JOINT HEARING BEFORE THE NEW YORK STATE
SENATE STANDING COMMITTEE ON HEALTH AND
SENATE STANDING COMMITTEE ON CODES

PUBLIC HEARING:

CRIMINAL DRUG DIVERSION OF NON-CONTROLLED SUBSTANCES

TO CONSIDER LEGISLATION CRIMINALIZING THE IMPROPER TRANSFER AND INAPPROPRIATE POSSESSION OF NON-CONTROLLED SUBSTANCES AND THE SUBSEQUENT EFFECTS ON MEDICAID EXPENDITURES AND PUBLIC HEALTH

Van Buren Hearing Room A, 2nd Floor
Legislative Office Building
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12:30 p.m.

PRESIDING:

Senator Kemp Hannon
Chairman
NYS Senate Standing Committee on Health

Senator Stephen M. Saland
Chairman
NYS Senate Standing Committee on Codes

PRESENT:

Senator Martin J. Golden
NYS Senate Standing Committee on Health
NYS Senate Standing Committee on Codes

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SENATOR HANNON: This is the Senate Standing Committee on Health and the Senate Standing Committee on Codes.

Today is June 7th, Tuesday. This is Hearing Room A.

We're starting late because we've been pyramiding with, senate finance laws took longer, senate health took longer. But, Senator Saland, the chair of codes, and myself as chair of health, felt that we should have this hearing.

It's a subject area that has not received sufficient attention. It is about the expanding black market in non-controlled substances.

While everybody is focused on the bigger questions, supposedly, this has been an expanding area. And we have a series of experts to come and check today, led off by our state Medicaid inspector general, James Sheehan.

Then we have the special narcotics prosecutor for the entire city of New York, Bridget Brennan.

We have the -- Peter Jenik, who is the executive deputy commissioner of HRA, in the city.

Then we have the assistant director of the bureau of fraud investigation, Philip Schaffroth.

And, finally, we have the very capable

executive director of the Pharmacist Society of the state of New York, Craig Burridge.

So, this is not as formal as some hearings, but this is an idea of obtaining some information, exchanging some ideas, and trying to see how we can do a better job as a state in each of the subdivisions, and the very important subdivision in New York City, in controlling these items.

Senator Saland, do you have any comments to begin with?

SENATOR SALAND: I'll be very brief, particularly since we are running a little late.

Certainly, the problem of substance abuse and drugs are in the media, day in and day out.

And somehow or other, the idea that there may be this vast market in other medications and prescription drugs seems to go, to a considerable degree, unnoticed, or perhaps not noticed enough, but it is a very serious problem. It is a problem which certainly ripples through our Medicaid system, and one which, hopefully, with the results of today's hearing, may well warrant even greater public attention than it has received to date, and should appropriately be receiving.

And I thank Senator Hannon for his leadership

and willingness to work collaboratively in trying to structure a means by which to better deal with what seems to be an ever-growing, burgeoning problem.

SENATOR HANNON: And Senator Martin Golden, who has a background in law enforcement, and an interest, and continuing interest, in all matters health, on the committee.

SENATOR GOLDEN: I'm just here to be informed, and to help, if any legislation can be brought forward to make some corrections, and to get this under control.

And I congratulate my colleagues, the two chairmen here, from Codes and from Health, in moving this forward.

Thank you.

SENATOR HANNON: Thank you.

Mr. James Sheehan, New York State Medicaid Inspector General.

Thank you for taking the time to come and join us, and share your insights.

MR. SHEEHAN: Thank you, Chairman Hannon.

SENATOR HANNON: A considerable list of items in your background to give us good insights.

MR. SHEEHAN: Thank you, Mr. Chairman.

Chairman Hannon --

SENATOR HANNON: Oh, I just -- we are all being taped. And, so, this R2D2 device opposite you is the cam.

We don't have -- this takes place with stenographers. And, also serves, we'll be putting the hearing up on the senate website.

MR. SHEEHAN: Excellent.

Excellent, I think, as long as it goes well.

Chairman Hannon, Chairman Saland, and Senator Golden, I appreciate the opportunity to speak to you today about the Office of the Medicaid Inspector General.

And I work on the issue of prescription drug diversion.

SENATOR HANNON: Could you pull the mic a little closer?

MR. SHEEHAN: Sure. Sorry.

The Medicaid program, as with other payers, has been impacted by those who seek to profit from the practice of prescription drug diversion.

As the chairman is well aware, we were created to prevent, detect, and investigate fraud and abuse within Medicaid. And I want to talk today about OMIG's work to combat this issue.

Of course, at the outset, I would say that

the vast majority of physicians and pharmacists and Medicaid enrollees are honest, and we're going to focus today on the exceptions.

The issue of prescription drug diversion has been the subject of focus for the department of health for a substantial period of time.

As early as 2002, the department investigated drug-diversion incidents of Serostim, which is an HIV anti-muscle-wasting drug, which is also one of the highest-cost Medicaid-provided drugs.

It was also a popular drug in the body-building industry; very expensive and very difficult to obtain.

In 2003, the state department of health and our predecessor agency investigated a doctor named Mikhail Makhlin, the state's top prescriber of Serostim.

Upon reviewing medical data, the department and those recipients participating, Dr. Makhlin had no history of receiving anti-viral medications or Serostim.

Four of these recipients were identified as having negative HIV test results. And these recipients receiving the drug apparently were reselling it.

As a result of the state's investigation, Dr. Makhlin was excluded from the Medicaid program, had his license revoked, and was ordered to pay -- repay more than $140,000.

And the state department of health placed Serostim on a prior-approval drug list which required the prescriptions receive approval before being filled.

After OMIG was established in 2006, we began to focus on the issue of prescription drug diversion.

In 2007, we identified two recipients who received large quantities of prescription narcotics by a doctor named Michael Chait.

Dr. Chait pled guilty to fraud in the Medicaid program. He surrendered his license, and he was ordered to repay $944,000.

As a result of the work with Dr. Chait, there was an expanding review of recipients using him to obtain prescriptions and narcotics, resulting in a restriction of 23 Medicaid enrollees.

Problem doctors are not the only wrongdoers engaged in prescription drug diversion. Pharmacies are part of this fraud as well.

In 2009, OMIG formed a specialized pharmacy

investigations unit of Medicaid investigators, subject-matter-expert pharmacists, to investigate Medicaid fraud and abuse in pharmacy.

Prescription drug diversion is a principal goal of this unit.

In 2010, we investigated improper behavior and drug diversion as a result of an agency-wide initiative to review Medicaid claims submitted for deceased recipients; which I think I've discussed before, here.

In one case, OMIG identified 46 prescriptions dispensed to 17 deceased Medicaid recipients, all 17 at one skilled-nursing facility.

Upon further investigation, we discovered that the supervising pharmacy consultant, Brian McCutcheon, who owned Echo Pharmacy which serviced the skilled-nursing facility, at the time of the OMIG review, they did not have an in-house Medicaid-enrolled pharmacy.

Mr. McCutcheon created false telephone and fax prescriptions for dead recipients who had resided at the SNF. He funneled those prescriptions to his pharmacy, Echo, and did not dispense or deliver the prescriptions and refills to the SNF.

Echo's records reflect that 35 prescriptions

telephoned into the pharmacy.

The Echo produced four original prescriptions which had the SNF nursing home printed at the top, which had reportedly been faxed to the pharmacy.

We interviewed the physicians, and they said they use their own individual prescription pads; would never use the SNF's prescription pads.

They also stated, they had never seen, and had not signed, the false prescriptions.

As a result, we did an inventory review, which is one very common technique in this area, to compare Medicaid claims and invoices from wholesalers.

Echo was unable to demonstrate adequate quantities of purchased drugs to match its Medicaid billings.

Mr. McCutcheon and Echo Pharmacy were excluded from Medicaid, and they were required to repay $269,000 to the state.

At the end of 2010, our pharmacy investigations unit began an inventory-verification review initiative.

These types of reviews look for pharmacies with significant surges in billings over short periods.

We looked at new pharmacies that bill Medicare [sic] several million dollars in one year as compared to the neighboring pharmacies.

We do "CVRs," credential verification, and look at purchase information for their top 10 drugs.

Again, the concern is, that pharmacies are buying drugs from elicit sources or gray-market sources.

If the pharmacy has billed more than they purchased, we test out our drug-diversion theory.

At this time, the initiative uncovered two pharmacies with discrepancy in their inventories; in one case, upward of a quarter million dollars, and another with a similar substantial amount.

But the key here is, we expect to find, when we go in, that the invoices that come from wholesalers exceed the Medicaid purchases. And what this allows us to do, is to identify both the organization and individuals involved in the diversion.

Pharmacy investigations also looked at another pharmacy, Loving Pharmacy, storing prescription drugs for non-clients with other pharmacy labels on the bottles, all right, and storing medications without any labels; all of these

activities in violation of the law.

And this can be indicative of a pharmacy buying drugs from non-authorized sources, and then using those sources to fill prescriptions for its own customers.

The pharmaceuticals were seized by the [unintelligible] department of education, and Loving Pharmacy was excluded.

In addition, there's also involvement of Medicaid recipients.

In cases of recipient involvement, OMIG places the recipient on what's called "restriction"; limiting the individual to just one doctor and one pharmacist.

In the last reporting year, OMIG saved New York State 433 million from restricted recipients. And that, basically, is a comparison of the medical purchases, primarily pharmaceuticals, before the restriction, and the amount of drugs, and other things, used after.

This year, OMIG investigated a recipient we will call "John Doe," for drug-diversion activities.

Doe confessed that he was approached by another individual who promised to pay Doe between 300 and 400 for her [sic] prescription refilled.

This seemed like a pretty good business to Mr. Doe, and he began to recruit other recipients for this activity.

He offered other recipients $50 to $100 to borrow or rent their benefit cards.

He took the cards, had prescriptions printed in each borrowed-recipient's name. Went to the pharmacy to fill them. Convinced the pharmacist that he was an AIDS activist, filling and picking up the prescriptions for the different recipients.

What we discovered was, that, his prescriptions were put on stolen blank prescription pads.

He cost, we think, at least $20,000.

He was placed on "restriction referred."

We're working with local enforcement to track down other members of this drug-diversion ring.

Recipient restrictions have -- as we said, have allowed us to place 2,579 recipients on restriction, primely based upon pharmaceutical abuses.

During the same calendar year, over 9,000 recipients had restriction at some point during the year.

We're pleased to be joined here today by

representatives of the New York City's Human Resources Administration and the special drug prosecutor.

We have active relationships with these offices, and with the DA's office in Manhattan.

Just last one -- last week, one case was jointly developed against a physician named Suresh Hemrajani, resulting in an indictment based upon $700,000 case of fraud.

According to the indictment, Dr. Hemrajani had been prescribing AIDS drugs for patients who did not suffer from AIDS, and falsifying lab tests to pave over his activities.

These are high-cost drugs. The retail value, per recipient, is over $1,500 a month, which should explain why they're in such high demand.

Dr. Hemrajani involved a number of recipients in this practice. And we're continuing to look at both the recipients and other physicians.

Governor Cuomo has shown great leadership in tackling the issue of Medicaid fraud and abuse.

His Medicaid redesign team, on which Chairman Hannon participated, was successful in finding ways to reign in spending on the Medicaid program.

The changes encompassed within the MRT proposals, such as the requirements for long-term pharmacies to dispense drugs in smaller quantities, and the transition of much of the pharmacy benefit to managed care will yield reductions and opportunities for diversion.

OMIG will also be developing new activities as a result of the Medicaid redesign team.

Proposal 154-5 has the goal of allowing OMIG access to the cash-payment prescription data currently corrected [sic] by the bureau of narcotics enforcement, which will allow us to identify Medicaid recipients who are paying cash for medications, especially narcotics.

It will also allow us to restrict and refer recipients to local districts and law enforcement.

Thank you, Senators, for the chance to speak today.

I'll be happy to answer any questions you may have related to the prescription drug diversion and OMIG's work.

SENATOR HANNON: In jumping to what the press usually does, is: So, Mr. OMIG, how much does this cost the state every year?

MR. SHEEHAN: This is --

SENATOR HANNON: Do you have any way of quantifying?

Because I'm going to get asked that. And I've looked at all of different numbers here, and it looks pretty difficult.

MR. SHEEHAN: It's very difficult for us to quantify. This is an activity which is cyclical.

The FBI's first investigation of health care was a prescription drug diversion -- a series of prescription drug diversion cases back in the early '90s.

It really respond- -- it's a very marketplace driven activity. It responds to the cost of drugs and the availability of expensive prescriptions.

So, it seems to me the key is, to make sure that you're looking at the data to stay on top of what's going on, and also your reacting to the street information.

SENATOR HANNON: The -- it's the street -- I would guess, part of the major tool of detecting is knowing which drugs are susceptible to diversion. And -- because, at the beginning, we had the human -- the stuff for the bodybuilders that was --

MR. SHEEHAN: Right.

SENATOR HANNON: But this is getting to be

much beyond that. It's just not used for another purpose.

MR. SHEEHAN: Uhm -- the -- right, the key here is, if you look at the average wholesale price of a drug, or the stated price of a drug, and compare it to what's -- if you have a source of free access to get the drug, you look for the margin that you're going to make.

So, the drugs we would focus on are drugs which have very high average wholesale prices and are in common use.

And there are a lot more high-priced drugs than there were 10 years a ago.

SENATOR HANNON: And, then, part of the diversion is not diverting from, say, the AIDS community to the bodybuilding community, but now it's recycling it back into the rogue pharmacy?

MR. SHEEHAN: Well, it's the -- the recycling issue has been around for a long time. And one of the difficulties is, that, in 19 -- the Prescription Drug Marketing Act, back in about 1990, said to the FDA: You have to develop pedigrees for drugs. So, we want to make sure, if drugs are brought into pharmacies or sold through wholesalers, we can tell where they came from.

The FDA took no action on that until 2006.

And when they did, they said, pharmacies don't have to look at this issue. It's focused on the wholesalers, and which ones didn't get the drugs from the manufacturers.

So, part of the difficulty is the loophole that federal law has allowed to exist.

SENATOR HANNON: And has that been filled in now by the FDA?

MR. SHEEHAN: The FDA --

SENATOR HANNON: Are they starting to?

MR. SHEEHAN: -- in 2006, they issued new regulations which apply to wholesalers, which do make it somewhat easier. But the pharmacies are not required to do anything with that.

Does that make any sense?

SENATOR HANNON: Yeah.

And the requirements are things, like, bar coding everything, and every package?

MR. SHEEHAN: It's -- actually, it's what's called "a pedigree," which is a document identifying the source of prescription drugs.

SENATOR HANNON: Oh, so it's not on the drug itself. It would be, like a bill of lading?

MR. SHEEHAN: Right -- well, essentially,

yes.

And, in addition, the FDA issued guidance last year, concerning what you're thinking of, which is: How do you identify the product by bar code and for physical reading?

SENATOR HANNON: So, okay.

All of which, so, we're in an evolving area as we're moving forward with this?

MR. SHEEHAN: Well, I think some of these issues are being addressed.

We certainly are addressing it at OMIG in terms of the fraud issues. But some of the control issues are federal.

SENATOR HANNON: And do you have enough tools?

I mean, you talked about excluding people from the Medicaid program, which is a determination, I believe, you issue.

But, also, limits on utilization.

Is that another formal action?

MR. SHEEHAN: Right. That's -- we take what's called "a restriction action."

We review the recipient's medical history, and then it's reviewed by medical professionals. And then we issue a decision, which says,

"You're hereby restricted to one physician and one pharmacy."

SENATOR HANNON: And how complicated and lengthily a process is that?

MR. SHEEHAN: It was -- it has been pretty complicated in the past.

"MRT," the Medicaid redesign team, created a shorter path to the same result, which we think will be very helpful in undertaking these activities.

SENATOR HANNON: Thank you.

SENATOR SALAND: Just a couple of questions, and they're not necessarily related, your response to some of the questions from Senator Hannon.

The discussion has basically been delving into an issue as an intrastate issue.

And, is there, to some extent, interstate, or given our proximity to Canada, international ramifications to this issue?

MR. SHEEHAN: One of the issues the FDA has faced -- they have a task force on drug diversion and counterfeiting -- is that it's not a state -- it's not, you know, these drugs are fungible. They go across state borders.

And the question is: How do drugs get in the distribution system, whether they are from the

activity we're talking about today, which is diversion; or counterfeit; or improper importation?

All three of those are -- contribute to this, what's called "the gray market."

SENATOR SALAND: And if I could just, unrelated, but piggyback onto some question that Senator Hannon asked: When you're dealing with providers, as distinguished from recipients, I noted in your testimony, in one instance, somebody lost their license.

What is the range of sanctions that you are able, either to recommend or to seek?

And, to the extent that there are criminal aspects or sanctions, is that within your realm, or does that befall a district attorney's office that you work cooperatively with?

MR. SHEEHAN: The criminal sanction is within the responsibility of the Medicaid fraud control unit, the attorney general's office, and the district attorneys for each district. And, of course, the special prosecutor for narcotics in New York City.

So, we -- when we identify the probable cause, or a suspicion of fraud, we'll refer those cases to those agencies, and work collaboratively

with them.

We also work with the U.S. Attorney's Office and task forces throughout New York State.

So, the remedies we've talked about -- the remedy of exclusion; the remedy of restriction; the revocation of licenses, which takes place in education or in the office of professional medical misconduct -- is within the state executive branch.

The criminal prosecution is within my colleagues in the prosecutors' offices.

SENATOR SALAND: Thank you.

SENATOR HANNON: Senator Golden?

SENATOR GOLDEN: Thank you, Mr. Chairman.

The matrix that you use, the criteria for that matrix, is that different than, downstate, upstate?

Is it -- and how is it -- how do you get, and set, that criteria?

MR. SHEEHAN: Are you -- Senator Golden, are you speaking of, for providers, or for the recipient restriction?

SENATOR GOLDEN: Both.

MR. SHEEHAN: For the providers, I can't say we have a matrix. We consider all the evidence. There are cases that are different enough, and we've

tried to develop the evidence and follow where it leads.

With respect to recipient restriction, we use the same model throughout the state, which is, primarily, a data analysis and medical-record review.

So, that it would not differ, depending on the county.

SENATOR GOLDEN: And that matrix is updated monthly, from --

MR. SHEEHAN: Well, it's -- I wouldn't say monthly.

As improvements occur, as we see -- one of our questions always is: Where do our cases -- successful cases come from?

And, so, it's a collaborative process, to say:

How many pharmacies should this -- do we see patients going to?

How many physicians do we see them getting prescriptions from?

SENATOR GOLDEN: And you have enough dollars there for the technology and for the matrix and for the criteria that you created? And, you're able to create cases, based on the dollars that you have and

on the technology?

MR. SHEEHAN: Senator Golden, would you try that question again? I'm having trouble hearing.

SENATOR GOLDEN: On the dollars that you have presently, and the workforce that you have --

Pardon me?

SENATOR SALAND: Closer to the mic.

It's terrible acoustics.

Brand new, and terrible here.

SENATOR GOLDEN: The cases that you presently worked, the technology that you use for the matrix, and the criteria that you've created, is there enough technology? is there enough money? do you have enough dollars? to be able to do these overlays, this matrix, and be able to come up with the cases that you need?

MR. SHEEHAN: We've been very fortunate, Senator, in two ways.

First, is: We have access to, I think, the best tools of any state in the country, on these issues.

So, we have an excellent data warehouse.

We have a salient product which has been very helpful to us in looking at these kinds of patterns.

In addition, because New York is the largest

Medicaid program in the country, and because we have $200 billion worth of stored data about claims, vendors in this area come to us, and say: We will come to you for free, and we'll show you how our product works, so it will help you to identify the issues.

We've been taking advantage of those in the last couple of years, very aggressively.

SENATOR GOLDEN: Thank you.

MR. SHEEHAN: And taking advantage in a positive way.

SENATOR HANNON: Thank you.

SENATOR SALAND: Thank you.

MR. SHEEHAN: Thank you, Senators.

SENATOR HANNON: Appreciate your time and your insights.

Bridget Brennan, special narcotics prosecutor for the city of New York.

Whoever printed these cards up; the reason I hesitated, instead of saying, "prosecutor," it says "prospector."

[Laughter.]

SENATOR HANNON: Now, you're joined, with -- by...?

MS. BRENNAN: I'm joined by my executive

assistant district attorney, Christine Hammond, who's worked very hard on legislation in this area.

SENATOR HANNON: Great. Welcome.

SENATOR GOLDEN: I have to excuse myself, Mr. Chairman. I've just been called to a meeting.

SENATOR HANNON: Okay.

SENATOR GOLDEN: Thank you.

SENATOR HANNON: This is a busy day, so, excuse us.

You're going to make a presentation. And I believe that people will be able to see it on the sides there.

MS. BRENNAN: Okay.

Thank you very much.

I greatly appreciate the opportunity to address this committee.

And I want to thank, in particular, Senator Saland and Senator Hannon for their interest in this area.

It is a growing problem that we are facing, day in and day out.

I'm the special narcotics prosecutor for New York City.

Typically, my office prosecutes felony narcotics crimes throughout the five boroughs of

New York. And, we come to this area almost by accident.

[Slide being shown.]

My agency has identified an escalation in the diversion and abuse of all prescription drugs, controlled substances and non-controlled, over the past five years.

We're facing an epidemic of abuse of opiate drugs, like oxycodone and Percocet.

Because these drugs are opiate-based, with the same primary ingredient as heroin, they're considered narcotic drugs when not properly prescribed and used for medicinal purposes.

My office is bringing more criminal prosecutions involving these opiate-based prescription drugs throughout New York City than ever before.

In New York City last year, for example, we surpassed 1 million prescriptions for oxycodone alone in 2010, that, in a city of 8 1/2 million people. Enough oxycodone to fill one prescription for every eighth man, woman, and child in that city.

Overdose deaths related to prescription drugs continue to soar.

The city health department noted a 20 percent

increase from 2007 to 2009.

And our caseload in my office involving criminal investigation into the diversion of prescription drugs has tripled over the past three years.

And, so, as I say, we come to this area almost by accident.

Against this backdrop, my office has run into a startling oversight in the state law when it comes to the sale and resale of non-controlled substances.

[Slide being shown.]

Just by way of background: Non-controlled substances are generally non-addictive. And, so, they are not generally the subjects of the cases that we typically bring.

However, these drugs can be highly expensive medications, like HIV drugs or asthma drugs or cholesterol medications.

And when I speak of "diversion," I'm talking about the distribution of these drugs, not by pharmacists who have obtained them directly from a pharmaceutical company and maintained them under conditions carefully specified by the manufacturer.

I'm referring to organizations which purchase prescriptions from people, often Medicaid

recipients, then repackage the drugs and sell them in any number of retail outlets.

We have seen non-controlled substances sold in bodegas, storefronts, which maintain them in far from sanitary conditions, and then resell them.

We have also seen unscrupulous pharmacies repurchase these drugs on the black market, and use them to fill legitimate prescriptions, often billing Medicaid a second time for the same drugs which were already purchased.

We have seen criminal organizations collect and stockpile these drugs, sometimes, we believe, for shipment to overseas sellers.

I would like to show you what we have found, evidence we recovered, in a case about one year ago.

[Slide being shown.]

$4 million in pills recovered in Yonkers. All these drugs were non-controlled substances.

Nearly 6,500 bottles of illegal prescription drugs, carrying a street value of $4.25 million, are pictured here.

And as I say, we come to these cases almost by accident.

In this instance, we believed we were investigating a very high-level narcotics

organization that was running an organization throughout New York City.

It had all the same hallmarks of a narcotics organization: a hierarchy, certain counter-surveillance techniques, a lot of money was changing hands.

And we obtained a search warrant for this location, only to find that it was stockpiled with 6,500 bottles of prescription medication, but all non-controlled substance.

The list of drugs that we recovered in this case fills 45 pages.

In this case, that we worked with the drug enforcement administration -- because, as I said, we believed we were on to a narcotics organization that was operating in New York City -- we arrested two individuals.

Once we inventoried the drugs that we had, and found that we had no narcotic drugs, and not even any controlled substances, substances like, Ambien, which might be typically abused; and, therefore, fall under the jurisdiction of some state statute, we realized that what we had was mere possession of a non-controlled prescription drug, which is prescribed, which is prohibited by no

statute in New York State.

We contacted the Westchester DA's Office. They couldn't prosecute the case.

We contacted federal authorities.

And, this had been going on for some time now.

And we recently learned that they did not believe that they were going to have sufficient evidence to be able to prosecute this case.

What we believed was happening here, was that, these drugs were being collected from numerous people who were using either Medicaid or insurance, but not paying substantial amounts of money for these drugs.

There were collection points.

These drugs were then being collected by middlemen, and brought to, what we would call, in narcotics terms, "a stash house"; where, then, the drugs were being repackaged, so that they would look like they were in pristine condition, and that they could be sold back to a pharmacy.

Now, what we don't know, is where these -- exactly where these drugs were destined, after we -- or, were destined to be retailed, because we had no leverage over those defendants whom we arrested, and

attempted to commence a prosecution.

And so, then, we couldn't learn -- neither, could we really learn their organizational structure, in terms of stockpiling the drugs; nor could we learn where these drugs were intended to go.

Obviously, that's critical information.

This is a huge amount of drugs. And they are not being handled under the conditions which would be recommended for these drugs.

And, if these drugs would then be distributed, it certainly has the potential for jeopardizing the health of thousands of New Yorkers.

And this is not the only case like this we have seen. We have, in a sense, stumbled into these cases in my office, time and time again.

And that is why I'm so pleased that you have called this hearing. And that you are also inviting our partners in this, who we have been talking to for the last two years, since we really began to focus on the oversight in the law with respect to these drugs.

Remember, to criminal organizations, anything that is worth money is fair game.

And these drugs are worth very substantial

amounts of money.

Let me show you just one drug.

[Slide being shown.]

This drug, we had, I believe, hundreds of boxes of this drug. This is an AIDS drug.

We had half a million dollars.

Each box of this drug that we recovered, based on our inventory, was worth one-quarter of a million dollars.

And we had two boxes of this, this drug alone.

And to criminal organizations, you see, they have clearly identified a failing in our oversight system, which is worth $4.5 million to them, and they have little to no exposure.

And, clearly, they are exploiting it, at great cost to all of us.

You've already heard from Inspector General Sheehan, with regard to the issues for Medicaid cost. And Medicaid dollars are precious now.

But, there are huge costs in terms of public health.

We are well aware of stories throughout the nation, of drugs that turned out to have been

diverted, but end up in legitimate pharmacies and are obtained by people who have illnesses.

By diabetics who take insulin, which has not been maintained under the conditions that it was supposed to be maintained, and their blood sugar escalates to very unsafe levels.

These kinds of stories we have heard again and again.

So, the issue is, basically, two-pronged:

There is certainly a major public-health issue that we're seeking to address with this legislation.

And, in addition, there's a major Medicaid cost, and insurance cost as well.

[Slide being shown.]

The drug diversion is so rampant on certain street corners, like this one on 157th Street and Broadway in Manhattan, which has become known as a spot where people can sell all of the prescription drugs they have collected through whatever means they might employ.

Through theft, through fraudulent prescriptions, those are the primary ways that we see.

"The New York Times" ran a story on this

particular corner.

[Video-still being shown.]

And this particular corner is a source of many complaints in Manhattan. So many, that the police have put up a surveillance camera on the corner because, people, ordinary citizens, complain, that, when they leave a pharmacy, they're accosted by someone asking them to sell them their prescriptions.

So, I would like, at this point, if you would allow me to have Christine Hammond explain to you the kind of operation that you -- we typically see, and you'll see how much it mirrors our typical drug-dealing organizations.

Christine?

[Video playing.]

MS. HAMMOND: What you have here is a surveillance tape. It goes about two minutes.

You'll see a subway exit there.

That is the location where many people are accosted for their drugs if they happen to have a Duane Reed bag in their hand.

This gentleman, here, is -- you're going to see, he has a prescription bottle in his pocket that he's about to sell.

He's connected to these two gentlemen that are walking in front of him. They're going into this doorway, here, where it's a little hard to see because the picture is small.

But, they're going into the doorway, where the -- they're looking -- the gentleman who is buying the prescription medication, is looking at the bottle -- right here, you can see, he's looking at the bottle -- to make sure that it's sealed, because it has less value if it's not sealed. It's harder to sell back into a pharmacy if it's opened.

And, so, they have made the exchange. The man in the blue shirt has given it to the man with the sleeveless T-shirt.

This second man, here, is now coming out and giving him the money.

You're going to see in a second, the exchange of the money.

This gentleman, here, is now -- has the prescription drugs. The man in the black shorts has the prescription drugs in his pocket.

And they're now walking off.

The gentleman in the black shorts is going to be walking off, up the street, to bring that sealed prescription bottle to the stash house, which you

saw. Bridget Brennan showed you pictures of the stash house. That's -- would be where you gather the drugs.

And, these -- there's several people here, who are all part of this organization, buying the prescription drugs, waiting for people to walk up.

This is 157th and Broadway; well-known in this business, for where you go if you want to sell prescription drugs that is non-controlled.

And, now, the guy we call "the runner," has walked up the street and taken the drugs to the stash house.

MS. BRENNAN: So, you see at this stage, we have no real effective laws to address this particular issue.

We have diagrammed for you, the basic outline of the scheme.

[Slide being shown.]

Medicaid recipients receive the drugs -- get the drugs from the pharmacies, sell them to street dealers who pay a fraction of the costs that Medicaid is paying.

The drugs are collected at stash houses.

From those stash houses, they can go to any number of points for redistribution.

Some of the drugs, if they're the opiate drugs, may be siphoned off and be used in street deals.

Some of the drugs, we believe, may be going overseas. Some may be going to online pharmacies.

Some may be going to legitimate pharmacies. They do sometimes have the identifying information altered so that they can get them back into the regular chain.

But, in any event, obviously, that's not my area of expertise.

My great concern is, we can't find out where those drugs are going. And we have no effective means of addressing this problem.

And not only do we see it from the public-health perspective, and the perspective of protecting our public resources, but, also, ordinary citizens complain about it.

At this point, I would like to turn the microphone over to Christine Hammond, so she can describe to you the statute that we have been working on with some of our partners who testified here today, or will testify here today, that we believe might address this legislative oversight.

SENATOR SALAND: May I interrupt for a question?

MS. BRENNAN: Yes, sir.

SENATOR SALAND: And perhaps either of you, or Mr. Sheehan, might: Is there ever a set of circumstances, that you might be aware of, where: A legitimate producer, a major pharmaceutical house, is producing the, X, Y, Z, drug, and they have more product than they can market; and, they dumped that product, either in another country, someplace else; and, they dump it at such prices, that are so below the market here, that it becomes attractive for somebody else to buy that product, bring it back here, even without any criminal intent?

Is there such an industry or business process?

MS. BRENNAN: I wouldn't be able to answer that question.

SENATOR HANNON: It's called Canada.

MR. SHEEHAN: Senator Saland, I have looked at this issue previously, in my past job. And the -- there's what's called "the gray market."

All right?

And that's, basically, those are -- that's product that wholesalers are marketing to hospitals

and to pharmacies, which did not come directly, officially, from the manufacturer.

So, that gray market does exist.

And --

SENATOR SALAND: Is that part of this illegal trade? Or is that --

MR. SHEEHAN: In certain circumstance --

SENATOR SALAND: -- is there any oversight to that?

MR. SHEEHAN: In certain circumstances, it is legal to engage in those transactions.

As we talked earlier about the pedigree issue? If you buy from that kind of a wholesaler, if the wholesaler is selling that drug, he or she has to maintain a pedigree, saying where the drug came from.

And, obviously, it has to be accurate. It would be a violation of FDA law.

SENATOR SALAND: So, there's a paper trail, there's registration, there's --

MR. SHEEHAN: That's the theory.

But if the problem is at the pharmacy level, they don't have to maintain the pedigree, under federal law.

Thank you.

I interrupted. I'm sorry.

MS. BRENNAN: No, that's all right.

I'm just going to give a brief overview of the bill that has been introduced by both of you.

SENATOR HANNON: Closer to the mic.

MS. HAMMOND: Oh, sorry.

I'm just going to give a brief overview of the bill; it has three parts.

One is: An enhancement of the criminal diversion of prescription medication.

[Slide being shown.]

The second is: A new Article 179, which deals with fraudulent prescription dispensing and procurement of non-controlled prescription medication.

I think one of biggest challenges of this bill is just giving its title.

The next part of this bill is Article 219, which deals with the unlawful possession of non-controlled substances.

I'm just gong to go through those briefly.

[Slide being shown.]

Article 178, as you probably know, has been around for many years. And it basically deals with the sale, for money -- unlike a drug deal, which

does not require actual money exchanged -- the sale for money of prescription medications.

And that is, essentially, a misdemeanor.

What it does not have, and where we needed an enhancement, is for the people who are buying those prescription drugs; the guy in the black pants that you saw in the video, the guy who's doing it all day long, and buying from Medicaid recipients.

A Medicaid recipient might just show up once a month when they get their prescription.

The guy in the black pants is there, doing it all day long. And, the current law does not cover him sufficiently.

[Slide being shown.]

So, we put in enhanced penalties for multiple sales.

We put in a provision to allow an undercover, to buy, or to sell, the drugs without reducing the penalties.

And we also put in extra penalties if a physician or a pharmacist is involved in this diversion of prescription medication.

We also looked at good-faith exceptions, of course, for Good Samaritans.

Someone, who, for example, is bringing a

prescription medication home to grandma, something like that, we certainly would not want to criminalize that kind of Good Samaritan behavior; nor for wholesalers who are transporting the drugs.

[Slide being shown.]

The second piece that we worked on was this new Article 179, which has a title that's quite a mouthful.

I broke it into three pieces, just for the ease of describing it.

One is: Fraudulent prescribing.

And this is completely new.

So, it is -- it criminalizes someone prescribing drugs, whether or not they're a physician, if they're not authorized to issue a prescription.

If you are authorized to issue a prescription, but you know the person to whom you're prescribing the medication has no medical need for it, or it is not issued in good faith.

For example: Willful blindness.

We see some of these doctor mills, where doctors are not asking any questions before they prescribe medication.

And the penalties are higher for licensed

physicians, and for repeated conduct.

[Slide being shown.]

The case that Inspector General Sheehan just mentioned, that was in the newspaper just on Friday, dealt with a doctor exactly along these lines.

He was writing HIV prescriptions to people who came in, and simply said, "I have HIV."

No tests were done. It was never verified they were actually sick.

And that allowed these Medicaid patients to get into the circle of, getting the Medicaid to pay for their prescriptions, into the stash houses, and back into the black market.

[Slide being shown.]

Fraudulent dispensing is another piece of it.

This is aimed particularly -- primarily at the pharmacies.

This is where, if the pharmacist knows, and has reasonable grounds to believe that the person receiving the medication has no medical need; or, if the prescription -- knowing, and has reasonable grounds to know, the prescription was forged; or, was not issued by a physician in good faith.

This last provision is of, we have seen examples where doctors and pharmacists are working

hand in hand.

An unscrupulous doctor is working with an unscrupulous pharmacist, would be a good example of that.

There are higher penalties for licensed pharmacists than non-licensed pharmacists.

And higher penalties for repeated conduct.

[Slide being shown.]

Finally, within this one -- Section 179, we looked at criminalizing fraudulent procurement.

These are people who are submitting the prescriptions, and receiving medication, knowing that they have no medical need for it, or knowing that the prescription was forged.

And, again, there are higher penalties for repeated conduct.

[Slide being shown.]

We've seen any number of examples of fraudulent procurement; people who are in the business of submitting forged prescriptions.

We have seen one case, where, a gentleman would call in prescriptions, posing as a doctor.

And I believe that Phil Schaffroth has some great examples of the lengths to which they go to pose as doctors.

We included in the recent amendment to the bill, electronic prescriptions. This is a new thing that we're seeing that doctors are using.

I think the criminal element is still learning how to use this, but I fully expect that, shortly, that will be part of the criminal process.

So, we included that.

We also included prescription forms.

We've seen, in a case that Bridget Brennan had, where, the sale of blank prescription forms.

You can imagine how powerful that is; to sell a blank prescription form, because then you can write anything in it you want.

And, so, we wanted to make sure that that was covered by the statute as well.

Here is a typical prescription form.

[Slide being shown.]

It is not something that can be duplicated on a color copier.

It has many different items that make it hard to counterfeit. It's got a bar code. It has various things on it, that, if it you rub it or touch it, it changes color.

So, they are quite valuable.

[Slide being shown.]

Finally, the provision has, in Article 219, this is the one that deals with unlawful possession of non-controlled prescription medication.

As Bridget Brennan said, there was no crime to charge for that $4 million worth drugs in that one location.

So, in this context, we certainly created a good-faith exception for physicians, pharmacists, and Good Samaritans.

But the penalties increase with, value, and the quantity of the medication possessed.

So, for example: The lowest level, which is a misdemeanor, is someone who possesses, 20 pill, or medication worth more than $200; going up to the highest, which is a B felony, of 10,000 pills with a value of over $100,000.

Those "possession" statutes will help us to prosecute and investigate runners, like the gentleman in the black shorts, all the way to the person who had the 4.25 million worth of prescription drugs in their stash location.

And, so, we are very happy that you are supporting this bill. And we think there's a great need, and it will save the state a great deal of money.

Thank you.

MS. BRENNAN: Thank you very much.

I would like to also make mention of the great help that we have received from the bureau of narcotics enforcement.

As we have had more and more cases in this area, we have found them to be just a tremendous resource. Extraordinarily helpful, dedicated.

And I wanted to make sure to acknowledge their hard work at this hearing.

I would be happy to take any questions that you have.

SENATOR HANNON: To what extent will their people say: We have legitimate reasons to have drugs that are not prescribed to us?

Do we have things that are transferred within a family? Do we have clinics? Do we have -- I mean, are there any legitimate reasons that there will be objections raised?

MS. BRENNAN: We've tried to address this in the language of the bill, with Good Samaritan exceptions, with that sort of language crafted into the bill.

We're happy to work on it further.

Obviously, that's not our intent. We

don't -- we have no interest in capturing that sort of an individual.

Our real concern is, both, to protect the public health, and to provide a mechanism for addressing this huge issue of siphoning off precious Medicaid dollars.

SENATOR HANNON: In a similar vein, would we have objections from pharmacies who say, We didn't know"? Or from wholesalers who said, "We didn't know"?

Is there -- does this arise?

MS. BRENNAN: Again, we tried to build in the language.

I'm going to let Chris speak to that, specifically.

MS. HAMMOND: Well, one of the elements of the crime, which, as you know, as prosecutors, we have to prove every element of a crime beyond a reasonable doubt.

And one of the elements would be, that the pharmacist, or whoever, knew, or reasonably should have known, that these bad acts were happening.

So, it is not someone who is clueless. Because, we understand, in many instances, a perfectly legitimate pharmacist will not know any of

this.

So, this is solely for a pharmacist who knows that they are dispensing medication, based on a forged prescription, or based on a prescription written by a doctor who knows that the patient is not ill.

But they have to know, and we have to prove that beyond a reasonable doubt.

SENATOR HANNON: Because I can think of other reasons, causes, for incentives to have drugs enter the system, if, once it's already established.

You could have people trying to label as a proprietary drug, something that is actually generic; so, that, it does have the same effect, but it may cost one-tenth of the price.

Or, something that's totally fraudulent, but is introduced, and it's -- it is falsely identified.

And, so, people can monetize that type of elicit behavior.

MS. BRENNAN: Yes, I don't believe, specifically, that this bill would address the issue with respect to mislabeling the drugs.

I have seen other state statutes which have done that in other states, but this bill would not address that issue.

SENATOR HANNON: No, I know you're trying to fill the gap.

But, I'm just trying to think of, once you have the system going, then people can take advantage of the system, that that four-cornered chart that you had, showing how you can get money out of this whole thing.

MS. BRENNAN: Yes.

I mean, clearly, there is a lot of public money at stake. And criminals look to exploit any advantage that they can in the system, where they see some weaknesses.

And they've identified a weakness here, and they're trying to exploit it.

SENATOR HANNON: Yeah.

And, while we've had the inspector general talking about Medicaid, I would imagine, given the fact that we have a very thorough, it doesn't -- it's not 100 percent, but it covers 80 percent of the people in the state, as simple as, private health insurance.

So, I would imagine, the same type of fraud is being conveyed to -- and they're supposed to have investigative units in each of the private plants.

Have you worked with them at all, or contact?

MS. BRENNAN: It has come up in some of our cases. And we have worked with them from time to time.

You're absolutely right, that it's not -- the issue is not Medicaid per se.

The advantage that's exploited, is that, someone else is paying for the drugs.

And, then, the individual obtaining them can turn around and sell those drugs at no cost to himself, and he's made money.

And we have worked with different private insurers.

It's a very difficult area to work in, but we have -- it has come up in some of our cases.

SENATOR HANNON: Thank you.

Thank you very much.

SENATOR SALAND: Just, briefly: Your possession counts, your lower counts, your misdemeanor counts --

MS. HAMMOND: Yes?

SENATOR SALAND: -- would they apply, if, for example: You had a vial of Nexium which had been prescribed to you; I'm a Nexium user; you are no longer using Nexium because you've switched to something else, and you gave it to me?

MS. HAMMOND: If I gave you more than 20 pills, or it was worth more than $200, it might.

We were trying to find a line, where we understand --

SENATOR SALAND: But assume no money exchanged.

MS. HAMMOND: No, I understand.

Yes, it would not be money exchanged.

We understand that people do share medication, at some limited level. Of course, there is health implications to it.

But, we were trying to find the -- the amount above which. I just can't imagine the people sharing that large number of medications.

But, this is what we've been discussing, to try and find that.

SENATOR HANNON: It is absolutely amazing what people have on hand.

I, and many of my colleagues, have been having "Shed the Med" programs.

MS. HAMMOND: Yes.

SENATOR HANNON: And the police have picked up on those. I think they had a universal one.

Standing there on a Saturday morning, watching people walk up to us -- now, we have a

police officer to handle the diversion -- shopping bags of drugs that have been left by their parents who died, or they had an illness and they don't have it anymore.

It's just astounding how much is out there.

So...

MS. BRENNAN: It is absolutely astounding. And I think it's great that we have those drug take-back programs, for all kinds of reasons, including a pattern that we've seen among groups of young people, which is, people bring handfuls of prescription drugs in, just have, pill parties; pharma parties.

You know, the best practice is, just to get rid of what you're not using.

SENATOR HANNON: I thank you.

We have a couple more folks.

MS. BRENNAN: Thank you so much.

SENATOR HANNON: I really appreciate all of your hard work, and your time to come up here. And, that's a very effective video.

MS. HAMMOND: Thank you.

SENATOR SALAND: Thank you.

SENATOR HANNON: Next joining us is the executive deputy commissioner of HRA, Peter Jenik.

And he's going to testify with Philip Schaffroth, who is the assistant director of the IREA Bureau of Fraud Investigation.

MR. JENIK: Thank you, Senator.

SENATOR HANNON: Thank you for taking the time.

MR. JENIK: Thank you for inviting us today to speak here.

We're going to give you an approach of what the city is doing to combat prescription fraud.

The bureau that oversees this was formed some 30 years ago. And over the years, we have seen changes in welfare fraud.

SENATOR HANNON: For the record, "HRA"?

MR. JENIK: Human Resources Administration of New York City.

SENATOR HANNON: Of the city of New York.

MR. JENIK: The department of social services.

SENATOR HANNON: Okay.

And, then, Philip, would you give us the full identification of "IREA," and the agency you're with.

MR. JENIK: No, IREA is the parent of HRA.

It's called "Investigation, Revenue, and Enforcement Administration," which I oversee.

And Phil works in the bureau of fraud investigation that handles and investigates all criminal actions within the social services program.

SENATOR HANNON: Thank you.

So, you're both, HRA, city of New York.

MR. JENIK: Right.

SENATOR HANNON: Thank you.

I just wanted to put that on the record.

MR. JENIK: What a mouthful.

So, we're going to take an approach of what we're doing in the city.

And as I was saying before, the bureau, which was founded over 30 years ago, was to investigate potential fraudulent activities in the welfare system.

[Slide being shown.]

In 2000, we came together, and we saw that the people who may prey on the system changes their approaches, and we have been tracking that over the years.

It came to light that we were seeing more activity in the Medicaid program.

We sat down, and we decided at this point of time, we should get together with our partners in the state and city.

[Slide being shown.]

We set up a meeting with the department of health, the Medicaid fraud units, and this has grown into the special narcotics in the office of the MEG -- OMIG operation, and Jim Sheehan's operation.

We primarily looked at clients, what was happening in street, and we took that approach. But, the approach we wanted to do, was to take the providers, because the clients lead to providers, and everyone's involved in this.

So, we then put a team together and took the approach.

So, when we do investigations at this present time, we invite all these parties in, with us, to do the investigation. We bring the OMIG in, we bring the local prosecutor, or we'll bring in the special narcotics.

We work with the NYPD very closely because they have a great intel on the ground, and funnels investigations in to us. But we also are working with the FBI task force, on Medicare, and various other agencies, such as the DEA and other state

agencies.

[Slide being shown.]

Just to give you a little highlight: Since the program started in 2000, over 2,600 arrests have been conducted. And way over 95 percent of people have been convicted in this area.

We've restricted, by recommending to the state, to put 6,000 people on restrictions.

And we have identified $35 million of fraudulent diversion of prescriptions, where we actually get a forge, or we know that the prescription was diverted.

And over -- the $7 million of cost avoidance by putting people on restriction. Then, by closing down bad doctors or pharmacies, we do save money in that way too.

MR. SCHAFFROTH: I'd like to discuss how I think this problem originated.

What happened, going back some time, probably in late 1990s, drug dealers saw an opportunity out there to approach Medicaid recipients at methadone clinics that had obvious drug problems.

They saw the recipients had drug problems, and they'd have benefits to pay for the drugs that they were able to obtain.

So, what they did initially is, they would get all the forged prescriptions. And at the time, they would use -- they could go in for a prescription for, like cough medicine, to a doctor, white-out the information, and then --

SENATOR SALAND: Excuse me, may I ask you, as I should do, to pull your mic just a little closer.

MR. SCHAFFROTH: Sure.

SENATOR SALAND: Thank you.

MR. SCHAFFROTH: So, what they did is, they would go into a doctor's office, get a prescription for cough medicine, then white-out the information on the prescription, and then write it for whatever medication they want.

The state addressed this issue by making state-issued prescription pads.

[Slide being shown.]

However, the problem has continued because what they now do is, they pay -- they pay people to go in and dress up as doctors, to go into clinics. They approach the cleaning crews that work in these locations. They pay them $100 per prescription, to -- and that's not for a pad. That's per prescription, which there's no charge. There's no real charge if someone steals the prescription pad

because there's no value designated towards it.

They also address -- they also have people who are working in doctors' offices, that are making minimum wage, and they'll pay them a certain amount of the money to steal the prescriptions for them.

And, then, if the doctor's office calls -- I mean, if the pharmacy calls the doctor's office, they answer the phone and verify the prescriptions.

In addition to this, what happened is, they would approach the people at the methadone clinics and ask them to fill a forged prescription. And they'd pay them, like, maybe, between $50 and $100 to fill the forged prescription, at which time, these medications that they were writing for were non-controlled substances.

Initially, the majority were controlled substances at first. But then there was a switch to non-controlled, because they realized that there were no real charges to be able to be generated against them for them possessing this.

The medications range -- and it's not just AIDS medications. They range from, approximately, $400 of one prescription, to $13,000.

So, they saw an opportunity to take these -- to sell these prescriptions back -- put it in the

black market and sell it back to pharmacies.

Now, a pharmacy who would -- might traditionally buy a medication from the manufacturer or the distributor, for a $13,000 medication, they would, traditionally, have to pay, let's just say, 12,900, to give an example. So, maybe they'd make $100 profit on a prescription.

But, if they could buy it from the black market for $6,000, then they're making a $7,000 profit per prescription.

So, what they do now is, they create what's called the "wish list."

[Slide being shown.]

And, the wish list is a list that's given to the stash houses and the buyers on the street, to -- what drugs they're looking for for that particular month.

These filter down, from the stash houses, to the street people that you saw in the video.

Those street people then give it to bodegas and storefronts throughout the entire city, because this black market is so vibrant, that it's all over the city.

So, where its initial point is, is that, the Medicaid recipients, besides the forged

prescriptions that they were filling and selling to the writers, that would eventually make its way to the black market, these people are now selling their legitimate medication that they need to take.

And they might take, instead of -- if they -- if they're HIV positive, rather than take the medication, maybe it's a prescription for medication with five refills, they'll take the -- they'll sell the first four, and then take the final one, so, if they go to the doctor and they're tested, it will show in their blood system that they are taking the medication, when, in actuality, they're not, and their conditions are worsening. And, then, they're prescribed the medication again.

But, these medications that they sell on the black market work its way back through the whole filter, to -- eventually, to the stash houses, and then back to the pharmacies.

Now, what these stash houses are doing, is, they prefer sealed bottles. And what they do is, they remove the label off of the bottle -- the manufacturer bottle.

[Slide being shown.]

And they do this with a lighter fluid. And the lighter fluid removes the label from the --

removes the pharmacy label without doing any damage to the manufacturer label.

So, once the label is peeled off, the rest of it evaporates, and it looks like it's in pristine condition, for them to sell back to the pharmacy.

[Slide being shown.]

Now, we come across -- some of the health risks that we're seeing is, like I said, the -- we're talking about: Expired medication here. We're talking about spoiled. We're talking about contaminated.

Some of these stash houses are -- the conditions that these medications are found on, at the time:

Loose pills sitting out on a table, past the expiration date.

In a hot trunk of a car, once we -- we've had some pull-overs, where we find medication kept in a trunk that's probably 120 degrees, way past the point of spoil.

So, when someone like me or you goes to pick up a legitimate medication, or our families, we're potentially buying medication that's spoiled, expired, and won't work for us, that's been paid for multiple times, over and over again, by the

taxpayer.

[Slide being shown.]

This is an example of -- now, what we're finding is, when we come into the stash houses, like Christine addressed earlier, the charges that apply for possessing this are non-existent.

And the only way we're able to get to the next level of finding out the pharmacies, is, we're finding these logbooks that are kept in the stash houses, indicating how much their payout to the pharmacy is, what they're getting for each medication, the names and numbers of the pharmacies.

If we do not find these logbooks, there's no leverage over these people to get any information with regards to the next level.

And we've had several confidential informants that have worked closely with us, that were part of the -- part of this organized crime, part of this drug-diversion family, here, which they've updated us, that, they're told to say that these medications, at time of arrest -- because they know they're going to be out tomorrow -- that these are being diverted overseas to family members, and being sold over there.

When, in actuality, that's not the truth.

That's the story they're told to tell.

These are all going back to pharmacies, according to multiple sources, and according to these logbooks that we found in these stash houses.

[Slide being shown.]

This is one of the first cases, "Operation Fraud Way," back in 2000, at which, if you look at the medication, some of those are in loose bags.

Those are the medications that are being rebottled, resealed.

They actually have resealing equipment to put it in, so it looks like it's in pristine condition; where, they cut the tinfoil, reseal it to the bottle, put it on, and it looks like it's in fine condition.

They pay a little bit less for the unsealed bottles because they have to do the extra work, but they're still paying for these pills out on the street.

In addition to this, this is -- this case, back in 2001, we found $1 million worth of medication in this stash house.

The medication that we found, that was only collected in one month's time.

So, back in nineteen ninety -- back in 2001, this medication cost the taxpayers $1 million. That's only for one month.

This operation was going on for well over a year. So, that's $12 million, right there, from that stash house.

This was the first of many stash houses to come.

[Slide being shown.]

[Slide being shown.]

[Slide being shown.]

This is a recent takedown, which I can't give too much detail to because the case is still active.

It's a $10 million stash house that we took down in April of 2011.

$10 million, like I said, once again, of the taxpayer money, this was only one month's worth of medication.

We could tell by the dates on labels that this was gathered only in the last month.

So, this stash house is bringing in $120 million of our taxpayer money, on a regular basis, per year.

And this is the stuff that's going back to the pharmacies.

This has become so prevalent, that, the people on the black market, the area that Christine showed in Washington Heights, it's probably about a seven-block radius, where -- originally, this was where all the medications that were gathered throughout the entire city.

If it was bought in a bodega, the bodega would eventually -- like, a bodega in Brooklyn, it would eventually be brought back to Washington Heights and sold to these individuals here.

What happened is, gangs got interested in this. And they'll go around the perimeter, and they'll buy the medication from the recipients before they ever reach the center core.

As soon as they buy it, they'll take it, go one more block in, and sell it.

Now, these people are wise to not buy controlled substances, because they know of the charges that they can face by buying the controlled.

They know not to carry weapons, but they do have enforcers; what they refer to as "enforcers."

If there's an issue out there, where they feel their life is in danger, or someone's going to rob them, they call an enforcer down, that carries a

weapon.

And they'll come down, he'll flash his weapon, to let you know that, you know, this is going to be handled, and taken care of.

So, there is a lot of violence that overlays into this also.

[Slide being shown.]

We had a case recently, March 2010; it was a stash house that originally started off in Washington Heights, and made its way over into Jersey.

And there was a complaint from one of the people; it was in an apartment in New Jersey. They received a complaint, that they could smell gases coming through the floor. So, they called the local police.

The police showed up at the apartment, knocked at the door, and three individuals wearing gas masks opened the door.

When they opened the door, they saw all the -- the entire apartment was sealed with plastic, to try and prevent the gases from going up. And they found, at that time, $5 million worth of medication.

Now, the boxes that you see there, at the top

left-hand corner, with the yellow containers, that's the lighter fluid that I referred to earlier, used to remove the labels.

These people make approximately $500 a day, just from removing these labels from this medication.

These prescriptions -- all these prescriptions that were found, came from New York City at this particular thing. So, they moved outside, so as not to raise anyone up in Washington Heights because that is an interested of target.

The black market has become so prevalent, that, like I said, the health risks of these people, some that are on legitimate medication, and the fact that, we could potentially buy, and our family members buy, this medication back, is a true problem.

The forged prescriptions that are going on, these people become -- that are still going on for the non-controlled substances, they're stealing blank prescription pads, which doesn't have the doctor's information on it.

They'll get from it a hospital, because --

SENATOR HANNON: Aren't they supposed to be using forge-proof prescription pad?

MR. SCHAFFROTH: Yeah, it's forge-proof, but what happens is, they're sent to hospitals that might have, maybe, you know, 50 or 60 doctors at the hospital.

So, what the hospital will do is, they'll buy a box of prescriptions, the state-issued pads, but it doesn't have the doctor's information printed on it yet.

They're able to get these prescriptions. And what they're doing is, they're printing the legitimate doctor's name on there, the legitimate doctor's license number; or, what they're putting down is, the drug dealer's phone number on there, so that, when they actually call to verify the prescription, at the pharmacy, they're calling the drug dealer up who is verifying.

They've taken it one step further in regards to, they will call the doctor's office, the drug dealers being, and they'll record the message from the drug dealers onto their voice mail, so, if they don't pick up, you're hearing a doctor's voice, saying that you've reached the doctor's office and that he can't get to the phone right now.

And, then, they're able to put the prescriptions through.

The phone-in prescription is another huge issue because there's no restrictions in regards to, you don't have to steal the pads in the first place. And what they'll do is, they'll call multiple pharmacies, maybe 12 pharmacies. And whoever has the medication in stock and says it can be ready in 5 minutes, that's the pharmacy that they go to to fill it.

Now, they know they're not going to receive a call back because they're calling from the doctor's office in the first place.

There's a website that exists out there that people are able to go through, and use the website, so it shows that the phone call being placed is coming from the doctor's office.

If they were to look at their caller ID, the phone number will come up as the doctor's office.

And, they're able to alter their voice through this website.

And, so, there's no reason for these pharmacies to call back to these locations and verify these prescriptions.

And, then, if it's going take anywhere over

an hour, because they know we normally take, you know, an hour to get there, to respond to a forged prescriptions, they're filling the prescription at whichever pharmacy will give it to them the quickest.

So, this problem is -- it's out of control at this point. And there's nothing really to move up to, to the pharmacies, to get anything on them.

SENATOR HANNON: Suppose they have one of these prescription pads.

Is there any chain used for non-controlled substances, to determine -- absent an investigation, is there anything for them to fear, that there's going to be any tracing of these forged prescriptions on the, quote, non-forged prescription pad?

MR. SCHAFFROTH: Is there any change for them to fear?

SENATOR HANNON: "Chain."

MR. SCHAFFROTH: Chain?

SENATOR HANNON: Chain of authenticity of the prescription.

MR. SCHAFFROTH: The only thing is, if a prescription pad is stolen, doctors are required to report to the bureau of narcotics enforcement that

the pad has been stolen.

And those numbers can be, like, you know, you can be alerted that "this pad" was stolen.

However --

SENATOR HANNON: Hence the report, the state DOH?

MR. SCHAFFROTH: "B&E"; bureau of narcotics enforcement.

Problem being, is that these people are wise to this. And when they steal pads, they -- sometimes, they'll steal from the middle of the pad. They won't use the initial numbers.

So, they'll leave the pad behind, they'll steal the bulk of it, and the doctor doesn't even realize it.

But there's so many people within the doctor's office that are involved in, the ordering of the pads, securing the pads, that these people are involved. They're making minimum wage. And they'll sell these pads for $100 per prescription.

Because of, you know, if you can get $400 to $13,000 per prescription, it's an investment worth investing in.

SENATOR HANNON: Thank you.

This is very rich, in terms of the

information, and very deep. And the implications go to the -- obviously, the criminal law, the tools you have.

And, then, to think -- for instance, I would think we have to tighten up the way the hospitals get this.

They certainly have new doctors coming in waves, once a year. But, there has to be exceptions to that, but it doesn't have to be as loose.

And, of course, the forge-proof prescription is just a recent innovation, three or four years old, at least for New York State.

MR. SCHAFFROTH: Yes.

SENATOR HANNON: So, that would be --

MR. SCHAFFROTH: Thank you.

SENATOR HANNON: Appreciate it.

MR. SCHAFFROTH: Thank you very much.

SENATOR SALAND: Thank you.

SENATOR HANNON: Craig Burridge, the Pharmacists Society of the state of New York.

MR. BURRIDGE: Good afternoon, Senators.

Thank you for allowing the pharmacists society to speak on this issue.

It's near and dear --

SENATOR HANNON: Well, after you heard the

testimony before you, you see why it was a logical thing.

MR. BURRIDGE: It's been something that we've supported, actually, for a number of years. We've gotten the language put in several different governors' budgets. It's always been pulled out.

And, you know, it is a frustration with our members.

And, you know, over our 132 years as an organization, you know, this society, and certainly my predecessor, who is sitting behind me, has been involved.

We've worked the bureau of narcotic enforcement. In fact, three years in developing the serialized form through the New York State Pharmacy Conference, which we gather with Medicaid and with the board of pharmacy, schools of pharmacy, and all the pharmacy organizations, about four times a year.

This is the process we use to make sure this was a workable form. Unfortunately, it's not without its bugs.

One of the -- as my -- my tenure as consecutive director, which has been a little over 18 years, I've heard this story from pharmacists,

frustrated by the shortcomings of the present statute to deal effectively with the organized version of prescription medications, that begins with an individual standing outside the pharmacy, offering to buy prescription drugs for cash.

Now, we refer to these street vendors as "backpackers," as they almost always have a backpack on them, and are known -- or, just a single word, as when spotting a potential seller, and that's "Medicaid."

In fact, a few years ago, one of our independent pharmacy owners down in New York City succeeded in getting law enforcement to show up, because he had a backpacker who was outside his pharmacy every day.

He had him arrested, but he was back on the sidewalk the same day, before he closed his pharmacy.

Extremely frustrating.

And, then, this is when we started to investigating, well, why was this individual being, basically, slapped on the wrist and let go?

And what we found was, that the possession of prescription drugs for the purpose of resale, and we were just astonished ourselves, that, in most cases,

this was just considered a misdemeanor, even though the average backpacker, when he was busted, had $44,000 worth of drugs in their backpack.

So, you know, when -- and the only way it was a felony under current law, was if the street price was $1,000. And they couldn't use the aggregate of the drugs in the backpack, but only a single product.

So, those authorities that have successfully prosecuted diversion rings tell us -- again, they're the ones that told us about the average bust and what was in their backpacks -- one of the things we did, prior to the OMIG being created, we contacted the Office of Medicaid Audit and Control, and we asked the state officials if they had any idea how pervasive this was in the selling of Medicaid drugs.

And at that time, the Medicaid auditors believed that the value of the diverted medications could be as high as 10 to 20 percent of the entire Medicaid drug budget.

10 to 20 percent; if you looked at, in terms of today, $5 billion is somewhere between a half -- half a billion and a billion dollars a year. And based on some of the numbers I've been hearing, they may not be too far off.

Recently, I spoke to an OMIG staff member, and the estimate he worked on, on patient diversions. And he said it was approximately 15 percent.

So, we're somewhere between 10 and 20 percent; so we're talking hundreds of millions of dollars.

And the shame is, and what has been said is, some of these patients actually need these medications, but somehow they need -- they prefer the cash.

We've had instances where I have had a pharmacist tell me, they've had HIV patients who, again, will sell their medications for a couple months, take it the third month. And, again, this is to buy heroin, and which is how they got HIV in the first place.

So, it's a very distressing situation.

Well, based on a number of reports when we reached out to our members, we really reached out more to our New York City-based independent pharmacy owners, what we understood from them, was that the New York City police did not routinely respond to them when it involved a backpacker or a diversion case. And this was very frustrating to them.

And we -- certainly, we look to work with law enforcement.

I recently met with the DEA on one of the take-back programs. It's really to have a number that pharmacies can call to get this resolved.

So, this frustration caused PSSNY to more -- or, led to our advocacy.

And what happened was, several years ago, we were invited, some of our members, to a meeting -- an informal work group on drug diversion, comprised of, federal law enforcement, and state officials from Medicaid audit control, the bureau of narcotic enforcement.

And this is where, one pharmacy owner described the following:

He said, "Each day, at the same time, a white non-descript van would stop at the street corner, collect a full backpack and switch it for an empty one."

And after months of investigations, I understand, there were five wholesalers in North New Jersey that were arrested and prosecuted.

It is not easy for a pharmacist to know whether or not a medication has been through the gray market.

I had a pharmacist call me, this was earlier this year. He was very concerned.

He said, "You know, I just have three bottles I just got from my wholesaler, sitting on my shelf."

And he said, "I noticed they didn't have the manufacturer's insert attached to them."

That's -- that describes the drug, the chemical compound, if there's any black box.

And he said, "Should I be concerned?"

And I said, "Well, why don't you bring one of the bottles over to the phone."

And I said, "Hold it up to the light and see if you can see any kind gumming on there, like, if there was a label."

And he said, there was.

He said, "Obviously, there was a label on these bottles."

I said, "You need to contact that wholesaler."

He didn't get any discounts on this. He paid the regular price. It came in his bin with all his other medications. But, it was just these three bottles that did not have that manufacturer's insert.

You know, they either come in the box, or

they're attached to the bottle.

So, that's probably one indicator; if it's sitting on the shelf without that insert, that it probably came from the gray market.

Now, we are -- first of all: We are gratified that the senate is taking a close look at this issue.

We did have one concern, under S5260A, and that was with the section, 179.10, paragraphs 2(A) through -(D). And I did discuss this on the prosecution. This has to do with fraudulent prescription dispensing.

Here's our concerns: And, it's not so much that we think that pharmacists would be prosecuted for this for unknowingly.

It's, we're more concerned about, what's the OMIG going to do if there was an investigation started on a pharmacy, to see if there was anything?

You know, would they be automatically cut off from Medicaid? -- which could literally put them out of business before there was any result to the case.

But -- there is a reason one.

In paragraph 2(A), prescriptions do not require that a diagnosis be listed.

Something we've ask for, we've had

legislation in, where the medical society does not like that.

We would prefer to have a diagnosis code. It's a patient-safety issue as well.

Any prescription written on a New York State-issued serialized forms are considered to be valid.

Again, we have all the checkpoints on them.

Pharmacists do not have access to a patient's medical record or diagnosis. And the dispensing pharmacy should not make a diagnosis determination at the pharmacy counter.

The pharmacists are responsible for judging whether a prescription is valid, based on, information available from the patient, in the patient's profile, and on the prescription.

When in doubt, the pharmacist must contact the prescriber and/or may refuse to fill the prescription.

By the way, this happens hundreds of times a day.

We have had pharmacists murdered; stabbed to death right in their doorway, stabbed to death when leaving their pharmacy, for refusing to fill prescriptions.

Robberies are up, I think, 1,300-plus this year alone, nationwide.

Secondly, in paragraph 2(B), it is a professional misconduct for a licensed pharmacist to dispense a prescription drug, with the exception of an emergency supply, without a prescription.

Pharmacists who dispense a medication without a valid prescription would be sanctioned by the Office of Professional Discipline. And would then likely be listed as disqualified from Medicaid and Medicare in a follow-up action by the OMIG.

Again, this is the concern, is, the follow-up action, you know, being charged, but never convicted. And, then, losing your Medicaid and Medicare business, which basically puts you out of business.

Paragraph 2(C); PSSNY supported the initiative to create official New York State serialized prescription forms as a way to prevent prescription forgeries.

OMIG estimates the Medicaid savings from this forgery prevention initiative is 50 million a year.

That was the initial estimate that we got from these forms.

Unfortunately, the system, and as you heard

earlier, is not 100 percent foolproof, as prescription pads can be stolen.

Typically, if a full pad is stolen, the prescriptions are written, and it's sent into the pharmacies, typically, within a 24-hour period.

In these cases, PSSNY has cooperated with B&E by notifying all pharmacies in surrounding counties via our e-alert system.

And that would be pharmacies that are obviously members ours and set up for our e-alert.

We also do a fax alert, which gets out to the majority. And we typically saturate the area.

We've used this system in the past when serialized forms were just for narcotics, for controlled substances. And we're able to work very closely with the DEA on that.

In fact, when a prescriber reports a stolen pad to either the board of pharmacy or the department of health, to B&E, the prescriber, in many cases, is also referred to PSSNY so that the serialized-number sequence gets on out to the pharmacies as quickly as possible.

We, typically, if that pad comes in, that e-Alert is sent out immediately. We don't -- you know, we have a person in the office who is

dedicated to that. We typically have the numbers, and we put our members on notice.

And, finally, in part of 2(D), at the point of dispensing, it is not possible for the dispensing pharmacist to determine whether or not a prescriber is acting in good faith.

Several times in past, PSSNY has asked Medicaid officials to add a hard-edit, so that a prescription claim would be denied immediately if the prescriber had been disqualified from the Medicaid program, even if the prescription is written a valid state-issued serialized form.

This request has not yet been implemented.

But, one other thing that we found out that's occurring, we had a doctor in the Hudson Valley area, who was, in fact, "DQ'd," disqualified, but he had his "NPI number," national provider identification number, on it, and not his license number. And he was only DQ'd under his license number.

And he was chewing out one of my pharmacists for not filling it.

Well, the pharmacist knew he was disqualified. And he said, "I cannot" -- "I can't submit this."

He said, "You submit this under the NPI number," while he refused to fill that prescription.

So, we are working.

We did mention this at the Medicaid Pharmacy Advisory Committee, and also the OMIG, that this is something we need to have included in any disqualification list, the NPI number of the prescribing, so, if they're DQ'd, they're DQ'd under both identities.

We find that this legislation is very complex, but do applaud your effort to address a serious problem that wastes taxpayer dollars.

But, we just remain concerned about that section. We think some of it can stay in.

I think there's issues in the area that just pharmacists have absolutely no control over. And, certainly, can't read the mind of the physician as to intent of that prescription.

One of the things that we think that's going to really help in this, is, really focusing on recipient fraud and criminal diversion of prescriptions, targeting those individuals.

Again, I was down in Manhattan a few years ago. I was going to a fundraiser at the Sheraton New Yorker.

I stepped out of my cab, with my son, and we heard "Medicaid." And there was a backpacker standing in front of Duane Reed.

They typically stand, where there's four corners, or there is an exit into the subway; someplace where they have multiple routes of escape.

And my son turned, thought he was speaking to him, and he said, "What did he say?"

I said, "He said 'Medicaid.'"

I said, "Wait till that door opens. If they have a pharmacy" -- "a prescription bag in their hand, he's going to say 'Medicaid.'"

Well, then, a woman stepped out with a prescription bag, and he said, "Medicaid."

So, we know it's still going on.

And, by the way, that occurred several years after that large bust in Jersey, where they were tracking this organization.

One of the other things, too, is that the OMIG staff, or 650 employees, they don't have very many working on recipient fraud.

And I understood, one was laid off. I spoke to him yesterday.

You know, we think that that needs to be beefed-up a little bit, and that the penalties

should be stiffer.

I know get routed to a pharmacy. But, again, there are some good tracking things.

You know, when you get that information -- if you can catch these people when it's in the backpack, or in their pocket, all the information is on there: the dispensing pharmacy, the doctor's name, and patient's name.

And I think, if there's a pattern of physicians, you can find it.

The other thing that I would suggest to law enforcement, is, really work with us.

We get phone calls all the time; a pharmacist's looking out his window. He sees a line going around the corner to a physician's office. People going up, and coming out with a fistful of prescriptions, like, two minutes later.

You know, and he said, "This is going on all day."

They're more than willing to throw them under the bus, but they have to be protected, because it's dangerous for them.

I had a pharmacist who turned in a bodega, for purchasing -- he knew was purchasing diverted prescriptions.

And it turned out, I think the bodega was doing about $50,000 a week.

And the owner came in, after him, and he threatened this pharmacist and his family.

And, then, the pharm- -- and when the man -- well, first of all, he said, "I had nothing to do with it."

Well, when he left, he looks up on the wall, and there's his license, that he's required by law to post, with his home address right below it. Right there on the wall.

So, he was calling me, to ask if there was some way he could block that and not get in trouble with the board of pharmacy.

Which, the board of pharmacy said, you know, they understand that now, and they're going to allow a pharmacists to have that left off of any renewals they want in the future.

But, that's how concerned he was with his own safety, and that of his family.

So, again, focus on the backpackers.

I think, if you -- because you have people selling legitimate prescriptions, for the money, for drug use, or whatever.

If you focus on making it tough for that

person who is buying it, and you cut off the source of them selling it, those that need the prescriptions, if there's no place for them to sell it, they're going to use them, hopefully. They'll be adherent with their drug regiment.

And the other thing, too, is, people stop stealing pads if you make it difficult for, you know, them to sell it.

And, again, for a society, we've been around a long time. We're more than happy to work with anybody through -- we have that New York State Pharmacy Conference.

I would certainly invite New York City to sit in on that.

I know a lot of the state agencies do.

We typically have -- our next meeting will be in September. And I'll get their information, and share that with them.

And I'm open for any questions.

SENATOR HANNON: Well, thank you, because you've provided a greater nuance to this. And it's obvious that this statute is necessary.

I mean, I think you pointed out some of the problems with it, when you're dealing with trying to -- for a pharmacist, and others, to determine

this injective intent of others; or, you know, have reasonable cause to know a doctor is not acting in good faith.

But, those are evidentiary standards, and they have to be addressed.

And I do think this is necessary. And I think, given the breadth of the diversion that has been outlined this afternoon, that there needs to be some careful thought as to, how we go forward.

What's the system, from retail, but, all the way back to the manufacturer, and say, you know: Everybody who's legitimate, that's fine. But, it's a straight line.

But, obviously, there's a lot of diversions along that straight line.

MR. BURRIDGE: And we understand.

Certainly, we've been working with Assemblywoman Paulin on her legislation, with the whole tracking of the drugs, right to the bottle, right into the pharmacy, to the patient.

We don't -- you know, our concern with that, right now, is really cost.

There are so many different ways of tracking prescriptions, whether it be a microchip; whether it be a three-dimensional, two-dimensional, barcoding.

Or, we had one particular gentleman that invented a DNA-type ink, which means, each bottle would have its own marker.

There are markers we're talking about placing in the actual pill, much like they do with explosives.

So, we're looking at that.

The problem that we have at the pharmacy level is, you may have, like, a primary wholesaler, or you may have two or three other wholesalers. But, if you've got 15 different ways of tracking it, you can't have 15 types of software, because, you have to pay for that software every year, you have to pay for the scanning devices.

SENATOR HANNON: We'll get there at some point.

MR. BURRIDGE: Yeah, so, it's an issue.

But, thank you very much.

SENATOR HANNON: Thank you very much.

Any concluding remarks?

So, I thank you very much.

I'll ask that the hearing be drawn to a conclusion.

And, I thank you very much for listening.

There has just been an absolute rich amount

of information for us to work on.

And, thank you.

(Whereupon, at 11:30 a.m., the joint hearing of the Senate Standing Committee on Health and the Senate Standing Committee on Codes was concluded.)