Sovereign by Law, *Vulnerable by Design*

A Tribal License Alone Does Not Reach Schedule III

21 C.F.R. § 1300.01 · "STATE MEDICAL MARIJUANA LICENSE" MEANS A LICENSE ISSUED BY

A STATE ENTITY	A DISTRICT OF COLUMBIA ENTITY	A FEDERAL TERRITORIAL ENTITY	INDIAN TRIBES
INCLUDED	INCLUDED	INCLUDED	NOT NAMED

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Rosado Advisory is a physician-led healthcare strategy and consulting firm specializing in cannabis medicine, physician-led clinical governance, Tribal health systems, regulatory strategy, public health, and healthcare innovation. The firm partners with sovereign Tribal Nations, healthcare organizations, policymakers, and industry leaders to develop evidence-based healthcare systems that improve patient safety, strengthen governance, and advance sustainable healthcare solutions. Rosado Advisory provides clinical-governance assessments and related advisory services.

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CONTENTS

In This Paper

FRONT MATTER

Key Findings iii

PART ONE · THE FINDING

Executive Summary 1

I. Start with Cherokee 2

II. The Mechanism: A Definition Written Without Tribes 3

III. The Consultation That Did Not Happen 4

IV. What the Exclusion Costs 5

V. The Sovereignty Trap 6

VI. The Remedy Is One Line 7

PART TWO · THE FRAMEWORK

VII. The Moment 9

VIII. The Gap 11

IX. The Evidence 13

X. The Framework 15

XI. The Exclusion 17

XII. The Path Forward 19

CLOSING

The Call to Action and Conclusion 21

Scope, Limitations, and Acknowledgments 22

References 23

About the Author 24

Key Findings

1. AG Order No. 6754-2026 moves marijuana to Schedule III in exactly two circumstances: an FDA-approved drug product, or a state medical marijuana license. All other marijuana stays in Schedule I.
2. The order defines that license as one issued by a state, District of Columbia, or federal territorial entity. Indian tribes are not named.
3. Cannabis authorized solely under tribal law therefore remains in Schedule I.
4. The Department of Justice certified that the order has no tribal implications. The order identifies no tribal consultation.
5. The remedy begins with six words added to a single definition at 21 C.F.R. section 1300.01, with conforming changes to § 1301.13(k): a proposed administrative correction that would not reopen the scheduling proceeding.
6. In the author's view, what gets a tribe through the door is physician-led clinical infrastructure: the Rosado Five Pillar Clinical Governance Framework, with a proposed ninety-day starting plan.

THE ORDER

AG Order No. 6754-2026
91 Fed. Reg. 22,714
Signed April 22, 2026
Effective April 28, 2026

PART ONE · THE FINDING

Executive Summary

AG Order No. 6754-2026, signed April 22, 2026 and effective April 28, 2026, is widely described as the rescheduling of marijuana. It is not.[1]

The order moves marijuana to Schedule III in exactly two circumstances: when it is contained in an FDA-approved drug product, or when it is subject to a state medical marijuana license. All other marijuana stays in Schedule I.

It then defines that term at new 21 C.F.R. section 1300.01 as a license issued by a state entity, a District of Columbia entity, or a federal territorial entity. Indian tribes are not named. They are not carved out, not excepted, not addressed. They are absent from an exhaustive list.

Indian tribes are not named. They are not carved out, not excepted, not addressed.

Cannabis authorized solely under tribal law remains in Schedule I. Not because any tribe failed a federal standard, but because the federal standard was written in a vocabulary that does not contain the word “tribe.”

The Department of Justice then stated, under its own Executive Order 13175 heading, that the order has no tribal implications and no substantial direct effects on Indian tribes. The order identifies no tribal consultation.[1]

The consequences are immediate: continued Schedule I exposure, exclusion from an expedited DEA registration pathway whose priority window has closed, no path out of Section 280E of the kind state-licensed competitors may now have, no recognition of tribal patient certifications, and no equivalent research clarification.

The remedy begins with six words added to a definition. Section VI states it.

NORTH CAROLINA

No medical program.
No adult-use program.
No medical marijuana license of any kind.

SECTION I

Start with Cherokee

The Eastern Band of Cherokee Indians operates a tribally licensed cannabis program on the Qualla Boundary.

The State of North Carolina has no medical cannabis program and no adult-use program. North Carolina issues no medical marijuana license of any kind.

Under AG Order No. 6754-2026, Schedule III status requires an FDA-approved drug product or a state medical marijuana license. The Eastern Band holds neither, and cannot. There is no North Carolina license in existence for it to obtain.

Sovereignty did not shield the Eastern Band. Sovereignty is the thing that disqualified it.

The Eastern Band is not a tribe that failed to meet a federal condition. It is a tribe for which the condition cannot be met, will not become meetable by any action it takes, and would only become meetable if North Carolina chose to create a cannabis program.

A sovereign Tribal Nation's federal drug classification now turns on the legislative decisions of a state government it does not belong to. Sovereignty did not shield the Eastern Band. Sovereignty is the thing that disqualified it.

THE DEFINITION

21 C.F.R. § 1300.01 Added by AG Order No. 6754-2026, effective April 28, 2026

THE SCHEDULE

21 C.F.R. § 1308.13(g)(2)–(4) carries the same limitation

SECTION II

The Mechanism: A Definition Written Without Tribes

The order adds a new definition at 21 C.F.R. section 1300.01:

> "State medical marijuana license means a license issued by a state entity (or by a District of Columbia entity or a federal territorial entity) authorizing the licensee to manufacture, distribute, and/or dispense marijuana or products that contain marijuana for medical purposes."[1]

Indian tribes are not in the sentence.

States are in. The District of Columbia is in. Federal territorial entities are in, reaching Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands.

Indian tribes are not in the sentence.

The Schedule III entries at 21 C.F.R. section 1308.13(g)(2) through (g)(4) carry the identical limitation. The result is that an unincorporated territory, possessing no inherent sovereignty, now enjoys a federal cannabis pathway that a treaty-recognized sovereign Tribal Nation does not.

EXECUTIVE ORDER 13175

Consultation and Coordination with Indian Tribal Governments
65 Fed. Reg. 67,249

SECTION III

The Consultation That Did Not Happen

Executive Order 13175 obligates federal agencies to consult with tribal governments before promulgating regulations with tribal implications.[2] The order addresses this under its own heading and disposes of it in two sentences:

A rule that leaves every tribal license out of its definition, certified as having no substantial direct effect on any Indian tribe.

> "This action does not have tribal implications warranting the application of E.O. 13175. It does not have substantial direct effects on one or more Indian tribes, on the relationship between the Federal government and Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes."[1]

That sentence sits in a rule granting federal Schedule III status, registration eligibility, and potential tax relief to licensees across forty states, the District of Columbia, and the territories, while marijuana authorized by a tribal license alone remains in Schedule I.

The order identifies no tribal consultation, and the author is aware of none. On the order's own account, there was nothing to consult about. The administrative record now contains the Department's own written finding that a rule leaving every tribal license out of its definition has no substantial direct effect on any Indian tribe.

This is the most vulnerable sentence in the order.

SECTION IV

What the Exclusion Costs

Each consequence flows from the text of the order and the rule it creates.

PROVISION	STATE-LICENSED PROGRAM	TRIBALLY LICENSED PROGRAM
Federal schedule AG Order No. 6754-2026	**Schedule III** when subject to a state medical marijuana license	**Schedule I**, federally indistinguishable from illicit cannabis
DEA registration § 1301.13(k)	Expedited pathway; priority processing and interim authority for filings within 60 days	**A tribal license alone does not qualify**; the priority window has closed
Federal tax 26 U.S.C. § 280E	**May no longer be subject** to the deduction disallowance, as the order states	**May remain subject** to it
Patient certification § 1301.13(k)(5)	State-law certification may substitute for a federal prescription	**No recognition** for a tribal health authority's certification
Research sourcing AG Order No. 6754-2026	DEA-registered researchers sourcing from a federally registered state licensee are not liable solely because of that source	**No equivalent clarification** for a supplier licensed only by a tribe
Deference to local law § 1301.13(k)(8)–(10)	State law satisfies federal labeling, packaging, security, and disposal requirements	**Tribal law given no effect** anywhere in the rule

FIGURE 1. How AG Order No. 6754-2026 treats two programs operating lawfully under their own governments. Every difference turns solely on which sovereign issued the license. The order notes that it is not a determination of any taxpayer's federal tax liability.

Two dispensaries operating lawfully under their respective governments can face materially different federal tax exposure.

Because 280E reaches only Schedule I and II trafficking, qualifying state-licensed activity may now fall outside the deduction disallowance, while activity under a tribal license alone may remain subject to it.[3] Two dispensaries operating lawfully under their respective governments can face materially different federal tax exposure, depending on the taxpayer and the facts, and turning in large part on which sovereign issued the license.

The order clarifies that DEA-registered researchers who source from a federally registered state licensee are not liable solely because of that source. It offers no equivalent clarification for suppliers licensed only by a tribe, narrowing the ways Indian country can contribute to the evidence base on which future scheduling decisions will rest. Section IX returns to that cost.

THE MECHANISM

Federal legitimacy is wholly derivative of state licensure.

SECTION V

The Sovereignty Trap

Section 1301.13(k)(2) makes state license conclusive evidence of authorization. Section 1301.13(k)(3) provides that if that state license is suspended, revoked, or expires, the federal registration is automatically suspended.

Federal legitimacy is therefore wholly derivative of state licensure. The federal government did not build a cannabis oversight regime. It adopted the states' regimes and attached federal consequences to them.

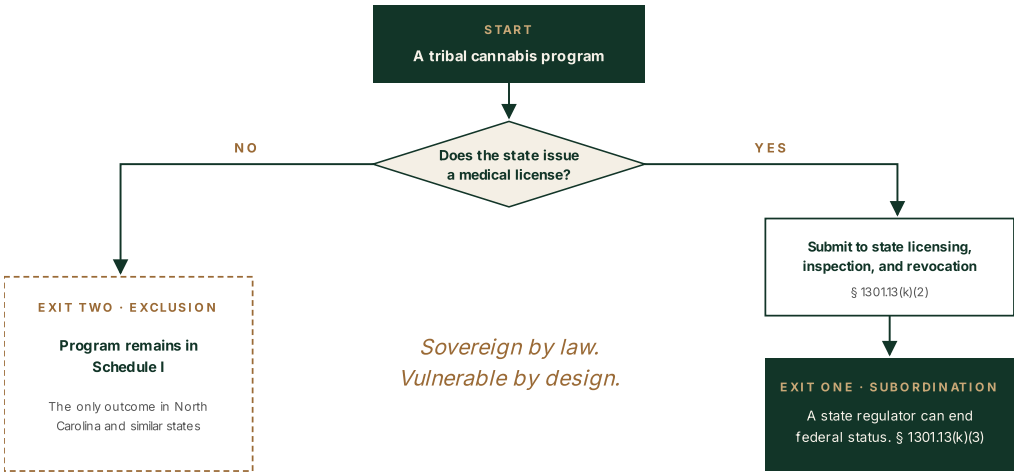


FIGURE 2. The Sovereignty Trap. Every path available to a tribe under the order ends in subordination or exclusion, and in states without a medical program, only exclusion.

For a tribe, this closes a loop with one exit. To reach Schedule III, a tribe must hold a state medical marijuana license. To hold one, it must submit its cannabis operations to the licensing, inspection, recordkeeping, and revocation authority of a state government, and accept that a state regulator can extinguish its federal status by revoking a permit.

In North Carolina, and in every other state without a medical program, even that exit does not exist.

The rule offers Indian country a choice between subordination and exclusion, and for some tribes it offers only exclusion. Sovereign by law. Vulnerable by design.

WHAT IT REQUIRES

No reopened scheduling proceeding. One amended definition, carried through § 1301.13(k). Counsel to confirm whether any statutory change is also needed.

SECTION VI

The Remedy Is One Line

As proposed, this would not reopen the scheduling proceeding. It begins with amending a single definition, which the Attorney General can do by the same kind of order that created it.

CURRENTLY READS	"...a license issued by a state entity (or by a District of Columbia entity or a federal territorial entity)..."
SHOULD READ	"...a license issued by a state entity (or by a District of Columbia entity, a federal territorial entity**, or a federally recognized Indian tribe**)..."

CONFORMING CHANGES § 1301.13(k)		
	(k)(2) Authorization	A tribal license is conclusive evidence of authorization, as a state license is.
	(k)(3) Suspension	Suspension, revocation, or expiration of the tribal license suspends registration on the same terms.
	(k)(5) Certification	A certification under tribal law may substitute for a federal prescription.
	(k)(8)–(10) Local law	Tribal law satisfies labeling, packaging, security, and disposal requirements, as state law does.
	Research sourcing	Assess whether the order's research clarification also needs an express extension to tribal licensees.

FIGURE 3. The proposed amendment to 21 C.F.R. section 1300.01 and its conforming changes in § 1301.13(k).

UNCHANGED

The Administrator's public-interest review under 21 U.S.C. § 823 remains fully intact.

Six words. They extend to sovereign Tribal Nations the treatment the rule already extends to unincorporated territories, without reopening the scheduling findings or creating a new federal obligation.

Because Section 1301.13(k) refers repeatedly to state law and state licenses, the conforming changes carry the amendment through. Some registration provisions of the Controlled Substances Act itself also refer to state-law authorization, so counsel should confirm whether a statutory change is also needed. The Administrator's public-interest review under 21 U.S.C. section 823[4] remains intact, including discretion to deny or revoke where diversion controls, recordkeeping, or safety measures are inadequate. No tribe would be waved through. Eligible tribal licensees could apply.

That is where Part One ends and Part Two begins. The fix gets a tribe to the door. What gets a tribe through it, in the author's view, is clinical infrastructure.

PART TWO

The Framework

A physician-led framework for building clinical and regulatory readiness.

VII The Moment
VIII The Gap
IX The Evidence
X The Framework
XI The Exclusion
XII The Path Forward

HEMP

Most of the redefinition takes effect December 11, 2026, after a one-month delay.

SECTION VII

The Moment

Two federal actions. Six months. No clinical roadmap.

The federal cannabis landscape shifted twice, and tribal health systems were not in the room for either change.

The first shift came from Congress. P.L. 119-37, Section 781, enacted November 12, 2025, redefines hemp from a delta-9 THC standard to a total-THC calculation standard.[5] In September 2026, Congress delayed most of that change by one month, to December 11, 2026; cannabinoids that cannot be produced naturally by the plant lose hemp status on November 12.[6] The U.S. Hemp Roundtable estimates that roughly 95 percent of hemp-derived cannabinoid products on the market become federally non-compliant under the new definition.[7] Tribal communities that integrated hemp wellness products into their health programs, CBD formulations, low-THC therapeutic preparations, and topical cannabinoid therapies face abrupt reclassification of those modalities with no clinical transition framework in place.

The second shift came from the executive branch, and Part One of this paper documents what it actually did. It did not reschedule marijuana. It rescheduled FDA-approved products and state-licensed medical marijuana, and left all other marijuana, including everything authorized by a tribal license alone, in Schedule I.

The opportunity Schedule III can create is real: fewer federal barriers to research, potential reimbursement pathways, more conventional clinical documentation, and greater physician engagement inside health systems previously prohibited from touching the substance. For communities whose relationship with plant medicine has been criminalized for generations, that shift matters.

Tribal Nations simply are not in it.

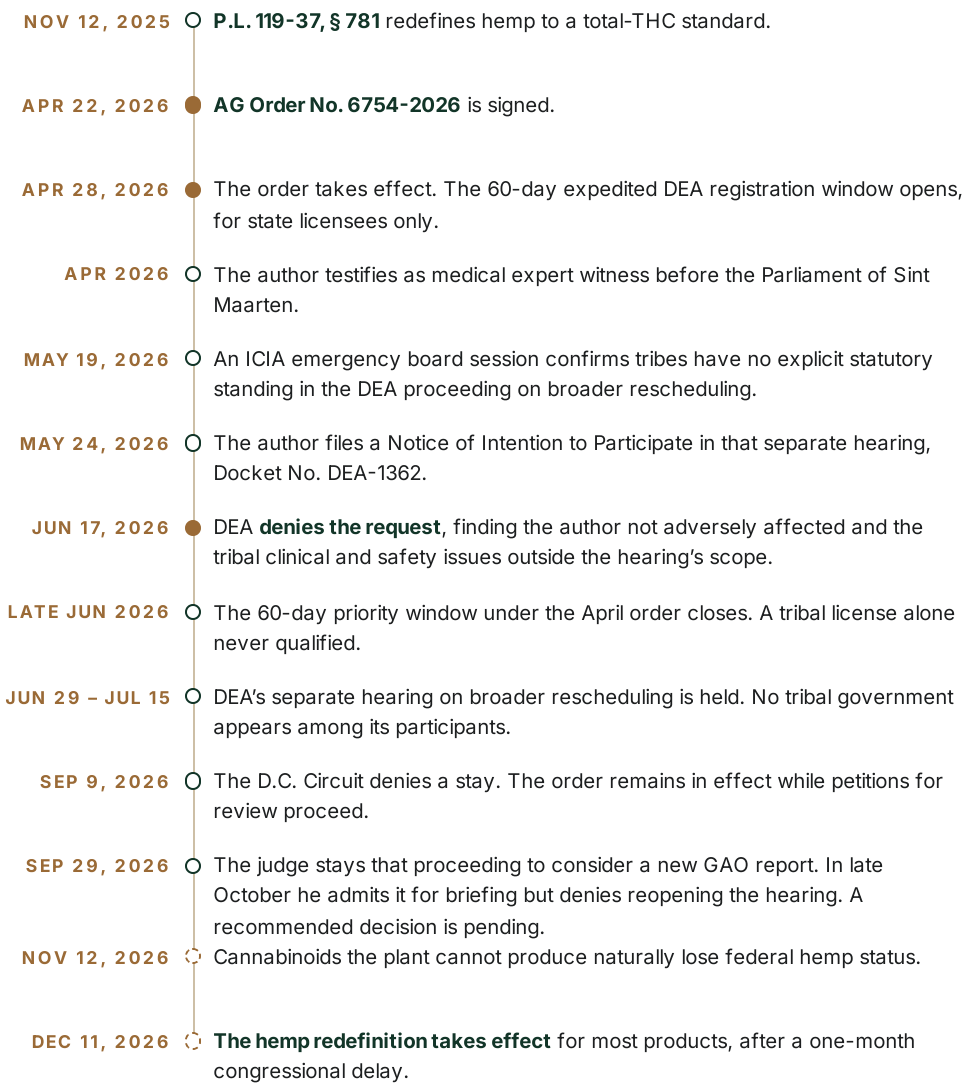


FIGURE 4. Federal actions and tribal standing, November 2025 to December 2026. Copper markers are the decisive dates; dashed markers are dates still ahead. The April order and the later hearing are separate proceedings.

The law moved. The clinical system has not.

This paper is written for the tribal health director sitting in a clinic right now, with no physician framework, a federal deadline bearing down, and no advisor telling them what to do. The law moved. The clinical system has not. That gap is where people get hurt.

THE MARKET

93 tribally owned outlets
67 Tribal Nations
10 states
Up 19 percent in a year

SECTION VIII

The Gap

The industry built the roof before it built the foundation.

Tribal cannabis commerce has expanded quickly. The clinical infrastructure supporting individual programs varies, and it warrants assessment.

Across ten states, 93 tribally owned cannabis outlets serve patients and customers under the sovereign authority of 67 Tribal Nations. That network grew 19 percent in a single year.[8] By commercial measures, tribal cannabis is succeeding. Its clinical footing is far harder to see: an outlet count says nothing about physician oversight, protocols, or monitoring, and in the author's experience those safeguards are often missing.

The cannabis industry at large was built commercially before it was built medically. Dispensaries opened before dosing protocols existed. Products reached patients before adverse event monitoring was in place. In the author's experience, many tribal programs inherited those structural deficits and carry the additional weight of sovereign complexity that most cannabis consultants are not equipped to address.

Recurring clinical-governance gaps identified through the author's work and review include:

1 **Limited or undefined physician oversight models.** Without a physician in a defined clinical governance role, there is no clinical authority to set dosing standards, review adverse events, supervise intake, or certify that the program meets any evidence-based standard of care.

2 **Lack of Indigenous-specific dosing evidence.** The research base from which dosing guidance would derive is predominantly non-Indigenous. Tribal communities may differ in burdens of disease, trauma exposure, healthcare access, and cultural relationships with cannabis medicine, factors poorly represented in the existing clinical literature.

3 **Inconsistent adverse event monitoring.** Without adverse event data, programs cannot detect safety signals, cannot improve protocols, and cannot demonstrate to a federal regulator that they operate responsibly. This is not only a patient safety failure. It is a regulatory liability, and it bears directly on the safety measures Section 1301.13(k) treats as the mark of a sound program.

The industry built the roof before it built the foundation.

4 **Limited Indigenous-specific provider training and CME.** The physicians and nurse practitioners staffing tribal health clinics have, in the author's experience, few if any Indigenous-specific cannabinoid medicine curricula available to them.

5 **Limited tribal research infrastructure.** Tribal Nations are positioned to generate the population-specific data that would make care for their communities evidence-based rather than extrapolated. In the author's experience, few yet have the infrastructure to do it.

Without defined clinical oversight, sound protocols, and adverse event monitoring, important patient-safety safeguards may be missing.

THE GAP	THE FRAMEWORK COMPONENT THAT ADDRESSES IT
Physician oversight	1 · Medical Director Governance Model
Indigenous-specific dosing evidence	2 · Clinical Protocols, informed by 5 · Research Infrastructure
Adverse event monitoring	2 · Clinical Protocols and 3 · Documentation & Records Framework
Provider training and CME	4 · Provider Training & CME Pathways
Research infrastructure	5 · Research Infrastructure

FIGURE 5. Each recurring gap maps to a component of the Rosado Five Pillar Clinical Governance Framework described in Section X.

ADOLESCENT COHORT

2.19

adjusted hazard ratio for incident psychotic disorder after past-year adolescent use

SECTION IX

The Evidence

The evidence for clinical oversight.

The argument for physician-led clinical infrastructure is not hypothetical. It rests on clinical evidence and on the author's experience across clinical settings and sovereign jurisdictions.

When a licensed physician evaluates a patient before cannabis medicine is recommended, establishes a documented indication, monitors response over time, and adjusts the therapeutic approach on clinical findings, the program gains the safeguards this paper proposes: a documented clinical record and a way to detect and respond to harm. Observational studies in selected clinical populations report improvements in patient-reported outcomes under structured medical-cannabis care, with adverse events that can be monitored and managed clinically.[9,10] They do not test this specific framework, but they are consistent with the author's clinical experience across more than four decades in healthcare.

The public health stakes of unmonitored access are not abstract. A cohort study of more than 460,000 adolescents screened between 2016 and 2023 found that past-year cannabis use was associated with significantly elevated adjusted hazard ratios for new psychiatric disorders before age 26: psychotic disorder (aHR 2.19), bipolar disorder (aHR 2.01), depressive disorder (aHR 1.34), and anxiety disorders (aHR 1.24).[11] The association does not establish causation, and the study did not analyze American Indian and Alaska Native youth separately, but for a population carrying a disproportionate baseline burden of trauma and mental health conditions, its findings counsel particular caution about unmonitored access.

This is not an argument against tribal cannabis programs. It is an argument for physician oversight within them.

And the data gap compounds the exclusion. The HEALthy Brain and Child Development Study, the largest NIH-funded longitudinal study of early brain development in the country, is enrolling more than 7,000 families; in its first published findings, 17 percent of mother–infant pairs met its threshold for prenatal cannabis exposure.[12] Its published findings report no Indigenous-specific analysis, and AG Order 6754-2026 offers no equivalent research clarification for suppliers licensed only by a tribe, the protection that might have begun to build one.

Direct engagement with tribal health systems, including the author's work with the Lac du Flambeau Band of Lake Superior Chippewa Indians and Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin, provides ground-level intelligence no literature review replicates. The author's April 2026 testimony before the Parliament of Sint Maarten offers an illustrative example of how physician-designed clinical governance can be presented within a sovereign policymaking process.

And the data gap compounds the exclusion.

TIMELINE

A proposed ninety-day starting plan, adaptable to each Nation.

SECTION X

The Framework

The five components, and what each one is for.

Physician-led clinical infrastructure is a defined set of components that can be assessed and begun within a proposed ninety-day starting plan, adaptable to each Nation's priorities, approvals, resources, and existing infrastructure. The components are modular and sequenceable to tribal governance timelines and budget realities. This framework is not one size fits all. It is sovereign by design. The regulation does not prescribe this framework. It is the author's proposed model for building the safety, governance, documentation, training, and research capacity that can strengthen clinical and regulatory readiness, and it has not been independently validated as a condition of DEA registration. Rosado Advisory offers clinical-governance assessments based on it.



FIGURE 6. The Rosado Five Pillar Clinical Governance Framework. Each component is modular and can be sequenced to a tribe's governance timeline and budget.

01 Medical Director Governance Model

Defines the physician's authority within the program: what decisions require physician sign-off, what clinical thresholds trigger physician review, and how the role interfaces with tribal regulatory authority and health system leadership. Every program operating without this is operating without a clinical authority structure.

This framework is not one size fits all. It is sovereign by design.

02 Clinical Protocols

Patient intake, dosing, monitoring, and adverse event response. The operational questions tribal health staff face every day, calibrated to tribal population health data and reviewed as evidence evolves.

03 Documentation and Records Framework

Insurance billing, research authorization, and federal regulatory review all require records demonstrating the program operated with clinical standards in place. This is also the file a DEA registration application draws on.

04 Provider Training and CME Pathways

Indigenous-specific cannabinoid medicine education for the clinicians already staffing tribal health systems, building internal capacity over time rather than importing it indefinitely.

05 Research Infrastructure

Data collection systems, IRB relationships, and research partnerships that let the tribe generate population-specific cannabinoid safety and efficacy data, positioning it as a scientific authority rather than a passive recipient of policies made without its data.

THREE POINTS OF CONCERN

Tribal licenses are not named in the rule.
The order identifies no tribal consultation.
No tribal government appears among the hearing's participants.

SECTION XI

The Exclusion

The exclusion is written into the April order. No tribal government appears among the participants in the separate hearing that followed.

Part One establishes that the exclusion is definitional. It is written into 21 C.F.R. section 1300.01, and a tribal license alone cannot cure it. Earlier analysis, including the author's own, described a regulatory trap in which tribes must either accept a state license or operate under tribal law alone and potentially remain outside the Schedule III framework. There is nothing potential about it.

The California Attorney General's position, that a tribe must hold a state license to do business with state licensees off tribal lands, is now the federal architecture rather than one state's interpretation of it.[13]

TWO PROCEEDINGS

The April order: AG Order No. 6754-2026, effective April 28, 2026.

The later hearing: broader rescheduling, Docket No. DEA-1362, held June 29 to July 15, 2026.

The Order, the Hearing, and the Denial

The April order. AG Order No. 6754-2026 was signed April 22, 2026 and took effect April 28. It created the definition Part One examines, and its own text certifies that it has no tribal implications. It identifies no tribal consultation. The later hearing neither produced it nor will amend it.

The later hearing. DEA is separately considering whether to transfer marijuana more broadly to Schedule III, in a proceeding with an administrative hearing (Docket No. DEA-1362).[14] In the assessment of the ICIA emergency board session of May 19, 2026, tribal governments have no explicit statutory standing in it: the Controlled Substances Act gives sovereign tribal governments no designated role as governmental parties in the rulemaking that will shape cannabis regulation on their own lands.

The June 17 denial. On May 24, 2026, the author asked to participate in that hearing, on the premise that what tribal governments cannot do as entities, individuals can. On June 17, 2026, DEA denied the request. It concluded that, as a supporter of rescheduling, the author was not adversely affected or aggrieved, and that the issues he raised, including clinical infrastructure and safety for tribal populations and the effect of hemp enforcement on tribal health systems, did not bear on the statutory questions the hearing would decide.[14,15] The hearing went forward from June 29 to July 15, 2026. On September 29, the judge stayed the proceeding to consider a newly released GAO report. In late October he admitted the report for briefing but declined to reopen the hearing.[19] A recommended decision is pending.

The rule omits tribal licenses, and the hearing that followed included no tribal government.

Neither the hearing nor the denial created the exclusion; the April order did that on its own. But the two records point the same way. The order left tribal licenses out of its definition, certified that doing so has no tribal implications, and identifies no consultation. In the later proceeding, no tribal government appears among the participants, and a physician who sought to raise tribal clinical concerns was told they fell outside the hearing's scope.

He was not alone. Other supporters of rescheduling were also denied participation.[20] That does not make the outcome less consequential for Indian country. It means the clinical concerns the author sought to present did not enter the hearing through his testimony.

None of this weakens the argument. It completes it. The rule omits tribal licenses, the order identifies no consultation, and no tribal government appears among the participants in the hearing that followed.

The Legislative Vehicles

S. 4315, the Hemp Safety Enforcement Act (Sen. Rand Paul, R-KY, with Sens. Amy Klobuchar and Joni Ernst), would let a state or Indian tribe elect primary regulatory authority over hemp and hemp-derived cannabinoid products in lieu of submitting a federal plan.[16] H.R. 2934, the STATES 2.0 Act (Rep. Dave Joyce, R-OH), would amend the Controlled Substances Act to explicitly empower states and tribes to regulate marijuana within their jurisdictions.[17] Both would address parts of the problem at the statutory level.

The proposed administrative remedy is narrower than either bill. The six-word amendment to 21 C.F.R. section 1300.01, with its conforming changes, is an administrative correction, subject to counsel's review of whether any statutory change is also needed. It is the narrowest available correction, and it should be the unified ask of every tribal cannabis organization, tribal health authority, and allied clinician in the country.

DEADLINE

The hemp redefinition arrives December 11, 2026, regardless of the order.

SECTION XII

The Path Forward

Build the file the federal government will eventually ask for.

The door is locked. It will not stay locked forever. When it opens, whether by amendment, by litigation, by consultation demand, or by act of Congress, the tribes that walk through first will be the ones already holding the file a federal registrant is asked to produce.

Section 1301.13(k) tells the Administrator that an applicant operating under a regime with robust protections against diversion, requirements for recordkeeping and reporting, and safety and inspection measures will generally satisfy the public interest. The rule writes that test for state-law regimes, but its substance is clinical and operational, and a tribe can build to it today, whether or not the definition has been amended.

Independently, the hemp redefinition takes effect December 11, 2026, regardless of anything that happens to AG Order 6754-2026. Further extensions or a replacement framework may come and should be tracked, but the clinical infrastructure gap exists independent of any statutory timeline. The programs that build physician-led clinical governance now will be defensible whenever enforcement arrives.

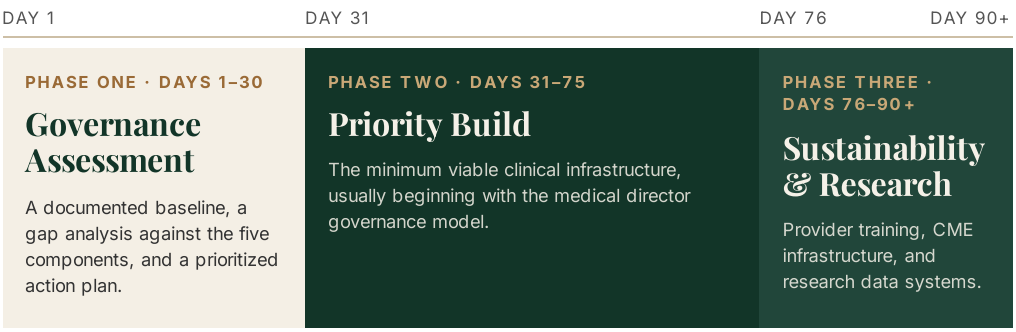


FIGURE 7. The ninety-day implementation path, sequenced to each tribe's governance timeline and budget.

Phase One: Governance Assessment (Days 1 to 30)

A structured clinical and regulatory diagnostic evaluating where the program stands against the five components. It produces a documented baseline, a gap analysis identifying what is absent, partial, or in place, and a prioritized action plan sequenced to the tribe's governance timeline, budget reality, and the December 11 date.

Phase Two: Priority Build (Days 31 to 75)

Implementation of the highest-leverage components in the sequence the assessment identified. For most programs this begins with the medical director governance model, because establishing physician authority precedes building protocols, documentation, or research infrastructure. The priority build is the minimum viable clinical infrastructure required to demonstrate physician oversight, documented protocols, and adverse event monitoring capacity.

Phase Three: Sustainability and Research (Days 76 to 90 and beyond)

Provider training pathways, CME infrastructure, and research data collection systems that build internal clinical capacity over time and position the tribe as a contributor to the Indigenous cannabis evidence base rather than a subject of it.

CLOSING

The Call to Action

TRIBAL HEALTH DIRECTORS

Conduct or commission an independent clinical-governance assessment. The diagnostic is what makes everything else possible, and it is the entry point, deliberately small.

TRIBAL CANNABIS ORGANIZATIONS AND THEIR COUNSEL

Put the E.O. 13175 finding on the record, and make the six-word amendment the unified ask.

CLINICIANS

Understand that a patient using cannabis obtained under tribal license is, today, in possession of a Schedule I substance under federal law, notwithstanding rescheduling. Patient counseling must reflect this.

Conclusion

Tribal Nations built the legal sovereignty to operate cannabis programs. In the author's experience, the clinical infrastructure to sustain those programs has too often not been built alongside them, and few have been offered help to build it.

AG Order 6754-2026 did not merely leave that gap open. It wrote the exclusion into the Code of Federal Regulations, certified that the exclusion has no tribal implications, and identified no tribal consultation in doing so.

The definitional fix is six words and it should be demanded. But a definition only gets a tribe to the door. What gets a tribe through it, in the author's view, is the physician-led clinical infrastructure this paper describes, and that work can begin today, in every tribal health system in the country, without waiting on a single federal signature.

Sovereignty is not enough. Sovereignty plus physician-led clinical infrastructure is the combination that holds.

CLOSING

Scope and Limitations

This is a clinical and policy analysis by a physician. It is not legal advice and is not offered as such. Tribal governments should obtain administrative counsel before acting on any element of it.

AG Order No. 6754-2026 is under petition for review in consolidated proceedings in the United States Court of Appeals for the District of Columbia Circuit. On September 9, 2026, the court denied a motion to stay the order, which remains in effect while the case is briefed.[18] If the order is vacated, state-licensed medical marijuana returns to Schedule I and the analysis in Part One changes materially. Separately, DEA's proceeding on transferring marijuana more broadly to Schedule III was stayed on September 29, 2026 while the judge considered a newly released GAO report. In late October he admitted the report and allowed supplemental briefs but denied reopening the hearing; a recommended decision is pending.[19] Nothing here assumes the outcome of either.

A broader rescheduling would narrow the exclusion but not end it: the expedited registration pathway, the recognition of patient certifications, and the deference to local law would still run only through a state license.

Whether a tribe operating under a state-tribal compact, in a state that maintains a medical cannabis program, could hold or be covered by a qualifying state license is not resolved here. If some tribes qualify by that route and others do not, the result is a two-tier regime among sovereigns, which is a further defect rather than a remedy, and the proposed amendment is intended to address that as well.

The proposed remedy is a policy recommendation. Tribal and federal counsel should confirm whether any statutory change is needed alongside it for particular categories of registrant.

LEGAL AND POLICY STATUS CHECKED THROUGH OCTOBER 27, 2026.

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Published cannabis clinical research cited here, including the work of Dr. Lihi Bar-Lev Schleider and colleagues at Tikun Olam, was reviewed by Dr. Bar-Lev Schleider prior to submission. She confirmed that the citations accurately reflect their findings and approved their use as presented. No co-authorship is implied by citation or acknowledgment.

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He practices in medical cannabis medicine, ketamine-assisted psychotherapy, and primary care, and has served as physician of record for a Florida medical cannabis practice since 2016.

He serves as Board Member and Medical Advisor to the Indigenous Cannabis Industry Association, National Medical Director of Minorities 4 Medical Marijuana, and on the Medical Advisory Board of the National Compassionate Care Council.

In April 2026 he served as medical expert witness before the Permanent Committee of Agriculture, Fisheries and Animal Husbandry of the Parliament of Sint Maarten, delivering a five-pillar clinical framework alongside Grant Thornton and New Frontier Data. He has conducted direct clinical engagement with tribal health systems including the Lac du Flambeau Band of Lake Superior Chippewa Indians and Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin.

He is the author of fifteen published works, eight in English and seven in Spanish, including a second edition, on medical cannabis, integrative care, and public health.

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FROM THE CONCLUSION

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