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Patient First Coalition Medical Cannabis Committee

Patient First Coalition

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Patient First Coalition & American Council of Cannabis Medicine

Joint Cover Statement

Medical Cannabis Schedule III Transition & Implementation Blueprint

The Patient First Coalition (PFC), in partnership with the American Council of Cannabis Medicine (ACCM), is pleased to present this body of work developed by the Patient First Coalition Medical Cannabis Committee. The Committee consists of 85 members representing a broad cross-section of stakeholders throughout the medical cannabis, healthcare, insurance, patient advocacy, pharmacy, technology, and regulatory communities.

Through the work of seven dedicated sub-committees, the Medical Cannabis Committee has spent significant time developing a comprehensive blueprint of recommendations designed to assist the Administration, legislators, and regulatory agencies in responsibly navigating the transition of medical cannabis from Schedule I to Schedule III status and the subsequent implementation process.

This initiative reflects a patient-first approach focused on public safety, responsible access, medical integrity, industry standards, insurance integration, research advancement, physician participation, compliance, and long-term sustainability within the evolving medical cannabis landscape. The American Council of Cannabis Medicine fully supports the efforts and recommendations of the Committee and has actively participated in the development and review of these materials.

As part of this process, the Committee has submitted public hearing statements and made expert testimony resources available to the Drug Enforcement Administration (DEA) in conjunction with the upcoming public hearing scheduled for June 29, 2026. These materials are attached herein for consideration and public review.

In the spirit of transparency, collaboration, and public engagement, the Patient First Coalition will formally provide public access and presentation of this blueprint and supporting body of work to legislators, Congressional offices, federal agencies, healthcare leaders, and industry stakeholders during National Medical Cannabis Day, held in conjunction with Healthy America 2026 – Taking the Capitol on Capitol Hill in Washington, D.C. on July 23, 2026.

The Patient First Coalition and the American Council of Cannabis Medicine remain committed to helping shape a responsible, patient-centered national medical cannabis framework that balances innovation, safety, accessibility, scientific advancement, and appropriate oversight as this historic transition moves forward.

Access Reports at:

www.yescann.org/dea

For media inquiries or additional information, please contact:

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Patient First Coalition (800) 524-2910 ext.375
communications@1stcoalition.org

Lexie Henderson (202) 349-9650 ext. 850
membership@accmforum.org

DOCKET NO. DEA-1362

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 21, 2026

RE: Patient First Coalition Supportive Comments Regarding the Proposed Rescheduling of Cannabis to Schedule III

To Whom It May Concern:

On behalf of the Patient First Coalition, we respectfully submit the attached stakeholder letters and recommendations regarding the proposed rescheduling of cannabis to Schedule III under the Controlled Substances Act.

The Patient First Coalition is a national coalition made up of more than 1,100 Ambassadors representing over 50 organizations, all committed to advancing patient-centered healthcare solutions and ensuring that patients remain at the center of policy development. Our coalition brings together healthcare leaders, patient advocates, physicians, pharmacists, innovators, wellness organizations, policy experts, and industry stakeholders focused on improving outcomes and expanding responsible access to care.

Within the Coalition, we host one of the nation's largest and most comprehensive Medical Cannabis Committees, bringing together a diverse cross-section of stakeholders actively working to develop sensible recommendations for an appropriate transition into a modernized federal cannabis framework. Our committee has focused extensively on implementation realities, patient protections, healthcare access, operational standards, rural healthcare concerns, dispensing models, reimbursement considerations, and long-term integration strategies. We have been building a recommendation tower looking at all agency implementation.

We applaud the Administration, and Department of Justice and the Drug Enforcement Administration for recognizing the medical value of cannabis and for taking meaningful steps toward modernization of federal policy. This transition represents a historic opportunity to improve patient access, expand scientific advancement, reduce stigma, and create a safer and more accountable cannabinoid healthcare system.

At the same time, the Coalition believes it is critically important that implementation efforts prioritize continuity of patient care and avoid unintended disruption to existing state-regulated medical cannabis systems that millions of patients currently rely upon. The attached letters reflect real-world perspectives from operators, healthcare stakeholders, patient advocates, and professionals working directly within these systems every day.

Among the key themes reflected throughout these submissions are:

- Preservation of state-regulated medical cannabis programs during federal transition
- Protection of patient access in rural and underserved communities
- Support for flexible dispensing and workforce models
- Fair transition pathways for existing compliant operators
- Recognition of both whole-plant medical cannabis and FDA-approved cannabinoid medicines within a parallel-access framework
- Creation of collaborative stakeholder engagement mechanisms during implementation

The Patient First Coalition believes strongly that this moment presents an opportunity to build a balanced and responsible framework that protects patients while supporting innovation, healthcare integration, public safety, and regulatory accountability. We encourage policymakers to continue engaging diverse stakeholders throughout this process to ensure that implementation reflects operational realities and patient needs across the country.

We appreciate the opportunity to provide these materials and stand ready to assist in future discussions, stakeholder engagement efforts, and collaborative policy development as this transition moves forward.

Respectfully submitted,
Shannon Burns
Legislative Director, Patient First Coalition

DOCKET NO. DEA-1362

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 21, 2026

RE: Supportive Stakeholder Submissions Regarding Proposed Rescheduling of Cannabis to Schedule III

To Whom It May Concern:

On behalf of the American Council of Cannabis Medicine (ACCM), we respectfully submit the attached stakeholder letters and recommendations regarding the proposed rescheduling of cannabis to Schedule III under the Controlled Substances Act.

The ACCM is a leading national organization focused on advancing safe, standardized, patient-centered medical cannabis access while supporting responsible integration within the broader healthcare ecosystem. Our membership and affiliated stakeholders include physicians, pharmacists, dispensary operators, growers, processors, healthcare executives, patient advocates, insurers, researchers, compliance experts, and industry leaders from across the United States.

We commend the Administration, and Department of Justice and the Drug Enforcement Administration for taking this historic and meaningful step toward modernization of federal cannabis policy. Recognition of the medical value of cannabis represents a major advancement for patients, healthcare providers, scientific research, and the continued development of responsible regulatory frameworks.

As implementation discussions move forward, ACCM believes it is critically important that federal policy preserve continuity of care for existing patients while also establishing a thoughtful transition framework that allows innovation, healthcare integration, public safety, and regulated market stability to coexist. The attached letters reflect concerns and recommendations from experienced stakeholders actively operating within state-regulated medical cannabis systems today.

Several consistent themes emerge throughout these submissions:

• Preservation of existing state-regulated medical cannabis programs during transition
• Protection of patient access, particularly in rural and underserved communities
• Flexible implementation pathways that support pharmacies, dispensaries, and healthcare providers alike
• Fair transition opportunities for compliant operators that have already invested heavily in safety, testing, and compliance infrastructure
• Recognition that whole-plant medical cannabis and future FDA-approved cannabinoid medicines should coexist within a parallel-access framework that expands patient choice rather than limits it
• Creation of collaborative stakeholder engagement mechanisms to support successful implementation

ACCM strongly believes this transition presents a once-in-a-generation opportunity to build a safer, more accountable, and more integrated cannabinoid healthcare framework in the United States. We remain committed to serving as a constructive resource to policymakers, regulators, healthcare stakeholders, and patients throughout this evolving process.

Our organization and affiliated working groups have spent considerable time evaluating operational realities, patient needs, insurance integration considerations, dispensing models, compliance standards, and healthcare connectivity infrastructure necessary to support a responsible national framework. We stand ready to assist federal agencies with stakeholder engagement, educational resources, implementation insights, and collaborative policy development moving forward. We have 100's of the nation's leading experts available for any support of commentary.

Thank you for your consideration of these comments and the attached submissions. We appreciate the DEA’s willingness to engage stakeholders during this important transition and look forward to continued collaboration focused on patient safety, healthcare access, and responsible modernization.

Respectfully submitted,

Doug Benns
Executive Committee Chairman
American Council of Cannabis Medicine

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 19, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an **interested person** who requests to provide **factual evidence and expert opinion** regarding rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026 in Arlington, VA.

First, I want to applaud the Department of Justice for publicly acknowledging the medical value of cannabis. Societies around the globe have *safely* used this medicine in a variety of application methods for ages. Reclassifying the plant from schedule I to schedule III rectifies 55 years of inaccurate placement in the Controlled Substances Act (CSA) and decades of misguided policy that has arisen as a result. I appreciate the expeditious manner in which the Administration is taking action. Thank you.

During the ensuing transition period, I hope to be of guidance to the Drug Enforcement Administration (DEA) as it contemplates the best manner in which to implement this significant and complex change. The following are some of my initial concerns as a medical cannabis patient who has successfully utilized cannabinoid therapy for over 20 years.

> **CONCERN:** Currently, I must obtain medicine from a combination of sources because no single business has been able to consistently meet my unique needs. In addition to traditional items available through state-regulated medical cannabis programs, I utilize products made from hemp-derived cannabinoids that require specialized methods to source and produce. Does the DEA have a plan to maintain patient access to a steady supply of non-intoxicating cannabinoids such as CBD, CBG, CBN, CBC, THCA and THCV?
>
> **CONCERN:** Most frequently, I procure medicine from state-licensed cannabis retail stores that stock a wide array of products made by high-quality cultivators and manufacturers. Currently, state licenses issued to Montana businesses by the Cannabis Alcohol and Regulatory Division (CARD) *do not* distinguish between medical and adult use. How does the DEA plan to preserve the existing supply chains that patients rely upon?
>
> **CONCERN:** As a patient with a valid recommendation to use a schedule III medication, I am entitled to certain protections under federal law, specifically the Americans with Disabilities Act (1990), Fair Housing Act (1968), and Section 504 of the Rehabilitation Act (1973), among others. Will the DEA issue guidance to employers, educational institutions, housing providers and others who have historically prohibited medical cannabis use?

CONCERN: As it stands today, patients and their caregivers are the only people who are able to register to participate in the "state regulated medical cannabis program" in Montana. This option is not offered to cannabis operators, health care professionals or ancillary businesses that serve patients. Will the DEA offer safe harbor to all professionals who are currently operating in good faith?

CONCERN: The expedited pathway now offered for DEA Registration presents a conundrum for business owners who currently provide medicine to patients through a merged market for medical and adult use. States like Montana, Washington, and California do not allow cannabis operators to hold a license for medical purposes only. As currently written, the language in the DEA Registration application is legally problematic for many state-regulated businesses that hope to become federally-compliant schedule III cannabis providers. How does the DEA plan to use information obtained from applicants? If certain cannabis products remain in schedule I, is there any guarantee information will not be used to target businesses that supply cannabis for non-medical purposes in accordance with state law?

Again, these are a handful of my initial concerns as the DEA determines precisely how to reschedule cannabis. My intent is to remain solution oriented and dialogue driven as we collectively navigate the historic opportunity before us. In the spirit of collaboration, I offer two simple, yet effective solutions to temporarily alleviate the above concerns during a period of transition:

1. I respectfully request that the DEA develop and implement an agency-wide **moratorium on federal interference** in state-regulated cannabis programs. Today, an estimated three to six million veterans, seniors and patients rely on the existing patchwork of state programs, both medical and non-medical, to provide products needed to treat complex and/or chronic health conditions that are sometimes terminal in nature. Please don't force ailing patients into an illicit market to get medicine that offers much-needed relief.
2. I would also like to see a **White House Cannabis Commission** established to ensure that patients, caregivers and health care professionals are equally represented in transparent discussions about the best way to ensure medical cannabis not only presents economic opportunity, but remains a safe, viable, and accessible treatment for Americans who need and deserve the health benefits that cannabis offers.

As a member in good standing of both the American Council of Cannabis Medicine and the Patient First Coalition, I am confident that my letter will reach the appropriate parties. I look forward to participating as an expert witness in the upcoming hearings on cannabis rescheduling.

Sincerely,

Kari Boiter

Kari Boiter
Medical Cannabis Patient Since 2005
Member, American Council of Cannabis Medicine
Member, Medical Cannabis Committee, Patient First Coalition

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 21, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an **interested person** who wishes to provide **factual evidence and expert opinion** on Attorney General Order No. 6753-2026 regarding rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026 in Arlington, VA.

First, I want to applaud the Department of Justice for publicly acknowledging the medical value of cannabis. Societies around the globe have *safely* used this medicine in a variety of application methods for ages. Reclassifying the plant from schedule I to schedule III rectifies 55 years of inaccurate placement in the Controlled Substances Act (CSA) and decades of misguided policy that has arisen as a result. I appreciate the expeditious manner in which this Administration is taking action. Thank you.

During the ensuing transition period, I wish to be a resource of guidance to the Drug Enforcement Administration (DEA) as it contemplates the best manner in which to implement this significant and complex change. I am writing today on behalf of patients and their caregivers, as well as the dedicated workers who have chosen to serve patients as their profession and lifelong career. Many patients relying on state-regulated medical cannabis programs are immobile, quadriplegic, or suffer from neurologically based diseases and other serious medical conditions that require consistent access to quality medicine and compassionate care. These patients often depend heavily on trained caregivers, many of whom have also dedicated their professional lives to this work. Any disruption to existing compliant state programs would not only impact businesses and workers, but also the vulnerable patients and families who rely upon these systems every single day.

The following are some of my initial concerns as a small business owner of a medical cannabis oriented company that employs workers in the medical cannabis industry; retired Founder/Director of UFCW International Union Cannabis Workers Rising Campaign; co-architect of the first ever state education agency certified joint medical cannabis and hemp apprenticeship program; and co-architect of statewide ballot initiatives, legislation, regulation and other forms of public policy concerning medical cannabis throughout North America.

> **CONCERN:** Many of the workers currently employed in the cannabis industry are graduates of joint apprenticeship and workforce development programs that required years of higher education, training, and certification through state-approved agencies. These individuals chose to dedicate their lives to careers in a regulated industry that was

built with compliance, professionalism, and public safety in mind. How will the DEA ensure that these existing highly trained workers that work compliantly in state regulated programs are not displaced or marginalized during any federal transition process? Many of whom made a joint investment along with their current employers to participate and achieve these certifications. We must think about the patients they serve, their caregivers, their careers, and the state-compliant employers that made this joint investment in their chosen lifelong careers.

CONCERN: Patients and caregivers across the country currently rely on regulated state cannabis programs for safe and consistent access to medicine. Reckless or premature federal interference could disrupt access for vulnerable patients while simultaneously devastating the livelihoods of workers employed throughout the industry. How will federal agencies protect both patient access and workforce stability while broader regulatory systems are being evaluated?

CONCERN: Federal interference in existing state-regulated cannabis programs could result in the immediate loss of thousands of artisan and craftsmen oriented jobs, many of them union positions, that provide healthcare coverage, retirement benefits, and long-term economic stability for working families. In addition to job loss, workers and business owners alike stand to lose years of personal investment, education, and compliance-related development. As a business owner, I have personally worked diligently to help establish state-compliant programs that uphold safety, accountability, collective bargaining, and workforce standards for these American jobs. Will the DEA consider a transition framework that protects patients, caregivers, existing workers, and compliant businesses that serve them during any rescheduling implementation?

CONCERN: The existing medical cannabis industry currently operates within a complex framework of approximately 40 different state regulatory systems, each with unique licensing, taxation, labor, and compliance structures. Integrating these existing programs into a streamlined federal regulatory system will require substantial coordination, planning, and time. What safeguards and timelines will be implemented to ensure that compliant businesses, workers, patients, and their caregivers are not harmed during this transition period?

CONCERN: Given the complexity of integrating state-regulated medical cannabis programs into any future federal framework, I respectfully request a minimum three-year moratorium on federal interference in existing compliant state cannabis industries. This temporary period of stability would allow regulators, workers, patients, businesses, and policymakers to collaboratively develop responsible federal standards while preserving American jobs, access to medicine, and public confidence in the regulatory process. Would the DEA support a transition period that prioritizes patient and caregiver stability, American workforce protection, and patient access before imposing new federal enforcement actions?

Again, these are a handful of my initial concerns as the DEA determines how to reschedule cannabis. My intent is to remain solution oriented and dialogue driven as we collectively

navigate this historic opportunity. In the spirit of collaboration, I offer two simple, yet effective solutions to temporarily alleviate the above concerns during a period of transition:

1. I humbly request that the DEA develop and implement an agencies of jurisdiction - wide **moratorium on federal interference** in state-regulated cannabis programs. Today, an estimated three to six million veterans, seniors and patients rely on the existing patchwork of state programs, both medical and non-medical, to provide products needed to obtain relief from complex and/or chronic health conditions that are sometimes terminal in nature. Please don't force ailing patients and their caregivers into a dangerous illicit market to get the only medicine that offers relief.
2. I also wish to see a **White House Cannabis Commission** established to ensure that patients, caregivers and health care professionals are equally represented in transparent discussions about the best way to ensure medical cannabis not only presents economic opportunity, but remains a safe, viable, and accessible treatment for Americans who need and deserve the health benefits that cannabis offers.

As a member in good standing of both the American Council of Cannabis Medicine and the Patient First Coalition, I am confident that my letter will reach the appropriate parties. I look forward to participating as an expert witness in the upcoming hearings on cannabis rescheduling.

Sincerely,

Dan Rush
CEO Canna4orce International
Chair, Medical Cannabis Committee, Patient First Coalition
Co-Chair, American Council of Cannabis Medicine Government Affairs Committee

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 20, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an **interested person** who wishes to provide **factual evidence and expert opinion** on Attorney General Order No. 6753-2026 regarding rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026 in Arlington, VA.

First, I want to applaud the Department of Justice for publicly acknowledging the medical value of cannabis. Societies around the globe have *safely* used this medicine in a variety of application methods for ages. Reclassifying the plant from schedule I to schedule III rectifies 55 years of inaccurate placement in the Controlled Substances Act (CSA) and decades of misguided policy that has arisen as a result. I appreciate the expeditious manner in which this Administration is taking action. Thank you.

During the ensuing transition period, I wish to be of guidance to the Drug Enforcement Administration (DEA) as it contemplates the best manner in which to implement this significant and complex change. The following are some of my initial concerns as a biologist and as a mother.

CONCERN: Limited translational pathways between state medical programs and FDA-level research

While the proposed Schedule III framework acknowledges medical use and expands federal registration opportunities for state-licensed entities, there remains a substantial gap between state-regulated medical cannabis systems and federally recognized clinical research pathways. The current proposal appears to primarily address registration, manufacturing, dispensing, and import/export oversight, but it does not sufficiently establish a coordinated translational infrastructure that allows preclinical findings to efficiently progress into human clinical investigation.

Today, much of the real-world patient data, observational outcomes, formulation experience, and product safety information already exists within state medical cannabis programs. However, researchers still face significant barriers in accessing standardized materials, multicenter data, funding support, and FDA-aligned pathways that would allow these findings to mature into rigorous clinical evidence.

I respectfully ask whether the DEA, in collaboration with HHS and FDA, would consider supporting a federally protected translational research pathway that permits qualified academic institutions, hospitals, and registered state medical cannabis operators to collaborate on preclinical studies, observational registries, biomarker analysis, formulation standardization, and eventual IND-supported clinical trials.

CONCERN: The proposed framework lacks protections and incentives for expanded scientific research

The proposed rule appropriately addresses regulatory controls, licensing, and treaty obligations; however, it does not adequately address how the United States plans to actively accelerate cannabis science itself.

For decades, Schedule I classification significantly restricted rigorous cannabis research. As a result, there are still major unanswered questions involving dosing, formulation consistency, cannabinoid-terpene interactions, long-term safety, neurobiology, oncology support, pain management, neurodegenerative disease, traumatic brain injury, PTSD, sleep disorders, and inflammatory conditions.

As a scientist involved in translational medicine and neurobiological research, I believe the next phase of policy should include a temporary moratorium and federal guidance that specifically allows:

- Expanded university partnerships with state-licensed cannabis operators;
- Federally protected observational patient registries;
- Access to standardized research-grade cannabis materials from licensed producers;
- Multi-state preclinical collaboration programs;
- Easier approval pathways for investigator-initiated clinical studies;
- Funding incentives for cannabinoid-focused translational science;
- Research access to full-spectrum and naturally derived formulations rather than isolated compounds alone.

Without these additions, the nation risks rescheduling cannabis without fully unlocking the scientific progress that rescheduling is intended to support.

CONCERN: Need for a translational model that supports existing medical cannabis producers.

I strongly support the DEA's acknowledgment that existing state medical cannabis systems have developed meaningful infrastructure and public health oversight. Many state-licensed operators have already invested heavily in cultivation standards, product testing, patient safety systems, formulation consistency, and physician education. These organizations should not be viewed solely as commercial entities, but also as potential translational partners capable of supporting federally aligned scientific advancement.

I respectfully propose the development of a "Translational Cannabis Research Network" model that would allow qualified state-licensed producers to participate in:

- Standardized research manufacturing,
- Batch-controlled product development,
- University-sponsored preclinical studies,
- Clinical trial material supply,
- Longitudinal patient registries,
- Pharmacovigilance and adverse event tracking,
- GMP-transition support for future FDA pathways.

Such a framework could create a bridge between existing state programs and formal FDA drug development while preserving patient access and ensuring scientific rigor.
Importantly, this model would support American innovation, encourage responsible industry participation, and reduce fragmentation between federal science and state implementation.

CONCERN: Need for clarity regarding naturally derived cannabinoids and innovation
The proposed order distinguishes naturally derived cannabinoids from synthetically derived compounds, while continuing to exclude certain synthetic cannabinoids from rescheduling consideration.

As cannabinoid science evolves, it will be critical to provide clear guidance regarding:

- Minor cannabinoids,
- Naturally occurring derivatives,
- Botanical combinations,
- Full-spectrum formulations,
- Novel delivery systems,
- Research involving combinations of cannabinoids with other therapeutic compounds.

Innovation should not outpace regulatory clarity. Researchers, universities, physicians, and manufacturers need transparent guidance that allows safe scientific exploration while maintaining appropriate safeguards.

As both a scientist and author, I have witnessed firsthand the growing need for safe, accessible, and scientifically justified alternatives for patients seeking relief. This moment represents an opportunity not only to correct outdated policy, but to establish the United States as a global leader in responsible cannabis science, translational medicine, and patient-centered innovation.

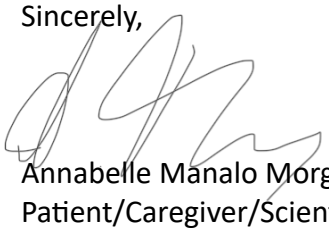
Again, these are a handful of my initial concerns as the DEA determines how to reschedule cannabis. My intent is to remain solution oriented and dialogue driven as we collectively navigate this historic opportunity. In the spirit of collaboration, I offer two simple, yet effective solutions to temporarily alleviate the above concerns during a period of transition:

1. I humbly request that the DEA develop and implement an agency-wide **moratorium on federal interference** in state-regulated cannabis programs. Today, an estimated three to six million veterans, seniors and patients rely on the existing patchwork of state programs, both medical and non-medical, to provide products needed to obtain relief from complex and/or chronic health conditions that are sometimes terminal in nature. Please don't force ailing patients into an illicit market to get medicine that offers relief.

2. I also wish to see a **White House Cannabis Commission** established to ensure that patients, caregivers and health care professionals are equally represented in transparent discussions about the best way to ensure medical cannabis not only presents economic opportunity, but remains a safe, viable, and accessible treatment for Americans who need and deserve the health benefits that cannabis offers.

As a Co-Chair of the American Council of Cannabis Medicine and committee member of the Patient First Coalition, I am confident that my letter will reach the appropriate parties. I look forward to participating as an expert witness in the upcoming hearings on cannabis rescheduling.

Sincerely,



Annabelle Manalo Morgan, PhD
Patient/Caregiver/Scientist/Business Owner since 2016.
Co-Chari, American Council of Cannabis Medicine
Committee Member, Patient First Coalition

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 20, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As a physician with more than a decade of clinical practice in cannabinoid medicine and an advocate for evidence-based cannabis policy, I submit this comment in accordance with 21 CFR 1300.01(b), which qualifies me as an **interested person** and seek to provide **factual evidence and expert opinion** concerning Attorney General Order No. 6753-2026 on the rescheduling of marijuana (cannabis). This letter serves as formal notice of my intent to participate in the hearing scheduled to begin June 29, 2026 in Arlington, Virginia.

I want to begin by acknowledging the historic significance of this action. The decision to move cannabis from Schedule I to Schedule III represents a long-overdue federal recognition of the medical and therapeutic value that clinicians and patients have observed for generations. Cultures around the world have *safely* used cannabis therapeutically for millennia, and a substantial body of contemporary clinical and translational research now supports a wide range of medical applications. This action begins to correct more than fifty years of misclassification under the Controlled Substances Act, and I welcome the Administration's willingness to engage substantively on this question.

Implementation, however, will determine whether rescheduling delivers on its promise or creates new harms in its execution. The concerns that follow reflect my clinical experience and policy advocacy, and are offered in the constructive spirit of partnership as the DEA navigates this complex transition.

> **CONCERN:** Schedule III placement may inadvertently reduce patient access rather than expand it. Most state medical cannabis programs operate on physician recommendations or certifications, not prescriptions. Schedule III substances, by statute, require prescriptions, yet most practicing physicians have received no formal training in cannabinoid medicine, and many remain unwilling to prescribe a substance that, at the federal level, is still controlled. Without coordinated guidance to state medical boards, dedicated physician education pathways, and clear federal protections for prescribers acting in good faith, this transition risks leaving the patients it claims to serve without willing providers. Will the DEA work with HHS, the FDA, and state medical boards to establish clinical guidance, physician training, and prescribing protections that match Schedule III's regulatory expectations to clinical reality?
>
> **CONCERN:** The current framework applies Schedule III only to products dispensed through state medical cannabis programs, yet a substantial portion of Americans

currently using cannabis for medical purposes do so through adult-use channels because they cannot afford medical certification fees, lack proximity to a willing provider, or live in states where the medical and adult-use markets have functionally merged. Many are veterans, seniors, low-income individuals, and people of color, populations who have disproportionately borne the harms of prohibition. Limiting the benefits of rescheduling to state medical programs perpetuates a two-tier system in which therapeutic access is conditioned on means rather than medical need. How will the DEA ensure that the millions of Americans medically using cannabis through adult-use channels are not left behind by this transition?

CONCERN: The Controlled Substances Act continues to bifurcate the cannabis plant based on a single arbitrary threshold - 0.3% Delta-9 THC by dry weight - rather than on the pharmacological effect of the finished product. Patients I've encountered routinely combine hemp-derived and marijuana-derived cannabinoids to achieve a single therapeutic outcome; the body does not distinguish between them, and neither should our regulations. Rescheduling marijuana while leaving the hemp/marijuana split intact preserves a framework that has produced gas-station intoxicants competing with state-licensed dispensaries, untested products entering interstate commerce, and confusion for patients, clinicians, and law enforcement alike. Will the DEA support a unified cannabinoid regulatory framework that classifies products by impairment potential rather than botanical origin?

CONCERN: While Schedule III does reduce the regulatory burden on cannabis research, the cost of DEA-compliant research infrastructure, e.g. secured facilities, registrations, ongoing compliance overhead, etc., remains prohibitive for many academic institutions and small enterprises. As written, the rescheduling functionally favors pharmaceutical companies capable of bearing those costs. The likely result is a research agenda focused on isolated, single-molecule formulations rather than the whole-plant, multi-cannabinoid medicine that patients actually use, producing evidence that does not reflect real-world clinical practice. How will the DEA, in coordination with NIH and HHS, ensure that research funding and infrastructure access support diverse research models, including investigation of whole-plant and multi-cannabinoid formulations?

CONCERN: Patients holding medical cannabis recommendations have faced persistent discrimination in employment, housing, healthcare, child custody, and other essential domains for decades, despite state-level protections. Schedule III placement should, in principle, bring cannabis under the same federal civil rights protections that apply to other prescription medications through the Americans with Disabilities Act, the Fair Housing Act, Section 504 of the Rehabilitation Act, and related frameworks. Veterans, seniors, and patients of color have disproportionately borne the collateral harms of cannabis prohibition, and this transition must include affirmative civil rights protections rather than further delay. Will the DEA coordinate with HHS, HUD, the EEOC, and the Department of Veterans Affairs to issue unified guidance protecting Schedule III cannabis patients from discrimination?

The concerns above are not exhaustive, but they reflect the issues I believe most urgently require coordinated federal attention. I raise them in the spirit of constructive engagement. To

address them during the transition period, I respectfully offer two concrete recommendations:

1. I urge the DEA to establish an agency-wide **moratorium on federal interference** in state-regulated cannabis programs throughout the transition period. An estimated three to six million Americans, including veterans, seniors, cancer patients, and individuals managing chronic and terminal conditions, currently rely on state-regulated programs, both medical and adult-use, for relief that conventional pharmaceuticals often cannot provide. Disrupting that access during implementation would push vulnerable patients into the illicit market and undermine the public health goals that rescheduling is intended to advance.

2. I further recommend the establishment of a **White House Cannabis Commission** charged with ensuring that patients, caregivers, clinicians, and public health experts are substantively represented - alongside industry and law enforcement - in the policy decisions that will shape cannabis medicine for decades to come. Without that structural balance, this transition risks being captured by commercial interests at the expense of the patients it is meant to serve.

I submit this letter as a clinician who has worked at the intersection of cannabis medicine, policy, and health equity for over a decade. I look forward to participating as an expert witness in the upcoming hearings and to contributing to a rescheduling process that honors the gravity of this moment for American patients and clinicians alike.

Sincerely,

Rachel Knox, MD, MBA
Physician & Cannabinoid Medicine Specialist; Co-Founder, Doctors Knox, Inc.
President, Association for Comprehensive Health Equity & Medicine (ACHEM)

DOCKET NO. DEA-1362

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 21, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) regarding the proposed rescheduling of marijuana (cannabis) to Schedule III under the Controlled Substances Act. As a participant in a pharmacy and dispensary subcommittee focused on the future of regulated medical cannabis access, I respectfully submit the following concerns and recommendations for consideration during this transition.

First, I want to acknowledge and applaud the Department of Justice and DEA for recognizing the medical value of cannabis and for taking meaningful steps toward modernization of federal cannabis policy. Rescheduling represents a critical opportunity to improve patient access, reduce stigma, support scientific advancement, and create a safer and more accountable cannabinoid healthcare system.

As the DEA evaluates implementation pathways, our subcommittee strongly encourages a framework that preserves existing state-regulated medical cannabis programs while also creating pathways for future FDA-approved cannabinoid medicines to coexist alongside them. Patients should not lose access to medical cannabis simply because the federal government modernizes its scheduling framework.

CONCERN 1 — Preservation of State Medical Cannabis Programs

Millions of Americans currently rely on state-regulated medical cannabis systems for access to cannabinoid therapies that are often more accessible and affordable than traditional pharmaceutical pathways. We are concerned that rescheduling could unintentionally destabilize existing state medical programs if interstate commerce or pharmacy access becomes limited only to FDA-approved products.

CONCERN 2 — Rural and Underserved Community Access

Many rural communities do not currently have adequate access to medical cannabis dispensaries or specialty healthcare providers. At the same time, these communities often rely heavily on traditional pharmacies for healthcare access. Any future framework should ensure that underserved populations are not disadvantaged by restrictive dispensing models and also have access to whole plant medicine, not only single molecule FDA approved cannabis.

CONCERN 3 — Flexible Dispensing and Workforce Models

Potential Schedule III implementation may create pharmacist staffing shortages and increased operational costs that could threaten the viability of small and rural medical cannabis operators. We encourage consideration of flexible dispensing frameworks, including telepharmacy support, apprenticeship pathways, and hybrid medical cannabis models.

CONCERN 4 — Fair Transition Pathways for Existing Operators

Many state-regulated medical cannabis operators have already invested heavily in contaminant testing, traceability systems, pharmacist oversight, and patient safety infrastructure. Existing compliant operators should be provided a realistic pathway toward DEA registration and future regulated interstate commerce participation where appropriate.

CONCERN 5 — Opportunity to Improve Healthcare Access

Cannabis policy reform presents an opportunity not only to modernize cannabis regulation, but also to improve healthcare delivery more broadly. Policymakers should support a parallel-access healthcare framework where state medical cannabis programs and FDA-approved cannabinoid medicines may coexist in a way that expands patient choice rather than limiting it.

Again, these are several of our primary concerns and recommendations as the DEA evaluates implementation of Schedule III cannabis policy. Our intent is to remain collaborative, solution-oriented, and focused on patient outcomes as this transition evolves.

We respectfully support:
1. A temporary federal enforcement moratorium protecting compliant state-regulated medical cannabis programs during transition.
2. A federal cannabis commission including patients, pharmacists, healthcare providers, regulators, cultivators, manufacturers, and dispensary operators.
3. Preservation of parallel patient access pathways through both state-regulated medical cannabis systems and FDA-approved cannabinoid medicines.

Sincerely,

Narith Panh
Chief Growth Officer / Dragonfly Wellness
Leadership Council / American Council of Cannabis Medicine
Co-chair, Pharmacy / Dispensary Subcommittee, Patient First Coalition

DOCKET NO. DEA–1362
COMMENT IN CONNECTION WITH THE RESCHEDULING OF MARIJUANA AND THE ADMINISTRATIVE HEARING COMMENCING JUNE 29, 2026

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 20, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking regarding the proposed rescheduling of cannabis from Schedule I to Schedule III under the Controlled Substances Act ("CSA"). As defined in 21 CFR 1300.01(b), I am an interested person who wishes to provide factual evidence and expert opinion regarding implementation of marijuana rescheduling and the ongoing administrative proceedings associated with Docket No. DEA-1362.

First, I want to acknowledge the historic significance of the federal government recognizing the accepted medical use and therapeutic potential of cannabis. This transition represents far more than a scheduling adjustment. It is a systems-level policy shift that will directly affect veterans, patients, caregivers, active-duty servicemembers, healthcare professionals, transportation systems, workforce development programs, state-regulated cannabis systems, and the future of cannabinoid research in America.

CONCERN: Whole-Plant Cannabis and Full-Spectrum Therapeutic Systems

Cannabis treatment often functions as a layered therapeutic system rather than a conventional single-compound pharmaceutical model. Veterans may simultaneously utilize inhalants for rapid symptom management, tinctures for dosage precision, edibles for long-duration support, topicals for localized pain, and cannabinoid-specific

formulations tailored toward individualized therapeutic response. Federal implementation should avoid narrowly limiting recognition to isolated cannabinoid pharmaceutical systems while excluding whole-plant and full-spectrum formulations currently relied upon by patients under State-regulated programs.

Cannabis and hemp contain numerous major and minor cannabinoids, terpene systems, flavonoids, and other compounds that may possess therapeutic significance individually or synergistically. Continued research is necessary to better understand therapeutic applications, safety profiles, interaction systems, chemotype characterization, phenotype evaluation, dosage optimization, and individualized patient response.

CONCERN: Veteran Access, Compassionate Care, Mental Health Support, and Indigenous Veteran Inclusion

Millions of veterans currently rely upon cannabis for symptom management related to chronic pain, PTSD, traumatic brain injury, sleep disorders, anxiety, appetite stimulation, neurological conditions, and other service-connected conditions. Many disabled veterans face mobility limitations, transportation barriers, geographic isolation, financial hardship, and inconsistent continuity of care.

Peer-supported veteran wellness environments may also help reduce isolation, encourage emotional communication, and rebuild camaraderie among veterans processing traumatic experiences. Many veterans report positive experiences participating in cannabis-supported peer groups where they are able to reduce anxiety, communicate more openly, and support healthier emotional processing.

Federal implementation should also recognize that Indigenous and Native American veterans may approach cannabis not only therapeutically, but also through cultural, traditional, spiritual, and tribal healthcare frameworks. Indigenous consultation should remain part of future implementation discussions involving compassionate access and continuity-of-care protections.

CONCERN: Personal Cultivation, Therapeutic Horticulture, and Veteran Self-Sufficiency

Many veterans report that cultivating cannabis for personal therapeutic use provides meaningful benefits through routine, horticultural engagement, stress reduction, emotional grounding, and greater connection to the treatment process itself.

This comment does not request creation of a federal constitutional right to cultivate cannabis. Rather, it respectfully requests enforcement non-interference guidance for

State-authorized patient and caregiver cultivation systems operating lawfully within State medical frameworks.

For disabled, rural, or low-income veterans, personal cultivation may reduce financial barriers associated with maintaining consistent therapeutic access. Veterans should have access to cultivation education, cannabinoid science education, processing knowledge, and support systems allowing them to responsibly process and manage cannabis products for their own therapeutic needs.

Continued research involving cannabis genetics, chemotype characterization, standardized phenotype evaluation, and cannabinoid interaction systems may help support more consistent therapeutic research, individualized response evaluation, and evidence-based treatment development.

CONCERN: Clinical Education, Medication Interaction Awareness, and Cannabinoid Research

Many veterans currently take complex pharmaceutical regimens involving antidepressants, opioids, seizure medications, benzodiazepines, antipsychotics, sleep medications, and other compounds potentially affected by cannabinoid metabolism through cytochrome P450 pathways.

Cannabidiol (CBD) and other cannabinoids may affect CYP3A4, CYP2C19, and CYP2C9 metabolism systems, potentially altering therapeutic response to numerous pharmaceutical compounds. These interaction systems are mechanistically comparable in principle to well-known grapefruit-drug interactions but remain insufficiently understood by much of the public and many healthcare providers.

Federal implementation should prioritize evidence-based education for clinicians, pharmacists, veterans, caregivers, and healthcare systems regarding whole-plant medicine, dosage considerations, medication interactions, and individualized therapeutic response.

CONCERN: Workforce Development, Impairment Standards, Transportation Continuity, and Federal Transition Stability

Cannabis implementation presents substantial workforce-development opportunities for veterans transitioning into civilian careers. Veterans possess operational, scientific, medical, logistical, compliance, manufacturing, and leadership skills directly applicable to this emerging sector.

At the same time, current testing systems often fail to distinguish active impairment from historical metabolite presence. THC metabolites may remain detectable long after impairment has ceased, creating substantial concerns for veterans, active-duty servicemembers, transportation workers, healthcare workers, federal contractors, and regulated professions.

Federal implementation should support evidence-based impairment standards consistent with current pharmacokinetic science rather than relying solely upon historical metabolite detection. Veterans traveling for healthcare, family support, employment, or treatment programs also face inconsistent interstate transportation and continuity-of-care frameworks that should be addressed during implementation planning.

Again, these are a handful of my initial concerns as DEA determines how to implement marijuana rescheduling. My intent is to remain solution-oriented and dialogue-driven as we collectively navigate this historic transition.

In the spirit of collaboration, I respectfully offer two practical recommendations to temporarily alleviate many of the above concerns during the federal transition period:

1. I respectfully request that DEA develop and implement an agency-wide moratorium on federal interference involving State-regulated cannabis systems operating in good-faith compliance with State law, including medical cannabis, caregiver systems, and State-authorized patient cultivation programs.

2. I respectfully support establishment of a White House Cannabis Commission or Federal Veterans Cannabis Access Working Group ensuring veterans, Indigenous representatives, caregivers, clinicians, researchers, workforce experts, and healthcare professionals remain directly represented during implementation discussions involving cannabis rescheduling and federal transition planning.

As Founder & CEO of MedVets, Lead Ambassador for the American Council for Cannabis Medicine, Chairman of the Veterans & Registered American Apprenticeship Subcommittee, Coordinator for the California Statewide Cannabis & Hemp Joint Apprenticeship Committee, and Lead Ambassador for the Patients First Coalition, I appreciate the opportunity to participate in these historic discussions and respectfully request continued inclusion in future implementation conversations.

Sincerely,

Jacob “Big Jake” Lawrence
Founder & Chief Executive Officer, MedVets (501(c)(3))

Lead Ambassador, American Council for Cannabis Medicine
Chairman, Veterans & Registered American Apprenticeship Subcommittee
Coordinator, California Statewide Cannabis & Hemp Joint Apprenticeship Committee
Lead Ambassador, Patients First Coalition

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 21, 2026

Re: Response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026.

To whom it may concern,

I'm an **interested person** (under 21 CFR 1300.01(b)) able to provide **factual evidence and expert opinion** on Attorney General Order No. 6753-2026 regarding rescheduling of marijuana (cannabis). Please accept this as written notice of my intention to support and inform those participating in the hearing scheduled to begin on June 29, 2026 in Arlington, VA.

Please know that the Department of Justice's public declarations concerning the medical value of cannabis is a welcome relief to millions of patients who depend on cannabis for their wellness. The effective use of cannabis as medicine throughout human history is well understood. Reclassifying the plant from schedule I to schedule III rectifies 55 years of inaccurate placement in the Controlled Substances Act (CSA) and decades of related policy. I thank you for this Administration's bold and timely action in restoring medical cannabis to its proper place among medicines and wellness therapeutics and positioning it to attain its true potential through research and data.

During the unfolding transition period ahead, I can be of guidance to the Drug Enforcement Administration (DEA) as it considers best implementation mechanisms and methods. Below are some initial concerns as a business owner intimately involved in delivering services connecting industry participants, data, and knowledge to ensure the industry's long-term trajectory toward medicalization and improved patient wellness outcomes.

> **CONCERN:** Ensuring implementation occurs to enhance and preserve the ability of existing state-legal markets to evolve, accommodate increasing in insurance availability entering the space, and to connect its existing industry infrastructure to other services and industries essential to improving patient access, medical knowledge, and outcomes.
>
> As a technology provider to the American Council of Cannabis Medicine (ACCM), we can confirm that ACCM has spent years building the healthcare infrastructure layer connecting medical cannabis ecosystems, connecting patients, medical dispensaries, laboratories, and health/benefit plans, and others, and enabling their highly effective interaction through a HIPAA-compliant platform. Given these 10 years of development, we are certain the current Schedule III conversation needs to focus on bigger healthcare questions, especially including what existing systems need to be accommodated/ supported now that cannabis (post Schedule III) is inexorably moving into a more formal medical lane. Answering these questions and establishing the industry infrastructure to accommodate the industry's transition into the medical lane has been a primary focus of ACCM and its committee members and technology partners. While much has been accomplished already in this regard, and the industry pipeline exists, much remains to be done to ensure such industry infrastructure appropriately

accommodates the needs of medical-cannabis patients, interaction with the broader healthcare industries, and future access to the full spectrum of medicinal benefits to be attained.

Fine-tuning and thoughtfully expanding, and considering regulations affecting, this existing industry infrastructure—and its ability to truly serve the needs and best interests of patients—requires an appropriate multi-year timeframe. The medical-cannabis industry and existing state-legal programs require time for deliberation and perspective on what Schedule III means now that cannabis is being treated more clearly as medicine—particularly around pharmacy models, medical access, reimbursement and insurance coverage mechanisms (CMS, ONC, and major payers), and where state medical programs may need to evolve from here.

Some related questions include:

- How does the DEA anticipate preserving and supporting the existing infrastructure technologies patients, dispensaries, and insurance providers now rely on, and their interconnection with existing healthcare and insurance industry frameworks?
- Does the DEA have a plan to support existing and emerging technological interconnection and sharing of data between the medical cannabis industry and the healthcare, insurance/payer, and pharmaceutical industries and health care professionals and ancillary businesses serving medical-cannabis patients?
- Does the DEA have a plan to support interconnectivity between medical cannabis and the healthcare and insurance industries while also ensuring that the existing industry itself remains a growing and vibrant font of innovation and insight for the benefit of patient access to the fullest array of cannabis-derived remedies?

CONCERN: By standing on its own, and continuing to leverage the deep expertise already generated through decades of development serving patients within state-legal programs, the medical-cannabis industry is in the best position to establish and continue growing its own technology infrastructure tailored to, and already meeting the needs of, cannabis patients and the producers of cannabis products separate and distinct from, but capable of interacting with, technology systems serving other parts of broader healthcare and related industries. For medical cannabis to realize its medical potential and truly change patients' lives and healthcare for the better over the long term, preserving and expanding that existing expertise and knowledge base is essential.

Some related questions:

- How does the DEA plan to ensure the continued growth of the existing medical-cannabis industry and the protection/use of the deep well of knowledge and expertise already developed, and the infrastructure already built around and supporting/deploying that knowledge and expertise?

These are just some primary concerns as the DEA undertakes its deliberate consideration of how to federally implement rescheduled medical cannabis. By remaining solution-oriented and dialogue-driven we can collectively navigate this long-awaited opportunity. In the spirit of informed deliberation, I recommend two mechanisms to accommodate the above concerns during a transition period:

1. I earnestly request that the DEA develop and implement an agency-wide **moratorium on federal interference** in state-regulated cannabis programs. Today, three to six million veterans, seniors and patients rely on the existing patchwork of state programs, both medical and non-medical, to provide products needed to obtain relief from complex and/or chronic health conditions that are sometimes terminal in nature. Regulatory disruptions without a transition period we fear will force ailing patients into illicit markets to get medicine that offers relief.

2. I also earnestly believe establishing a **White House Cannabis Commission** can ensure that patients, caregivers and healthcare professionals are equally represented in transparent discussions about the best way to ensure medical cannabis not only presents economic opportunity, but remains a safe, viable, increasingly effective, and accessible treatment for Americans who need and deserve the health benefits that cannabis offers.

   As a member in good standing of the American Council of Cannabis Medicine, ACCM's Research and Standards Committee, and the Patient First Coalition's Medical Cannabis Committee, I'm confident this letter will reach the appropriate parties. I look forward to supporting and informing those participating in the upcoming hearings on cannabis rescheduling.

   Sincerely,

David Speaker
Chief Communications Officer, EM2P2, Inc. since 2018.
Member, American Council of Cannabis Medicine
Member, ACCM Research and Standards Committee
Member, Medical Cannabis Committee, Patient First Coalition

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 20, 2026

To Whom It May Concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I qualify as an "interested person" and wish to provide factual insight and industry-informed perspective regarding Attorney General Order No. 6753-2026 and the proposed rescheduling of marijuana (cannabis).

First, I would like to commend the Department of Justice for formally acknowledging the medical value of cannabis. Reclassifying cannabis from Schedule I to Schedule III represents a long-overdue correction to more than five decades of misclassification under the Controlled Substances Act (CSA), and the policy consequences that followed. I appreciate the Administration's timely and deliberate approach to this issue.

As the Drug Enforcement Administration (DEA) considers implementation of this significant regulatory shift, I respectfully offer the following concerns based on my experience operating a state-licensed cannabis business in Montana for the past 18 years—initially within a medical-only framework and later within a combined medical and adult-use market.

CONCERN 1: DEA Registration Pathway Conflicts with State Regulatory Structures

The expedited DEA registration pathway presents a practical and legal challenge for operators in states with integrated medical and adult-use markets. In states such as Montana, Washington, and California, cannabis businesses are not permitted to operate exclusively as "medical-only" licensees. As currently written, elements of the DEA registration process may place state-compliant operators in a legally precarious position. Specifically:

- How does the DEA intend to use information submitted through the application process?
- If certain cannabis products remain classified under Schedule I, what assurances exist that applicant disclosures will not be used for enforcement actions against businesses operating in compliance with state law but outside the scope of federal Schedule III allowances?

Without clear protection, the registration process may inadvertently discourage participation among otherwise compliant operators.

CONCERN 2: Lack of State-Level Guidance Limits Participation

At present, the State of Montana is unable to provide meaningful guidance to licensees regarding participation in a federal Schedule III framework. This regulatory ambiguity is creating hesitation among cultivators and manufacturers, particularly those who would need to restructure operations to participate as discrete Schedule III entities. Absent coordination or interim

guidance between federal and state authorities, this uncertainty risks significantly limiting participation in what is otherwise a promising regulatory pathway.

Proposed Interim Solution: Federal Non-Interference Moratorium

In the spirit of collaboration and a successful transition, I respectfully propose a temporary, agency-wide moratorium on federal interference in state-regulated cannabis programs during the implementation period.

An estimated three to six million Americans—including veterans, seniors, and patients with chronic or terminal conditions—currently rely on state-regulated cannabis markets for access to therapeutic products. Abrupt enforcement actions or regulatory uncertainty could disrupt access and inadvertently push vulnerable populations toward illicit markets.

A clearly articulated non-interference policy would:

- Provide stability during regulatory transition
- Encourage participation in the federal framework
- Protect patient access to necessary therapeutic options

Ryan Stanley
State-Regulated Cannabis Program Operator

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 22, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an **interested person** who wishes to provide **factual evidence and expert opinion** on Attorney General Order No. 6753-2026 regarding rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026 in Arlington, VA.

First, I want to applaud the Department of Justice for publicly acknowledging the medical value of cannabis. Societies around the globe have *safely* used this medicine in a variety of application methods for ages. Reclassifying the plant from schedule I to schedule III rectifies 55 years of inaccurate placement in the Controlled Substances Act (CSA) and decades of misguided policy that has arisen as a result. I appreciate the expeditious manner in which this Administration is taking action. Thank you.

During the ensuing transition period, I wish to be of guidance to the Drug Enforcement Administration (DEA) as it contemplates the best manner in which to implement this significant and complex change. The following are some of my initial concerns as a patient of 15 years.

> **CONCERN:** I am a Multiple Sclerosis patient. I was diagnosed in 2003. Since then, I have tried most of the pharmaceutical treatments available. Cannabis aka marijuana has been the most effective treatment for me. My health insurance does NOT cover any of the cost associated with procuring my medicine. It would be more than helpful if I didn't have to try to stretch my budget to afford the only medicine that offers relief from my condition.
>
> **CONCERN:** I have a real concern that with the rescheduling of cannabis will bring changes to the product its self. Will there be limits on potency? After all these years, I know what will work for me to give me relief. My medicine should not be dictated by rules meant for a recreational user. Medical users differentiated from recreational.
>
> **CONCERN:** Medical cards (prescriptions) from one state should be recognized nationwide. I am a legal user in Montana. I have a prescription from my physician that says I need it. There should be protection written into the law for medical users.

These are a few of my concerns. As you know, this is an historic opportunity.

1. I would ask that the DEA develop and implement an agency-wide **moratorium on federal interference** in state-regulated cannabis programs. Today, an estimated three to six million veterans, seniors and patients rely on the existing patchwork of state programs, both medical and non-medical, to provide products needed to obtain relief from complex and/or chronic health conditions that are sometimes terminal in nature. Please don't force us into an illicit market to get medicine that offers relief.
2. I also would like to see a **Federal Cannabis Commission** established to ensure that patients, caregivers and health care professionals are equally represented in transparent discussions about the best way to ensure medical cannabis not only presents economic opportunity, but remains a safe, viable, and accessible treatment for Americans who need and deserve the health benefits that cannabis offers. We need people in this commission who know the plant, understand the medical benefits and want to help create a fair and beneficial program.

Sincerely,

Nancy Moore
Medical Marijuana Patient Since 2010

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 22, 2026

To whom it may concern,

My name is Dale Sky Jones. I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an **interested person** who wishes to provide **factual evidence and expert opinion** on Attorney General Order No. 6753-2026 regarding rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026, in Arlington, VA.

I want to express my appreciation for the prompt and decisive actions taken by this Administration in this matter. I commend the Trump Administration and the Department of Justice for its formal recognition of the therapeutic use of cannabis, and for being the first since 1937 to acknowledge the utility of hemp for food, fiber, fuel, and feed. Global societies have historically utilized this botanical medicine with a proven safety profile across diverse clinical applications. The proposed reclassification from Schedule I to Schedule III serves to correct the erroneous categorization of the plant under the Controlled Substances Act (CSA) that has persisted for over 55 years, as well as the decades-long failed policy that has prohibited research, harmed communities, and prevented safe access.

During the ensuing transition period, I would like to provide guidance to the Drug Enforcement Administration (DEA) as you consider the best way to implement this significant and complex change. I am a cannabis policy advocate, educator, and Chancellor of Oaksterdam University, the nation's first cannabis college, founded in 2007, with over 120,000 alumni from 116 countries. I have worked directly to provide policy guidance and technical assistance under contract with State agencies for Florida, California, Connecticut, Minnesota, Missouri, and New Jersey, and the City of Denver, Los Angeles, Long Beach, Palm Springs, Oakland, the City and County of San Francisco, Monterey County, and Orange County, as well as the German Parliament and many academic institutions.

Oaksterdam is trusted worldwide, has no conflicts of interest, and holds no cannabis licenses; we are practical dispense knowledge and best practices to healthcare professionals, policy leaders, law enforcement, municipal staff, legal and tax professionals, entrepreneurship, workforce and apprenticeship programs. Oaksterdam provides quality solution-oriented navigation through historic shifts in policy and approach.

I have two decades of non-partisan educational experience in cannabis and hemp policy reform, including briefing both houses of Congress and testifying before the California legislature, creating the original blueprint for building coalitions in cannabis policy reform since 2007. My husband worked directly with medical necessity patients since 1995 who provided the first model for a medical dispensary with full local approval that became the

template for many we see today. Also, I am a mom of three children, aged from elementary to high school, with public safety - and their health and access to dangerous substances - at the top of my mind. The following are some of my initial concerns:

CONCERN: Rescheduling cannabis without a responsible transition plan puts millions of vulnerable patients at immediate risk. An estimated 1.8 million veterans and over 4 million seniors currently depend on cannabinoid medicine to manage chronic pain, PTSD, epilepsy, cancer symptoms, and other serious conditions. Forty states and the District of Columbia serve more than 6 million patients through state-regulated cannabis programs. Disrupting safe access while federal rulemaking remains incomplete is not a regulatory abstraction; it is a direct harm to real people with nowhere else to turn. Will the DEA commit to ensuring that no patient loses access to their medicine during the rulemaking transition period?

CONCERN: New federal regulatory mandates imposed without adequate transition time will severely disrupt established supply chains and the family-owned enterprises that form the backbone of the regulated cannabis industry. Over 15,000 small businesses are currently operating legally under state law, generating approximately $25 billion in state and municipal tax revenues that fund schools, public safety, and technical assistance programs. A five-year transition period is the minimum required to give the FDA, DEA, Congress, and state and local governments time to establish clear regulations, while allowing businesses to comply. Will the DEA commit to a transition period of no less than five years before imposing new federal mandates that could collapse state-regulated markets?

CONCERN: Veterans deserve equal access to medicinal cannabis through the VA. One in five veterans already uses state-legal cannabis as an alternative to opioids, contributing to a documented 41% decrease in both opioid addictions and overdose deaths. Yet VA physicians remain prohibited from recommending medicinal cannabis even in states where it is legal. The Veterans Equal Access Act must be passed immediately, consistent with the federal government's own acknowledgment that cannabis has accepted medical use. Will the DEA support passage of the Veterans Equal Access Act and work with the VA to ensure our veterans can access the medicine their physicians believe is appropriate?

CONCERN: Full-spectrum cannabinoid medicine must remain available to patients throughout the rulemaking process, including through a patient cultivation carve-out in any enforcement framework. A 2024 University of Michigan study found that 40% of cannabis consumers over age 50 cited medical reasons for their use. HHS and FDA must issue guidance to ensure that full-spectrum products remain available, and the November 2026 hemp enforcement deadline must be delayed to no earlier than November 2028 to preserve patient access during the rulemaking transition. Will the DEA ensure that patients' access to full-spectrum cannabinoid medicine is protected throughout the rulemaking period, consistent with Schedule III status and documented patient need?

CONCERN: Medicare and Medicaid must evaluate medicinal cannabis coverage consistent with its new Schedule III status. Millions of seniors and low-income patients who rely on cannabis for documented medical conditions currently pay out-of-pocket for a medicine

the federal government now acknowledges has accepted medical use. CMS must be allowed to provide coverage for medicinal cannabis purchased through state-regulated businesses that manufacture within the legal, permitted supply chain to Medicare and Medicaid beneficiaries, and this evaluation should proceed alongside, not after, the rulemaking process. Protecting state-legal operators during this period is consistent with longstanding DOJ guidance and bipartisan congressional support. It must be codified rather than left to annual appropriations riders that can be stripped away at any time. Will the DEA work with HHS and CMS to ensure that Schedule III rescheduling translates into real access and affordability for the patients who need it most?

These are a handful of my initial concerns as the DEA determines how to reschedule cannabis. In the spirit of collaboration, I offer two simple yet effective solutions to alleviate the above concerns during a period of transition:

1. I humbly request that the DEA develop and implement an agency-wide **moratorium on federal interference** in state-regulated cannabis programs. Today, an estimated three to six million veterans, seniors, and patients rely on the existing patchwork of state programs, both medical and non-medical, to provide products needed to obtain relief from complex and/or chronic health conditions that are sometimes terminal in nature. Please don't force ailing patients into an illicit market to get medicine that offers relief.
2. I also wish to see a **White House Cannabis Commission** established to ensure that patients, caregivers, and health care professionals are equally represented in transparent discussions about the best way to ensure medical cannabis not only presents economic opportunity, but remains a safe, viable, and accessible treatment for Americans who need and deserve the health benefits that cannabis offers. I volunteer to be a member, to help identify priorities, mitigate risk, and discover shared goals across interest groups through community-focused collaborative solutions.

As as Education Committee Chair for the Patient First Coalition, and a member in good standing of both the American Council of Cannabis Medicine and the Oaksterdam Nonprofit for Education, and a patient, I am confident that my letter will reach the appropriate parties. I look forward to participating as an expert witness in the upcoming hearings on cannabis rescheduling.

Sincerely,

Dale Sky Jones
Chancellor, Oaksterdam University
Chair, Medical Cannabis Education Committee, Patient First Coalition
Member, American Council of Cannabis Medicine

(510) 251-1544
dale@oaksterdamuniversity.com

Docket No. DEA-1362

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May __, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking concerning the rescheduling of marijuana/cannabis under the Controlled Substances Act. As an interested person under 21 CFR 1300.01(b), I respectfully submit this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026, in Arlington, Virginia.

First, I want to acknowledge the significance of this moment. The federal government's recognition of the medical value of cannabis represents a historic correction after decades of misclassification under Schedule I. Patients, caregivers, physicians, researchers, cultivators, manufacturers, and state-regulated businesses have carried the burden of an outdated federal framework for far too long. Rescheduling cannabis to Schedule III is not the final answer, but it is a critical step toward a more rational, evidence-based, patient-centered national policy.

My primary concern is patient access. Millions of Americans currently rely on cannabis through state-regulated medical programs for relief from chronic pain, neurological disorders, cancer-related symptoms, PTSD, sleep disturbance, appetite loss, seizure disorders, and other serious conditions. Any federal transition that disrupts state medical programs could unintentionally push vulnerable patients back into illicit markets or force them to lose access to products that are already working for them. I respectfully ask the DEA to clarify how it intends to protect continuity of access for patients during the transition to Schedule III.

My second concern is the preservation of state-regulated medical cannabis systems. These systems may be imperfect, but they represent years of state-level infrastructure, patient relationships, product testing, labeling rules, physician participation, and compliance investment. A federal framework should not erase this infrastructure overnight. Instead, it should recognize compliant state medical cannabis operators as essential participants in the transition. I respectfully request that the DEA adopt a practical non-interference policy for state-regulated medical cannabis programs while federal standards are being developed.

My third concern is the need for clear national testing, quality-control, and product-safety standards. Rescheduling without a unified framework for laboratory

testing, contaminant screening, cannabinoid and terpene reporting, batch consistency, labeling, adverse-event reporting, and chain-of-custody requirements could create confusion rather than public health protection. Cannabis should not move into a new federal category without a serious commitment to safety, transparency, and scientific consistency. I respectfully ask the DEA to support the creation of a national cannabis standards framework developed with input from patients, physicians, scientists, testing laboratories, cultivators, manufacturers, and state regulators.

My fourth concern is the protection of cannabis genetics, breeding work, and plant identity. The cannabis industry has developed over decades through breeders, cultivators, legacy operators, researchers, and patients who preserved and refined unique genetics long before federal policy acknowledged the plant's medical value. A future federal framework must include pathways for genetic registration, cultivar documentation, intellectual property protection, and transparent chain-of-origin records. Without this, the people who built the genetic foundation of the industry may be excluded from the legal medical system they helped make possible.

My fifth concern is research access. Schedule I has severely limited cannabis research and created unnecessary barriers for academic institutions, physicians, product developers, and public health experts. Schedule

III should meaningfully expand legitimate research opportunities, but that will only happen if the process is practical, affordable, and accessible to qualified researchers and compliant operators. I respectfully request that the DEA clarify how rescheduling will improve research access, support clinical data development, and encourage real-world evidence collection from existing state medical cannabis programs.

Again, these concerns are offered in a solution-oriented spirit. This is a historic opportunity to move from conflict to collaboration. The goal should not be to punish patients, physicians, or state-compliant businesses for surviving under a broken federal system. The goal should be to create a responsible national transition that protects patients, advances science, preserves access, and builds a safer medical cannabis marketplace.

For that reason, I respectfully request two immediate actions:

1. That the DEA adopt an agency-wide moratorium on federal interference in state-regulated medical cannabis programs during the transition period, so long as operators are acting in good faith under existing state law and public safety requirements.
2. That the Administration establish a White House Cannabis Commission or comparable federal advisory body to include patients, caregivers,

physicians, researchers, state regulators, veterans, scientists, testing experts, cultivators, manufacturers, and industry standards organizations in the creation of the national medical cannabis framework.

As a member of the American Council of Cannabis Medicine and Patient First Coalition, and as a professional working in cannabis genetics, standards, medical policy, and patient-centered reform, I welcome the opportunity to participate in the upcoming hearing and contribute constructively to this process.

Respectfully submitted,

Priscilla Agoncillo
Co-Founder, Original Breeders League
Chair, National Cannabis Industry Standards Committee for the
American Council of Cannabis Medicine

Docket No. DEA-1362
Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 20, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an interested person who wishes to provide factual evidence and expert opinion on Attorney General Order No. 6753-2026 regarding the rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026, in Arlington, VA.

First, I want to applaud the Department of Justice for publicly acknowledging the medical value of cannabis. Societies around the globe have safely used this medicine in a variety of application methods for ages. Reclassifying the plant from Schedule I to Schedule III rectifies 55 years of inaccurate placement in the Controlled Substances Act (CSA) and decades of misguided policies that have resulted. I appreciate the expeditious manner in which this Administration is taking action. Thank you.

My perspective is grounded in both clinical and operational experience. I came to this industry from a background in emergency medicine, where Standard Operating Procedures were the foundation of safe, accountable practice. I have carried those same values into cannabis. Since 2018, I have served as Compliance Officer and General Manager of Sacred Sun Farms, a vertically integrated, Tier 9 licensed cultivator and manufacturer in Montana that grows in light-deprivation, living-soil greenhouses. Our facility cultivates, extracts, and manufactures cannabis products, including hydrocarbon and solventless concentrates, full-spectrum oil, and a dedicated therapeutic line built around a balanced 1:1 CBD:THC cultivar formulated into topicals, edibles, capsules, and tinctures. Over those years, our company has become recognized as one of Montana's most compliance-focused operators, and I have worked closely with state trade associations, public health departments, the legislature's Economic Affairs Interim Committee, the Department of Revenue's Cannabis and Alcohol Regulatory Division, and DPHHS to help bridge the gap between operators and sound regulatory policy.

During the ensuing transition period, I wish to be of guidance to the Drug Enforcement Administration (DEA) as it considers the best way to implement this significant and complex change. The following are some of my initial concerns as a cannabis operator and compliance professional of seven years.

CONCERN: Under most state programs, including Montana's, the distinction between medical and adult-use cannabis exists only at the point of sale. Cultivation, extraction, and manufacturing are a single, undifferentiated process. A federal framework that places medical marijuana in Schedule III while adult-use cannabis remains in Schedule I would require operators to differentiate the two designations far upstream of retail, at the plant, the extraction run, and the production line, where no such modality currently exists in statute or in practice. Will the DEA clarify whether it expects this differentiation to be physical separation, and if so, will the agency assess the feasibility and cost for vertically integrated operators and coordinate with state regulators on a workable transition pathway?

CONCERN: Schedule III substances require DEA registration of those who handle them, yet the registration framework was designed around pharmaceutical manufacturers and distributors rather than state-licensed cannabis cultivators operating under comprehensive seed-to-sale tracking. The current filing window is brief, and many established, demonstrably compliant operators lack clarity on what registration will require of them. Will the DEA establish a distinct registration pathway or a defined transition period that recognizes the existing compliance infrastructure of state-licensed operators, thereby preserving continuity of lawful operations during the change?

CONCERN: Schedule III medications are ordinarily subject to FDA approval, a process that can require years and substantial investment. Our therapeutic line, standardized 1:1 CBD:THC products manufactured under state-tested conditions represents precisely the kind of product the medical pathway is intended to serve, yet the route from a state-regulated medical product to a federally recognized one remains undefined. Will the DEA, in coordination with the FDA, clarify a realistic and proportionate pathway for existing state-tested medical cannabis products, and will it recognize state Certificate of Analysis and testing regimes during the interim period?

CONCERN: Cannabis businesses remain largely unable to access conventional banking and lending. The compliance obligations that may accompany Schedule III, federal registration, facility modifications, and any FDA-related process all require capital that this industry, by virtue of its federal status, cannot readily obtain. Without a parallel resolution of access to financial services, well-intentioned operators may be unable to afford compliance itself. How does the DEA propose to reconcile the cost of Schedule III compliance with the continued absence of banking and lending access for the businesses expected to meet it?

CONCERN: Throughout any transition, the patients who depend on consistent, tested medical cannabis must not lose access to it. In Montana alone, patients rely on products like our therapeutic line for relief from chronic and sometimes terminal conditions. An abrupt or uncoordinated transition risks interrupting that supply and pushing vulnerable patients toward an unregulated market. Will the DEA commit to a transition timeline that expressly prioritizes uninterrupted patient access to state-regulated medical cannabis?

Again, these are a handful of my initial concerns as the DEA determines how to reschedule cannabis. My intent is to remain solution-oriented and dialogue-driven as we collectively

navigate this historic opportunity. In the spirit of collaboration, I offer two simple yet effective solutions to temporarily alleviate the above concerns during a period of transition:

- I humbly request that the DEA develop and implement an agency-wide moratorium on federal interference in state-regulated cannabis programs. Today, an estimated three to six million veterans, seniors, and patients rely on the existing patchwork of state programs, both medical and non-medical, to obtain products needed for relief from complex and/or chronic health conditions that are sometimes terminal in nature. Please do not force ailing patients into an illicit market to get medicine that offers relief.

- I also wish to see a White House Cannabis Commission established to ensure that patients, caregivers, and health care professionals are equally represented in transparent discussions about how best to ensure medical cannabis not only presents economic opportunity, but remains a safe, viable, and accessible treatment for Americans who need and deserve the health benefits that cannabis offers.

I have devoted my career to demonstrating that cannabis can be produced and regulated to the same standard of accountability I once relied on in emergency medicine. I look forward to participating as an expert witness in the upcoming hearings on cannabis rescheduling and to contributing constructively to a transition that protects patients, operators, and the integrity of state programs alike.

Sincerely,

Joanna Barney
Compliance Officer & General Manager, Sacred Sun Farms
Cannabis operator and compliance professional since 2018
Board Secretary, Policy Committee Chairwoman, Education Committee Chairwoman, Montana Cannabis Coalition

Docket No. DEA-1362

DOCKET NO. DEA-1362

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 20, 2026

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an interested person who wishes to provide factual evidence and expert opinion regarding Attorney General Order No. 6753-2026 concerning the rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026 in Arlington, Virginia.

First, I would like to commend the Department of Justice for acknowledging the medical utility of cannabis and for initiating a formal transition toward a more medically integrated federal framework. Reclassification from Schedule I to Schedule III represents a significant policy shift with broad implications across healthcare, regulatory oversight, commerce, reimbursement systems, laboratory operations, and patient access.

As this transition proceeds, I respectfully submit that the central challenge is no longer whether cannabis possesses medical value. The primary challenge now becomes how to implement medical integration responsibly, consistently, and at scale within operational, regulatory, and healthcare systems that were not originally designed to function under a federally coordinated medical framework.

The following represent several implementation-focused considerations that I believe warrant consideration during this transition period.

CONCERN: Lack of Standardized Product Definitions

At present, significant variability exists across cannabis products with respect to Chemistry, Manufacturing and Control (CMC), formulation, potency, composition, labeling standards, dosage consistency, and validated testing methodologies. This creates substantial challenges for scalability, repeatability, and clinical consistency across healthcare and regulated medical environments and limits the ability to establish reliable clinical baselines across jurisdictions related to safety, outcomes, and therapeutic integration.

Without standardized characterization of cannabis-based medical products, it becomes difficult for providers, researchers, regulators, and payers to evaluate consistency of outcomes or

establish clinical responses, patient outcomes, and longitudinal treatment consistency. How does the DEA intend to support alignment around standardized medical product characterization during the transition to Schedule III?

CONCERN: No Unified Laboratory and QA/QC Methodologies

In the absence of baseline laboratory harmonization, validated methodologies, and interoperable quality assurance frameworks, implementation risk may increase as medical cannabis integration expands across healthcare and regulatory environments.

This lack of consistency may undermine confidence among providers, insurers, researchers, regulators, and institutional stakeholders attempting to evaluate products across jurisdictions and healthcare systems. Will the DEA support coordination toward baseline quality assurance, validation, and laboratory interoperability standards during the transition process?

CONCERN: Lack of Interoperability, Traceability, and Auditability

Healthcare systems, payers, regulators, and reimbursement environments rely heavily upon interoperability, traceability, auditability, and standardized data coordination in order to support compliance, patient safety, product consistency, regulatory oversight, and longitudinal medical outcomes evaluation.

At present, cannabis-related operational environments remain highly fragmented across jurisdictions, with limited interoperability between laboratory systems, dispensing environments, compliance reporting structures, operational workflows, clinical outcomes systems, and broader healthcare coordination frameworks.

This fragmentation creates substantial implementation challenges as cannabis transitions into a federally coordinated healthcare environment. Without baseline interoperability standards, validated operational coordination frameworks, and audit-ready data systems, scalability, consistency, and institutional integration may remain difficult to achieve across healthcare and reimbursement ecosystems.

As cannabis transitions into a federally recognized medical framework, how does the DEA intend to support the development of interoperable, traceable, and audit-ready operational environments capable of supporting regulatory oversight, healthcare integration, patient safety, reimbursement participation, and long-term institutional scalability?

CONCERN: Reimbursement and Risk Underwriting Limitations

One of the most significant barriers to medical integration remains the inability of payers and reimbursement systems to reliably underwrite risk within a non-standardized operational environment.

Healthcare reimbursement models require:

- consistent product characterization,
- validated operational and quality assurance processes,
- repeatable outcomes data,
- traceability and auditability,
- and audit-ready operational frameworks,
- and basic, translational, and clinical research infrastructures capable of supporting evidence-based evaluation and longitudinal healthcare integration.

Without these foundational elements, reimbursement pathways may remain limited despite Schedule III reclassification. In the absence of standardized and interoperable operational environments, healthcare systems, insurers, pharmacy networks, and institutional providers may continue to face substantial barriers to scalable implementation and coverage coordination.

As cannabis transitions into a more formally recognized medical framework, how does the DEA envision coordination between healthcare systems, regulatory agencies, reimbursement environments, and broader institutional stakeholders in order to support scalable implementation, operational consistency, and long-term healthcare integration?

CONCERN: Transitional Implementation Complexity

The transition to Schedule III creates substantial operational overlap between:

- state-regulated systems,
- federal regulatory frameworks,
- medical and adult-use channels,
- healthcare providers,
- laboratories,
- pharmacies,
- manufacturers,
- and reimbursement systems.

This transition presents a highly complex implementation environment requiring phased coordination across regulatory, healthcare, operational, and reimbursement infrastructures in order to minimize disruption to patients, providers, and existing state-regulated medical programs operating in good faith.

As implementation proceeds, consideration should be given to frameworks capable of supporting:

- operational continuity,
- interoperability coordination,
- regulatory harmonization,
- auditability and traceability,
- reimbursement readiness,
- and scalable healthcare integration.

Accordingly, I respectfully support consideration of:

1. A temporary moratorium on federal interference involving existing state-regulated medical cannabis systems operating in good faith during the transition period; and
2. Establishment of a federal medical cannabis commission, interagency coordination framework, or implementation task force capable of addressing the operational, scientific, healthcare, reimbursement, and regulatory complexities associated with national medical integration.

Again, I appreciate the Department's willingness to engage in this historic transition process. My intent is to remain constructive, implementation-focused, and solution-oriented as stakeholders collectively work toward a safe, scalable, interoperable, and medically responsible framework for national medical cannabis integration.

I look forward to participating in the upcoming hearings regarding medical cannabis rescheduling.

Sincerely,

Dr. Elias Jackson
Member, American Council of Cannabis Medicine
Member, Medical Cannabis Committee, Patient First Coalition

DOCKET NO. DEA-1362

Drug Enforcement Administration
Attn: Administrator
8701 Morrissette Drive
Springfield, Virginia 22152

May 23, 2025

To whom it may concern,

I am writing in response to the Notice of Proposed Rulemaking (NPRM) issued by Acting Attorney General Todd Blanche on April 22, 2026. As defined in 21 CFR 1300.01(b), I am an interested person who wishes to provide factual evidence and expert opinion on Attorney General Order No. 6753-2026 regarding the rescheduling of marijuana (cannabis). As such, I am filing this written notice of my intention to participate in the hearing scheduled to begin on June 29, 2026 in Arlington, Virginia.

First, I want to applaud the Department of Justice for publicly acknowledging the medical value of cannabis. People around the world have safely used this plant medicinally for generations, and moving cannabis from Schedule I to Schedule III begins correcting decades of policy that simply did not reflect reality, science, or patient experience. I appreciate the Administration taking meaningful action on this issue.

As the DEA works through implementation of this historic change, I want to offer several concerns that I believe deserve careful consideration during this transition period.

CONCERN: My biggest concern is that federal action could unintentionally interfere with existing state cannabis programs and reduce patient access. Here in Oklahoma, patients, physicians, businesses, and voters fought hard to create a medical cannabis system that serves real people with real health conditions. Millions of Americans now rely on state-regulated cannabis access, and we cannot allow federal restructuring to take medicine away from patients who depend on it. As rescheduling moves forward, how will the DEA ensure that state medical cannabis programs remain protected and fully operational without unnecessary federal interference?

CONCERN: My second concern is the regulatory framework that will follow rescheduling. As the DEA defines registration requirements and future standards, it appears likely that cannabis may be pushed into a category that resembles pharmaceutical drug development without recognizing the unique nature of botanical medicine. Cannabis is not a single-molecule pharmaceutical product, and existing botanical drug development pathways have historically been difficult, expensive, and impractical for many operators and researchers. This process must be handled with scientific rigor, but it also must be realistic. Federal agencies should avoid

forcing cannabis into a broken framework that limits innovation, access, and research.

CONCERN: My third concern is education. Most Americans — including many policymakers, regulators, and healthcare professionals — still do not fully understand the medical importance of cannabis or the role of the human endocannabinoid system. Yet millions of patients use cannabis therapeutically for chronic pain, epilepsy, PTSD, cancer-related symptoms, neurological disorders, and many other serious conditions. If cannabis policy is going to evolve responsibly, there must also be a serious effort to educate decision makers and medical professionals on the science behind the endocannabinoid system and cannabinoid medicine.

CONCERN: My fourth concern is the protection of intellectual property in the cannabis space. Many individuals and small businesses have spent decades developing genetics, strains, cultivation methods, and formulations that have helped countless patients and built entire livelihoods. These innovators deserve meaningful intellectual property protections just like we recognize in other agricultural and pharmaceutical sectors. As federal policy changes, there needs to be a clear path to protect the work, research, and innovation that people have dedicated their lives to building.

CONCERN: My fifth concern is the people who remain incarcerated or continue to carry criminal penalties for marijuana-related offenses. It is difficult to fully call this progress while individuals are still sitting in jail or living with life-altering criminal records for conduct that the federal government is now acknowledging has medical value. Any serious cannabis reform conversation should include review of non-violent marijuana sentences and pathways for relief, reduction, or expungement where appropriate.

Again, these are a handful of my initial concerns as the DEA determines how to reschedule cannabis. My intent is to remain solution-oriented and dialogue-driven as we collectively navigate this historic opportunity. In the spirit of collaboration, I offer two simple but important solutions that could help ease many of these concerns during the transition period.

I respectfully request that the DEA develop and implement an agency-wide moratorium on federal interference in state-regulated cannabis programs. Today, millions of veterans, seniors, and patients rely on existing state systems to obtain products that provide relief from chronic, debilitating, and sometimes terminal medical conditions. Patients should not be pushed backward into illicit markets because of uncertainty created during federal transition.

I also strongly support the establishment of a White House Cannabis Commission to ensure that patients, caregivers, healthcare professionals, scientists, regulators, and industry participants all have a voice in shaping the future of cannabis policy in the United States. This process should remain transparent, patient-focused, science-driven, and centered on safe and accessible medical treatment for Americans who need it.

As a member in good standing of both the American Council of Cannabis Medicine and the Patient First Coalition, I am confident this letter will reach the

appropriate parties. I look forward to participating as an expert witness in the upcoming hearings on cannabis rescheduling.

Sincerely,

Charles “Chip” Paul
(Patient/Caregiver/Medical Provider/Business Owner)
Member, American Council of Cannabis Medicine
Member, Medical Cannabis Committee, Patient First Coalition