.3.9 NMAC.

There are exceptions allowed if the patient can produce “a statement by a medical practitioner explaining why a greater number of units of usable cannabis is medically necessary.” Rule 7.34.3.9 NMAC.

### Proposed Rule in Underline and Strikethrough Format

The underlined material indicates new language, the strikethrough material indicates language to be removed.

**7.34.3.9 QUANTITY OF USABLE CANNABIS THAT MAY BE POSSESSED BY A QUALIFIED PATIENT OR PRIMARY CAREGIVER:**

**A. Maximum quantity:** A qualified patient and a qualified patient’s primary caregiver may collectively possess within any three-month period a quantity of usable cannabis no greater than ~~230~~ 420 total units. For purposes of department rules, this quantity is deemed an adequate supply. (For case of reference: ~~230~~ 420 units is equivalent to ~~230~~ 420 grams, or approximately ~~eight~~ fifteen ounces, of dried usable cannabis plant material.) A qualified patient and primary caregiver may also possess cannabis seeds.

**B. Calculation of units:** For purposes of department rules, one unit of usable cannabis shall consist of one gram of the dried leaves and flowers of the female cannabis plant, or 0.2 grams (200 milligrams) of THC for cannabis-derived products.

**C. Medical exception:** A greater quantity of usable cannabis, not to exceed 115 additional units, may be allowed, at the department’s discretion, upon the submission of a statement by a medical practitioner explaining why a greater number of units of usable cannabis is medically necessary. Any such allowance shall be reviewed for approval by the program’s medical director.

**Reasoning for Rule Change and Increased Adequate Supply**

**I. NEW MEXICO’S LIMITS ARE ABNORMALLY RESTRICTIVE**

New Mexico’s patient purchase limitations are much more restrictive than those of other states. The following is a breakdown of how other states’ medical cannabis programs address the needs of their medical cannabis patients:

<b>State</b>	<b>Purchase limits (oz)</b>	<b>Supply period</b>	<b>3-month supply period (oz)</b>
Arizona	2.5 ounces	14-day period	15 ounces
Arkansas	2.5 ounces	14-day period	15 ounces
Colorado	2 ounces	At any time	180 ounces

Hawaii	4 ounces	15-day period	24 ounces
Illinois	2.5 ounces	14-day period	15 ounces
Maine	2.5 ounces	15-day period	15 ounces
Nevada	2.5 ounces	14 days	15 ounces
Oklahoma	3 ounces	“A single transaction”	270 ounces
Oregon	24 ounces	May possess at any one time	
Utah	4 ounces	30-day period	12 ounces
Washington	3 ounces	1 day	270 ounces

New Mexico appears to be the only state with such scant purchase limits. These examples indicate that other states are able to maintain regulatory control while offering patients access to cannabis in quantities sufficient to meet their medical needs.

New Mexico’s purchase limits are an outlier and one should not assume that New Mexican patients simply use or need less medicine than the patients of other states. It is more reasonable to assume that patient acuity should be comparable between states unless the NMDOH can point to specific patient data to suggest otherwise. What can also be safely assumed is that patients with unmet needs in the regulated market are seeking relief from the illicit markets.

The purchase limitations of other states are far more reflective of actual need than New Mexico's stringent eight ounces. These examples also show that Ultra Health's recommended 15 ounces per any 3-month period is in keeping with the industry practice.

## **II. PATIENT SURVEY RESPONSES INDICATE NEED FOR HIGHER LIMITS**

In May 2019 the DOH conducted a patient survey in connection with determining adequate supply and producer plant limits. On page 32 of the survey there are two important statistics worth noting here:

- When asked, "Would you purchase more cannabis or cannabis-derived products in a 90-day period if allowed?" Of the patients surveyed:
  - 48% answered YES
  - 49% answered NO
  - 3% don't know/won't say
- When asked, "Have you built up a tolerance to cannabis or cannabis products in the past year?" Of the patients surveyed:
  - 24% answered YES
  - 73% answered NO
  - 3% don't know/won't say

Nearly half of patients surveyed have indicated they would purchase more medicine in a 90-day period if allowed, therefore indicating a need for higher patient purchase limits. At its current enrollment of over 82,000+ patients, the survey indicates over 39,000 patients' needs are not met under the 230 unit limit.

In addition, one-quarter of patients have reported they developed a tolerance to cannabis during the past year, which indicates a greater need for purchase limits to be adjusted to accommodate tolerance to the medicine. Per the survey, this indicates nearly 20,000 patients could benefit from an adjustment to purchase limits and allow those patients to receive the beneficial use of medical cannabis as established within the purpose of the Lynn and Erin Compassionate Use Act to treat their debilitating medical condition.

## **III. DISCREPANCY BETWEEN QUALIFIED PATIENTS' POSSESSION LIMITS**

Another important factor in the discussion on patient limits is the discrepancy that currently exists between qualified patients with a personal production license (PPL) and those without. NMSA 1978 §26-2B-4(A) states, "A qualified patient or a qualified patient's primary caregiver shall not be subject to arrest, prosecution or penalty in any manner for the possession of or the medical use of cannabis if the quantity of cannabis does not exceed an adequate supply;

provided that a qualified patient or the qualified patient's primary caregiver may possess that qualified patient's harvest of cannabis.”

Rule 7.34.4.8 NMAC states, “A qualified patient or primary caregiver who holds a valid personal production license is authorized to possess no more than four mature female plants and a combined total of 12 seedlings and male plants, and may possess no more than an adequate supply of usable cannabis, as specified in department rule; provided that a qualified patient or qualified patient’s primary caregiver may possess that qualified patient’s harvest of cannabis. A personal production license holder may additionally obtain usable cannabis, seeds, or plants from licensed non-profit producers.”

Patients with PPLs could potentially cultivate more than the eight ounces deemed to constitute an adequate supply with the plant allotment allowed by rule. Patients with PPLs are also, rightfully so, allowed to purchase their full 230 units through the dispensary. This creates a huge disparity between classes of patients, all of whom deserve equal protection under the law. Increasing possession limits is the first step towards creating that equality and meeting *all* patients’ needs.

#### **IV. ACCESSIBILITY TO SAFE, LAWFUL, AND REGULATED MEDICINE**

Raising the purchase limits should increase incentive and accessibility for patients to purchase from a lawful, regulated source. When patients are restricted in the regulated system, from purchasing the quantities necessary to alleviate their symptoms, they have limited and less than ideal options.

One option is to suffer through their debilitating medical condition until they are able to visit a practitioner, receive their statement, mail their statement to DOH, and await notice of an increase from DOH that still may not be sufficient to meet their needs.

Another option is to travel over state lines and purchase from a regulated adult-use market that has higher purchase limits than New Mexico, and risk federal drug trafficking charges upon returning to New Mexico as well as criminal and civil penalties.

Another option is to purchase from the illicit market where patients are not restricted by arbitrary purchase limits, but risk incurring criminal and civil penalties, and the potential to consume contaminated products potentially worsening their debilitating medical conditions.

“The purpose of the Lynn and Eric Compassionate Use Act is to allow for the beneficial use of medical cannabis in a regulated system for alleviating symptoms of debilitating medical conditions and their medical treatments.” None of the options listed above meet the purpose of

the Act. Increased purchase limits will resolve this accessibility issue for patients and will allow for the beneficial use of medical cannabis.

Finally, in 2019 the Legislature and the Governor have made their position clear by adopting in statute "...a qualified patient's use of cannabis pursuant to the Lynn and Erin Compassionate Use Act shall be considered the equivalent of the use of any other medication under the direction of a physician and shall not be considered to constitute the use of an illicit substance or otherwise disqualify a qualified patient from medical care." In keeping with the spirit of the law, it would seem logical to allow deference to patient-need over archaic views to the use of medical cannabis as an illicit substance. Many of today's New Mexico caps on the medical cannabis program, including patient limits are an outgrowth of a 'war on drugs' mentality and not based on science or the community standard of care when measured against other more rational state approved programs.

## **V. COVID-19 IMPACT ON PATIENT NEEDS**

Again, the most commonly accepted, conservative industry standard for patient purchase limits equates to 15 ounces in a 90-day period. The advisory board should recommend to the Department an increase in patient purchase limits to no less than 15 ounces over 90 days to ensure patients can purchase back-stock medicine allowing them to meet the CDC's recommendation to have a 30-day supply of medicine on hand. This will also aid in reducing unnecessary dispensary foot traffic, limiting unnecessary travel, particularly in rural areas, limiting travel to other states for cannabis needs, and reducing illicit market activity where patients are dangerously exposed to contracting COVID-19.

Increased consumption of medical cannabis is a predictable outgrowth of the current environment, particularly because [85% of patients](#) enrolled in the New Mexico medical cannabis program have the qualifying conditions of PTSD (52%) or chronic pain (33%). These vulnerable populations need medical cannabis now more than ever. Increased anxiety and depression, deviation from normal day-to-day life, mental impact of being homebound, stress over loss of income, loss of access to other therapeutic treatments (i.e. water therapy, massage therapy, group therapy, etc.) all of these factors and more are contributing to cannabis patients' increased consumption needs as they seek some manner of relief during these trying times.

### **Summary/Conclusions**

The New Mexico Medical Program was approved in 2007 and suffered from limited patient growth and heavy-handed regulations for a number of years under the previous administration of Governor Susana Martinez. Thankfully, the medical cannabis program has benefitted from a national discourse on the acceptability of medical cannabis, favorable court



decisions in New Mexico triggering more dispensary locations and additional plants in production, expansion in the number of qualifying conditions, and an increased patient awareness/acceptability statewide.

During the eight years of Governor Martinez's administration a number of notable activities happened in surrounding states with regard to cannabis, including the legalization of the adult-use and sale in Colorado, approval and launching of both the medical cannabis program and adult-use in Nevada, and near passage of an adult-use program in Arizona. The vote failed in Arizona by 22,000 votes but the hotly contested campaign caused a surge in the medical cannabis program and now stands at nearly 230,000 cardholders.

More recently, during the new administration of Governor Michelle Lujan Grisham, the surrounding states have seen continued progressive evolution in the programmatic design of their medical cannabis programs. Oklahoma has put forth the most patient-friendly medical cannabis model in the region which has resulted in a soaring program of over 258,000 patients in the first year alone. Utah has joined the ranks of surrounding state approved medical cannabis programs by launching their model on March 1, 2020.

In all surrounding states with medical cannabis programs allowing for THC above 0.5%, New Mexico lags significantly in the approved amount of cannabis deemed necessary to constitute an adequate supply for qualified patients and caregivers. New Mexico's shortage in the allowance granted to patients creates an absurd and unreasonable result in which patients cannot adequately medicate without reliance on illicit, unregulated purchases from either surrounding states or the black market. Utah allows 50% more per medical patient than New Mexico. Nevada and Arizona allow 100% more per patient than New Mexico. Colorado and Oklahoma allow medical patients to buy more in as little as three days than New Mexicans can buy over three months. In fact, Oklahomans are allowed to purchase nearly 3,300% more per patient or 33 times what a similar patient would be allowed in New Mexico.

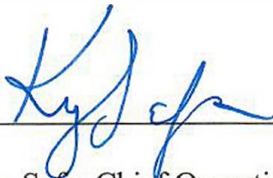
The purpose of the program is to serve the needs of all medical cannabis patients, not just a few. In order for the program to function and for the statutory purpose of the beneficial use of cannabis to be met, the rules on adequate supply need to reflect every patient's needs and provide for a robust program that allows patients to acquire more medicine if their debilitating condition calls for it. A program that does not allow patients to purchase what they need frustrates the purpose of the statute and forces otherwise legal participants to seek medicine from the black market, where cannabis can pose serious health risks that can be completely avoided if the department were to provide adequate patient purchase limits.

Whether considered individually or collectively, each element listed here justifies the need for increased adequate supply. New Mexico has abnormally restrictive state limits

compared with other medical cannabis programs nationally and regionally. There's a proven need for change demonstrated by patient voices in a survey produced by an independent polling contractor and provided by the NMDOH. There exists a discrepancy and inequality between the category of patients within New Mexico, those with a personal production license and those without. There is a legal obligation to provide safe, accessible medicine from the lawful regulated industry that is not being wholly met. Lastly, though certainly not least important, the unknown short to long term implications of COVID-19 on our medically vulnerable 82,000+ patients should cause us to reevaluate what is right for the patients. The need for change is clear.

We respectfully request the Medical Cannabis Advisory Board increase adequate supply to a minimum of the conservative industry standard of 15 ounces (or 420 units) for a three-month period. Ideally, the Medical Cannabis Advisory Board should commit to reviewing adequate supply annually and make recommendations for its adjustment as the program progresses.

Thank you for your time and consideration on this matter.



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Kylie Safa, Chief Operating Officer, Ultra Health®

**Supporting Documents (provided via electronic attachment)**

03 25 19 Petition to Initiate Rulemaking Process

NMDOH Response - Purchase limits

Medical Cannabis Patient Survey, May 2019

**Citations**

Arizona:

<https://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/36/02806-02.htm>

Arkansas: <https://www.healthy.arkansas.gov/programs-services/topics/medical-marijuana-faqs>

Colorado: <https://codes.findlaw.com/co/title-25-health/co-rcv-st-sect-25-1-5-106.html>

Hawaii: <https://health.hawaii.gov/medicalcannabis/files/2018/07/Act-116-18.pdf>

Illinois: <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3503&ChapterID=35>

Maine:

<https://www.maine.gov/dafs/bbm/mmmp/sites/maine.gov/dafs/bbm/mmmp/files/inline-files/2018-MMP-Rules-1111.pdf>

Ohio: <http://codes.ohio.gov/oac/3796:8-2-04v1>

Oklahoma:

<http://omma.ok.gov/Websites/ddeer/images/310-681%20EME2%20Medical%20Marijuana%20Rules%208-1-18%20wRedMark%20Revisions.pdf>

Oregon:

<https://www.oregon.gov/oha/ph/diseasesconditions/chronicdisease/medicalmarijuanaprogram/pages/top20.aspx#patientlimits>

Utah: <https://lc.utah.gov/~2018S3/bills/static/HB3001.html>

Washington: <https://app.leg.wa.gov/RCW/default.aspx?cite=69.51A.210>



Ultra Health<sup>®</sup>

March 25, 2019

**VIA Mail and Email**

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Re: Patient Purchase Limits - Petition to Initiate Rulemaking Process

Dear Secretary Kunkel,

Pursuant to Rule 1.24.25.10 NMAC, New Mexico Top Organics-Ultra Health, Inc. (Ultra Health) petitions the Department of Health to initiate a rulemaking regarding patient purchasing limitations, specifically to raise the patient purchase limitation to the common industry limit of 15 ounces in any three-month period; and eliminate the use of units as a system of measurement altogether, in exchange for the industry standard measurement of dry weight in ounces for flower and dry weight in ounces of THC for extracts and infused products.

As you may know, Rule 1.24.25.10 NMAC allows “any person” to “file a petition for rulemaking with an agency.”

Ultra Health recently discussed with Department staff the potential for building a more robust medical cannabis program for patients in New Mexico. One of the subjects we discussed was that most other states with medical cannabis programs have standards for patient purchase limitations that are far more accommodating than New Mexico’s.

Ultra Health has reason to believe that a reevaluation of patient purchase limitations will better the health and quality of life for the 70,000+ New Mexicans currently enrolled in the medical cannabis program.

### Existing Rule Regarding Patient Purchase Limitations

The current rule regarding patient purchase/possession limitations is Rule 7.34.3.9 NMAC, which states, “A qualified patient and a qualified patient’s primary caregiver may collectively possess within any three-month period a quantity of usable cannabis no greater than 230 total units. For purposes of department rules, this quantity is deemed an adequate supply.” This roughly translates to 8 ounces, or 230 grams, per 90 days.

To calculate a unit, “one unit of usable cannabis shall consist of one gram of dried leaves and flowers of the female cannabis plant, or 0.2 grams (200 milligrams) of THC for cannabis derived products.” Rule 7.34.3.9 NMAC.

There are exceptions allowed if the patient can produce “a statement by a medical practitioner explaining why a greater number of units of usable cannabis, or a higher concentration of THC in concentrated cannabis-derived product, is medically necessary.” Rule 7.34.3.9 NMAC.

### Proposed Rule in Underline and Strikethrough Format

The underlined material indicates new language, the strikethrough material indicates language to be removed.

#### **7.34.3.9 QUANTITY OF USABLE CANNABIS THAT MAY BE POSSESSED BY A QUALIFIED PATIENT OR PRIMARY CAREGIVER:**

**A. Maximum quantity:** A qualified patient and a qualified patient’s primary caregiver may collectively possess within any three-month period a quantity of usable cannabis no greater than 15 ounces. ~~.230 total units~~. For purposes of department rules, this quantity is deemed an adequate supply. ~~(For ease of reference: 230 units is equivalent to 230 grams, or approximately eight ounces, of dried usable cannabis plant material.)~~ A qualified patient and primary caregiver may also possess cannabis seeds.

**B. Dry weight measurement: ~~Calculation of units:~~** For purposes of department rules, dried usable cannabis plant material shall be measured in ounces, and all cannabis-derived products shall be measured by the dry weight of THC content in milligrams. ~~one unit of usable cannabis shall consist of one gram of the dried leaves and flowers of the female cannabis plant, or 0.2 grams (200 milligrams) of THC for cannabis derived products.~~

**C. Maximum THC content of concentrates:** A qualified patient or primary caregiver shall not possess a concentrated cannabis-derived product that contains greater than seventy percent (70%) THC by weight.

**D. Medical exception:** A greater quantity of usable cannabis, not to exceed 115 additional grams ~~units~~, may be allowed, and a concentrated cannabis-derived product with THC content greater than seventy percent (70%) by weight may be allowed, at the department’s discretion, upon the submission of a statement by a medical practitioner explaining why a greater amount ~~number of units~~ of usable cannabis, or a higher concentration of THC in concentrated cannabis-derived product, is medically necessary. Any such allowance shall be reviewed for approval by the program’s medical director.

**Legal Authority Authorizing the Agency to Adopt the Rule**

The Department of Health does have explicit statutory authority to create and adopt a rule regarding patient purchase/possession limitations. This statutory authority is shown by several interlocking provisions of the Lynn and Erin Compassionate Use Act. First, NMSA 1978 §26-2B-4(A) states, “A qualified patient shall not be subject to arrest, prosecution or penalty in any manner for the possession of or the medical use of cannabis if the quantity of cannabis does not exceed an adequate supply.” This provision indicates there is and should be a cap on the amount of cannabis a qualified patient may *lawfully* purchase.

Second, NMSA 1978 §26-2B-3(A) explicitly defines “adequate supply” as “an amount of cannabis, in any form approved by the department, possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver that is determined by rule of the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months and that is derived solely from an intrastate source”

Reading §26-2B-4(A) and §26-2B-3(A) together indicates the Legislature intended a limitation on the amount of cannabis a qualified patient could possess/purchase, and that the limitation should be based upon necessity and availability.

Finally, NMSA 1978 §26-2B-7(A)(2) explicitly directs and allows DOH to promulgate rules to “define the amount of cannabis that is necessary to constitute an adequate supply, including amounts for topical treatments.” This ties in with the previously cited sections to give DOH authority to set the limitation point for patient purchase/possession.

**Basis for Proposed Rule**

Ultra Health believes now is an appropriate time to reevaluate the patient purchase limitation rule, because the patient purchase limitation rule may require some patient survey data. If DOH plans to survey patients on other medical cannabis-related subjects (such as consumption patterns), DOH could also address the purchase limitation rule within that survey. Additionally, as DOH is working diligently to promulgate a new rule regulating plant count, it should be noted that a change in patient purchase limits will directly affect how many plants producers will need to meet patient demand. Therefore, it seems reasonable to address these issues simultaneously, to ensure consistency between supply and demand.

The use of units as a means of measurement is unique to New Mexico. Every other state’s medical cannabis program regulates purchase limits through more technical means of measurement (i.e. ounces, milligrams). The “calculation of units” as described in Rule 7.34.3.9 NMAC, does not serve the medical cannabis program well and is a common source of confusion for medical cannabis program participants. It also creates logistical complications with the State used tracking system. A conversion from units to ounces is the simplest, most timely, and cost-efficient solution for accurate tracking of transactions. It would benefit the program, and the program’s patients, to have more accurate tracking and collect more meaningful data.

As DOH knows, the medical cannabis program has undergone significant change in the years since the program was first implemented in 2007. One of the most significant changes is the expansion of available products. Whereas in 2007, most patients were simply purchasing the unprocessed dried flower material to smoke, more and more patients now prefer more sophisticated cannabis products, both smokable and non-smokable. For example, the medical market in Colorado experienced a 100% increase in concentrate use between the years 2014 and 2017 (Orens, Light, Lewandowski, Rowberry, and Saloga, 2018, p. 23). For the purpose of tracking purchases, supply of these products can be defined in terms of milligrams of dry weight THC content, as is the industry standard. Milligrams are consistent with the avoirdupois ounce, allowing for simple conversions and tracking.

Example Purchases:

<p><u>First Purchase:</u>  1 oz flower + 1500 mg concentrate + 200 mg edible = 1 oz + 1700 mg  1 oz flower + 0.053 oz concentrate + 0.007 oz edible = <b>1.06 oz usable cannabis</b></p> <p><b>15 oz purchase limit – 1.06 oz purchased = 13.94 oz remaining purchase limit</b></p>
<p><u>Second Purchase:</u>  2 oz flower + 500 mg concentrate + 1000 mg edible = 2 oz + 1500 mg  2 oz flower + 0.018 oz concentrate + 0.035 oz edible = <b>2.053 oz usable cannabis</b></p> <p><b>13.94 oz purchase limit – 2.053 oz purchased = 11.887 oz remaining purchase limit</b></p>
<p><u>Third Purchase:</u>  0.5 oz flower + 6000 mg concentrate + 60 mg edible = 0.5 oz + 6060 mg  0.5 oz flower + 0.212 oz concentrate + 0.002 oz edible = <b>0.714 oz usable cannabis</b></p> <p><b>11.887 oz purchase limit – 0.714 oz purchased = 11.173 oz remaining purchase limit</b></p>

Additionally, as cannabis producers have become more experienced and refined their methods, patients have also become more knowledgeable about their needs and consumption habits. DOH has not performed a patient survey since 2013, and given the significant changes in the program, a study on consumption and need patterns seems due.

Another important factor in the discussion on patient limits is Rule 7.34.4.8 NMAC. This rule allows patients with personal production licenses "to possess no more than four mature female plants and a combined total of 12 seedlings and male plants, and may possess no more than an adequate supply of usable cannabis, as specified in department rule." Patients with PPLs can easily cultivate more than 8 ounces with the plant allotment allowed by rule. Therefore, patients who do not choose to cultivate on their own should be allowed to purchase enough medicine to meet their needs. Ultra Health believes patients should be allowed 15 ounces over a 90-day timeframe, which is in line with the amount patients can buy in other medical markets.

Raising the purchase limits should increase incentive and accessibility for patients to purchase from a lawful, regulated source. When patients are restricted in the regulated system,

from purchasing the quantities necessary to alleviate their symptoms, they have three options, (1) suffer through their debilitating medical condition until they are able to visit a practitioner, receive their statement, mail their statement to DOH, and await notice of an increase from DOH, (2) purchase from the illicit market where they are not restricted by purchase limits, but risk incurring criminal and civil penalties, and the potential to consume contaminated products, or (3) purchase from a regulated market in another state that has higher purchase limits than New Mexico, and risk federal drug trafficking charges upon returning to New Mexico as well as criminal and civil penalties. Increased purchase limitations will resolve this accessibility concern for patients, while also reducing DOH’s administrative responsibilities.

New Mexico’s patient purchase limitations are much more restrictive than those of other states. The following is a breakdown of how other states deal with the needs of their medical cannabis patients:

<b>State</b>	<b>Purchase limits (oz)</b>	<b>Supply period</b>	<b>3-month supply period (oz)</b>
Arizona AZ Rev Stat § 36-2806.02 (2016)	2.5	14 days	15
Colorado Title 25 Health § 25-15-106 (g)(I)	2	At any time	*NC
Illinois 410 ILCS 130/10(a)	2.5	14 days	15
Maine 10-144 CMR ch.122 § 1(k)	2.5	“At any one time”	NC
Nevada NRS 453A.200 (3)(B)	2.5	14 days	15
Oklahoma 310:681-5-12	3	“A single transaction”	NC
Oregon 333-008-0080	24	May possess at any one time	NC
Washington RCW <b>69.50.357</b>	3	1 day	270

\*NC = *Not comparable*

New Mexico appears to be the only state with such scant purchase limits. These examples indicate that other states are able to maintain regulatory control of their programs even with higher purchase limitations, and without the use of a fabricated unit of measurement. If sustaining a robust medical cannabis program is the objective, we should try to be more compassionate towards patient needs. The purchase limitations of other states are far more reflective of actual need than New Mexico’s stringent eight ounces. These examples also show that Ultra Health’s recommended 15 ounces per any 3-month period is in keeping with the industry practice.

Ultra Health would be happy and willing to further discuss the data, the experience of other states, and the range of products it currently offers, so that DOH can better understand the



issue of patient purchase limitations and the complications that arise from the use of units as a system of measurement.

**Rulemaking Process**

Rule 1.24.25.10 NMAC requires an agency which has received a petition to initiate rulemaking to grant or deny the petition. If the agency denies the petition, it must “issue a concise written statement explaining its reason for denial.” Ultra Health looks forward to receiving the position of DOH regarding rulemaking for patient purchase limitations.

Respectfully,



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Cc: Kristina Caffrey, Attorney, Egolf, Ferlic, Martinez & Harwood, LLC

Arizona Legislature. (n.d.). Retrieved from <https://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/36/02806-02.htm> Colorado Revised Statutes Title 25. Health § 25-1.5-106. (n.d.). Retrieved from <https://codes.findlaw.com/co/title-25-health/co-rev-st-sect-25-1-5-106.html>

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Washington State Legislature RCW [69.50.357](#). Retrieved from <https://app.leg.wa.gov/RCW/default.aspx?cite=69.51A.210>