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THE DRUG ENFORCEMENT ADMINISTRATION'S ROLE IN COMBATING THE OPIOID EPIDEMIC

TUESDAY, MARCH 20, 2018

House of Representatives

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2322 Rayburn House Office Building, Hon. Gregg Harper [chairman of the subcommittee] presiding.

Members present: Representatives Harper, Griffith, Burgess, Brooks, Collins, Barton, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Clarke, Ruiz, Peters, and Pallone (ex officio).

Also present: Representative McKinley

Staff present: Jennifer Barblan, Chief Counsel, Oversight and Investigations; Mike Bloomquist, Staff Director; Ali Fulling, Legislative Clerk, Oversight and Investigations, Digital Commerce and Consumer Protection; Brittany Havens, Professional Staff, Oversight and Investigations; Christopher Santini, Counsel, Oversight and Investigations; Jennifer Sherman, Press Secretary; Alan Slobodin, Chief Investigative Counsel, Oversight and Investigations; Austin Stonebraker, Press Assistant; Hamlin Wade, Special Advisor, External Affairs; Christina Calce, Minority Counsel; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; and C.J. Young, Minority Press Secretary.

Mr. Harper. We will call to order the hearing today on the Drug Enforcement Administration's role in combating the opioid epidemic.

Today, the Subcommittee on Oversight and Investigations convenes a hearing on the DEA's role in combating the opioid epidemic. This crisis is a top priority of the nation and certainly of this committee and subcommittee.

Opioid-related overdoses killed more than 42,000 people in 2016. That's an average of 115 deaths each day. An estimated 2.1 million people have an opioid use disorder.

Since our earliest hearing in 2012, this subcommittee has been investigating various aspects of this epidemic.

In May 2017, the committee opened a bipartisan investigation into allegations of "opioid-dumping," a term to describe inordinate volumes of opioids shipped by wholesale drug distributors to pharmacies located in rural communities, such as those in West Virginia.

From press reports and this investigation, we have learned of opioid shipments in West Virginia that shock the conscience. Over 10 years, 20.8 million opioids were shipped to pharmacies in the town of Williamson, home to approximately 3,000 people.

Another 9 million opioids were distributed in just two years to a single pharmacy in Kermit, West Virginia, with a population of 406.

Between 2007 and 2012, drug distributors shipped more than 780 million hydrocodone and oxycodone pills in West Virginia.

These troubling examples raise serious questions about compliance with the Controlled Substances Act, administered by the DEA. The CSA was enacted through this committee in 1970.

This law established schedules of controlled substances and provided the authority for the DEA to register entities engaged in the manufacture, distribution, or dispensation of controlled substances.

The CSA was designed to combat diversion by providing for a closed system of drug distribution in which all legitimate handlers of controlled substances must maintain a DEA registration, and as a condition of maintaining such registration must take reasonable steps to ensure their registration is not being used as a source of diversion.

The DEA regulations specifically require all distributors to report suspicious orders of controlled

substances in addition to the statutory responsibility to exercise due diligence to avoid filling suspicious orders.

This hearing has two goals. First, the subcommittee seeks to determine how the DEA could have done better to detect and investigate suspicious orders of opioids, such as the massive amounts shipped to West Virginia.

The DEA has acknowledged to the committee that it could have done better in spotting and investigating suspicious opioid shipments.

What were the deficiencies and has DEA addressed them? DEA has a comprehensive electronic database containing specific information at the pharmacy level.

Could DEA use that database more effectively to investigate diversion and to facilitate compliance for the regulated industry?

The second goal is to find out whether the current DEA law enforcement approach is adequately protecting public safety. DEA statistics reveal a sharp decline since 2012 in certain DEA enforcement actions, immediate suspension orders, or ISOs, and orders to show cause.

The number of ISOs issued by the DEA plummeted from 65 in 2011 to just six last year. Former DEA officials alleged

in the Washington Post and on CBS' "60 Minutes" that the DEA's Office of Chief Counsel imposed evidentiary obstacles and delays for ISO and for orders to show cause submissions from the DEA field.

The conflict between the DEA lawyers and the DEA investigators allegedly resulted in experienced DEA personnel leaving the agency and a loss of morale.

The goal of laws regulating controlled substances is to strike the right balance between the public interest in legitimate patients obtaining medications in a timely manner against another weighty public interest in preventing the illegal diversion of prescription drugs, particularly given the rampant and deadly opioid epidemic throughout the nation.

Our investigation is intended to assist the committee's continuing legislative effort to strike the right balance. It is unfortunate that it's been a battle to get information out of the DEA.

We have made recent progress with the DEA, but at this time our investigation still does not have the full picture. DEA has made some commitments that should hopefully help the committee gain the information it needs, and we expect the DEA to honor those commitments.

And I welcome today's witness, DEA Acting Administrator Robert Patterson. We have serious concerns about policy that we need to discuss today. But we are steadfast in our support and certainly want to salute the dedicated workforce at the DEA. We need an effective DEA in this crisis.

I want to thank the minority for their participation and hard work in this investigation, and I now yield to my friend, the ranking member, Ms. DeGette.

Ms. DeGette. Thank you so much, Mr. Chairman.

And I am happy to kick off the whole series of hearings with the Energy and Commerce Committee this week with this oversight and investigations hearing.

Opioid overdose is now the number-one cause of unintentional death in the United States. Every day we hear reports of Americans dying and leaving loved ones, often children, to pick up the pieces, and these reports are heartbreaking.

The crisis has also had an economic toll. Estimates are that it's cost this country a trillion dollars since 2001, and here's the point at my opening statement where I show that Congress can still be bipartisan because today I want to talk, as the chairman did, about our committee investigation,

examining exactly how the opioid epidemic developed.

Our investigation, as the chairman said, focused on West Virginia, which has the highest opioid death toll in the nation. The numbers that we are seeing coming out are simply shocking.

A major 2016 news investigation, for example, reported that distributors shipped 780 million opioids to this state between 2007 and 2012.

Again, in five years, they shipped 780 million opioids to this small state of West Virginia. Now, we focus on West Virginia but I am hoping that the lessons we learned will apply nationwide, including in my home state of Colorado.

Administrator Patterson, I join the chairman in welcoming you here. We have a lot of questions and we'd like to know what you think failed us in West Virginia and, more importantly, what we can do to avoid this again.

We know something had to have gone wrong. For example, in DEA's own court filings, in 2008 the distributor shipped one pharmacy in West Virginia 22,500 hydrocodone pills per month. But our investigation also found that a number of pharmacies were sent even many times more that amount.

For example, the chairman talked about Kermit, West

Virginia. We looked at one pharmacy in Kermit, which has a few hundred people. Drug distributors supplied this pharmacy with more than 4.3 million doses of opioids, more than 350,000 per month in a single year, and then the next year 4 million doses of opioids.

What on earth were people thinking? Now, when the DEA finally shut down this pharmacy and took its owner to court, the owner admitted at its height the pharmacy filled one prescription per minute. I mean, who could think that this was a legitimate use?

News reports from the time describe pharmacy workers throwing bags of opioids, quote, "over a divider and onto a counter to keep pace."

One law enforcement agent noticed a cash drawer, quote, "so full the clerk could not get it to close properly." And this was not the only pharmacy to receive such massive quantities of opioids.

In another example, between 2006 and 2016, distributors shipped over 20 million doses of opioids to two pharmacies in one town of 3,000 people.

I want to know if the DEA thinks that this amount of pills sent to these pharmacies was excessive. In addition,

the Controlled Substances Act and applicable regulations required the distributor to tell DEA how many pills that distributor sold and to what pharmacies.

DEA compiles this information into a database called the Automation of Reports and Consolidated Orders System. It's called ARCOS.

I want to know how the DEA made use of ARCOS data from 2006 on and whether it relied on that data to monitor the number of pills that distributors sent to West Virginia.

Did the DEA perform analytic assessments of the pills the pharmacies received? Did it look at how many pills distributors sent to a town or region as a whole? And if so, I want to know why the DEA didn't act to stop these shipments.

I want to know whether the distributors themselves exercised appropriate due diligence before sending millions of pills to pharmacies.

For example, in a letter sent to all drug distributors in 2006 and 2007, the DEA gave them a list of circumstances that might be indicative of diversion, all of which plainly require distributors to know their customers before shipping them any opioids at all.

I want to know if the drug distributors met this standard when they shipped those pills to tiny West Virginia and, similarly, did the distributors comply with their obligations.

And I want to know also what the DEA is doing right now to stop painkillers from flooding our communities today.

We have had a lot of hearings on this, Mr. Chairman, but this is the first one to look in a hard way at this crisis developed.

We spend billions of dollars -- we spend countless hours of law enforcement time trying to stop illegal drugs from coming into this country and here we are, sending millions of doses of opioids to tiny little towns in West Virginia, all of this supposedly legally.

I think I can speak for the whole committee to say this needs to stop, it needs to stop now, and we need to figure out how we are going to protect our constituents and our citizens.

I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the chairman of the full committee, Chairman Walden, for purposes of an opening

statement.

The Chairman. Thank you, Mr. Chairman, and thank you for your leadership on this very important issue to the people we represent.

For nearly a year, this committee has been investigating how inordinate numbers of pills were shipped to pharmacies in rural West Virginia. The numbers that we have seen thus far, as you've heard, Mr. Patterson, are nothing short of staggering -- more than 20 million prescription opioids shipped to a West Virginia town with a population of fewer than 3,000 people.

Another West Virginia pharmacy, in a town with a population of fewer than 2,000 people, received an average of 5,600 prescription opioids a day during a single year.

As part of our investigation, we have also looked at the Sav-Rite pharmacies in Kermit, West Virginia, a town with a population of about 400.

During last October's full committee hearing, I asked your colleague at the DEA a very straightforward question: which companies provided the Sav-Rite number one pharmacy with so many opioids that it ranked 22nd in the entire United States of America for the number of hydrocodone pills

received in 2006?

After an extended and unnecessary delay, we finally received the DEA data and now know the answer to that question. But this isn't the end of the matter, however.

We have learned that in 2008, a second Sav-Rite location opened just two miles away from the original pharmacy. However, the second Sav-Rite was forced to close and surrender its DEA registration after it was raided by federal agents in March 2009.

Now, in most instances, this would be a success story. But in this case, the original Sav-Rite pharmacy -- the one that had received 9 million pills in just two years -- stayed open for another two years, and in those two years, Sav-Rite number one dispensed about 1.5 million pills into the community.

So the question is, how did that happen? How is it possible?

The raid on Sav-Rite two was based on observations made during undercover investigations conducted at both Sav-Rite locations as well as a pill mill medical practice.

As part of the undercover operation, federal investigators saw pharmacy customers sharing drugs with one

another in the parking lot, and as you've heard, a cash drawer so full the clerk could not close it, and learned that the owner of the Sav-Rite pharmacies apparently developed a quote, unquote, "get-rich-quick scheme" with a pill mill medical practice.

This scheme may have filled their cash drawers, but it was devastating to the community. It doesn't make any sense as to why the DEA did not shut down both pharmacies at the same time.

They were owned by the same person. They were part of the same criminal scheme. DEA has acknowledged that breakdowns occurred and lessons were learned, in this case and in others.

We need to make sure DEA has fixed its own problems so that an effective DEA is part of the many solutions needed to combat the opioid crisis.

As you know, people are dying. Lives are being ruined. We must be united in our efforts to end this horrible epidemic.

That is why myself and this entire committee have been so frustrated that it has taken so long to obtain DEA's full cooperation in this investigation.

303 And while progress is being made in DEA's efforts -- and
304 I appreciated our meeting on Friday -- we still have plenty
305 of unanswered questions coming in to today's hearing.
306 So I am hopeful we can learn the answers to those
307 questions today and I am also pleased with the commitments
308 DEA has made to fulfill our remaining requests in this
309 investigation.
310 And I expect those commitments to be honored, period.
311 If they are not, we'll be back talking again soon. Our most
312 pressing questions are intended to get DEA on a better path.
313 Every one of us on this dais and in this room supports a
314 strong and effective DEA. We know you have an enormous and
315 important job to do with dedicated agents and we are grateful
316 to all those in law enforcement and personnel at your agency.
317 Quite simply, we want you to have the tools and the
318 resources you need to help us combat this epidemic, among the
319 other many duties you have at DEA.
320 So I want to thank you for again being with us today,
321 Acting Administrator Patterson, and we look forward to your
322 candor.
323 And I would like to yield the balance of my time to the
324 gentleman from Virginia, Mr. Griffith. Before I do that, I

would remind the committee we will have two full days of hearings starting tomorrow and Thursday reviewing 25 pieces of legislation on the opioids epidemic, and we hope and expect everyone on the committee to attend those hearings.

With that, I yield to the gentleman from Virginia.

Mr. Griffith. Thank you, Mr. Chairman.

We have an implied constitutional responsibility to conduct oversight and ensure that the Controlled Substances Act strikes the correct balance between the public interest in legitimate patients obtaining medications against the weighty public interest in preventing the illegal diversion of prescription drugs.

A key issue is whether the DEA is adequately protecting public safety. DEA statistics reveal a sharp decline and immediate suspension orders -- ISOs -- since 2012.

ISOs are a DEA administrative tool not to punish but to protect the public from rogue doctors or pharmacists who would continue to provide opioids to drug abusers unless their registration was immediately suspended.

Former DEA officials alleged in the Washington Post and on CBS "60 Minutes" that the DEA's office of chief counsel, starting around 2013, changed its evidentiary requirements

for ISO submissions from the DEA field. DEA documents provided to the committee seem to substantiate this allegation.

Now, ISOs remind me of DUI cases in Virginia. When a police officer gets a driver off the road who's been drinking, their license to drive is administratively suspended in order to protect the public.

Trial on the merits is delayed, but not public safety. It's a similar principle here. Immediately suspend the rogue operator and protect the public.

I yield back.

Mr. Harper. The gentleman yields back.

The chair will now recognize the ranking member of the full committee, Mr. Pallone, for five minutes.

Mr. Pallone. Thank you, Mr. Chairman.

The opioid epidemic continues to devastate communities and families in every part of America, and every day 115 Americans lose their lives in an opioid overdose.

We must do more to help those struggling with addiction, and I am committed to working with all of my colleagues to advance meaningful legislation and resources to help combat this crisis.

Families all across this nation are looking to us for help, and it is my hope that DEA will work cooperatively with us on this effort.

In addition to advancing efforts to respond to this crisis, Congress also has a responsibility to figure out what went wrong and how it went wrong and how to make sure something like this never happens again.

And that is why this committee has been engaged in a bipartisan investigation into the role both DEA and drug distributors have in addressing the ongoing opioid crisis and what systems failed to protect the communities that have been so overwhelmed by this epidemic.

So I hope that the lessons we learn will help us address this urgent problem throughout the country, from New Jersey to West Virginia and beyond. Clearly, something went wrong.

The safeguards designed to prevent opioids from being diverted into the wrong hands simply did not work and our committee's investigation has found that drug distributors shipped millions of pills to multiple small-town pharmacies in West Virginia every year.

For example, a pharmacy in a town of 2,000 people received 16.5 million doses of opioids over a 10-year period

and there were other pharmacies in that area as well.

There is simply no way that there was an actual medical need for this incredible volume of opioids in this rural sparsely-populated area and I would hope that DEA can tell us what broke down in the safeguards that should have protected communities from these abusive practices.

These include failures by both the distributors and the DEA. For example, I have questions about the data that DEA collects and why they did not use it more aggressively to prevent the oversupply of opioids in certain -- in certain cases.

We know that distributors are required to tell DEA how many pills they ship each month and where those pills go. It is not clear, however, that DEA has used this data in the past, and if DEA is using this data now to help it curtail excessive pill distribution.

Distributors are also required to alert DEA when a pharmacy places an order for what appears to be a suspiciously large quantity of pills.

It appears that distributors have not always alerted DEA of those suspicious orders and may not even have had adequate systems in place to identify inappropriately large orders.

But at the same time, it is also not clear that DEA has always done enough with the suspicious orders they receive from distributors to alert the agency to possible anomalous shipments, and I hope we can get answers to both of these questions.

And when multiple distributors ship to a single pharmacy, possibly causing an oversupply, it is not clear that DEA has had an adequate system to identify and flag to the distributors that an oversupply problem may be unfolding.

Unlike DEA, who has access to comprehensive distribution data, distributors can only see what they supply to an individual pharmacy. Yet, if DEA is not flagging when multiple distributors are at risk of collectively oversupplying a pharmacy, then the result is another example of a system failure that can lead to diversion.

So it seems likely that failing to report suspicious orders by distributors has hurt DEA's ability to monitor the distribution of controlled substances and I hope that we will hear that this is no longer an issue today, and if it is, I'd like to know what tools DEA needs to help it to enforce this requirement.

At the same time, I do hope that DEA is making full use

of suspicious orders when they are reported to their field offices.

Finally, Mr. Chairman, while our investigation has focused on what went wrong in West Virginia, I also want to know how DEA is monitoring distributors across the country now.

Addictive drugs are still abundant in our communities and now new opioids are also being introduced to the market. So I hope that DEA is actively or proactively analyzing shipments of these pills and, where appropriate, stepping in and stopping the over-distribution of these drugs.

So I just want to thank Administrator Patterson for appearing before us. This issue is extraordinarily important and no entity can address it alone.

DEA and Congress must be allies in combating the opioid crisis and only by understanding what went wrong can we fix this system for the future.

So just, again, I know you're in the hot seat today but this is something that we need to work on together.

Thank you, Mr. Chairman.

Mr. Harper. The gentleman yields back.

I ask unanimous consent that the members' written

opening statements be made part of the record. Without objection, it will be entered into the record.

Additionally, I ask unanimous consent that Energy and Commerce members not on the Subcommittee on Oversight and Investigations be permitted to participate in today's hearing.

Without objection, so ordered.

I would now like to introduce our witness for today's hearing. Today, we have Mr. Robert Patterson, the acting administrator for the Drug Enforcement Administration.

We appreciate you being here with us today, Mr. Patterson, and you are aware that the committee is holding an investigative hearing and when so doing it has been our practice of taking testimony under oath.

Do you have any objection to testifying under oath?

Mr. Patterson. I do not.

Mr. Harper. Witness has anticipated no -- his response is no.

The chair then advises you that under the rules of the House and the rules of the committee, you're entitled to be accompanied by counsel. Do you desire to be accompanied by counsel during your testimony today?

Mr. Patterson. I do not.

Mr. Harper. Responds that he does not. In that case, I would ask that you rise and please raise your right hand and I will swear you in.

[Witness sworn.]

You are now under oath and subject to the penalties set forth in Title 18 Section 1001 of the United States Code. You may now give a five-minute summary of your written statement.

You can hit the button on the mic and you have five minutes to summarize your testimony.

Thank you again for being here, Mr. Patterson.

TESTIMONY OF ROBERT W. PATTERSON, ACTING ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION

Mr. Patterson. Thank you, and good morning.

Committee Chairman Walden, Subcommittee Chairman Harper, Ranking Members Pallone and DeGette, and distinguished members of the subcommittee, thank you for the opportunity to be here today to discuss the opioid epidemic and DEA's role in combating this crisis.

Over the past 15 years, our nation has been increasingly devastated by opioid abuse, an epidemic fueled for a significant period of time by the over prescribing of potent prescription opioids for acute and chronic pain.

This indiscriminate practice created a generation of opioid abusers, presently estimated at more than 3 million Americans.

Over the past few years, we have begun to see a dramatic and disturbing shift. As a result of the increased awareness of the opioid epidemic, prescriptions for opioids have started to decline -- obviously, somewhat a success.

But organizations, in particular the well-positioned -- in particular, the well-positioned Mexican drug cartels have

filled this void by producing and distributing cheap powdered heroin, often mixed with illicit fentanyl and other fentanyl-related substances and selling it to users in both traditional powder form and, in some cases, pressed into counterfeit pills made to resemble illicit pharmaceuticals.

There are two central elements DEA is addressing as part of this administration's collective efforts to turn this tide, with a third piece that must also be addressed.

First and foremost is enforcement. Based on our investigations, actions are undertaken every day using our criminal, civil, or administrative tools to attack the traffic in illicit drugs and the diversion of the licit supply.

Second is education. I strongly believe there is a real value and a natural fit for the DEA in this space and look whenever possible to partner with leaders in prevention and education.

The third element is treatment. The DEA is committed to doing what we can to improve access to drug treatment and recovery services, working alongside our partners at the Department of Health and Human Services, to utilize evidence-based strategies that minimize the risk of diversion during

this public health emergency.

Ultimately, the only way to fundamentally change this epidemic is to decrease demand for these substances and address the global licit and illicit supplies -- illicit supply concerns through the efforts of DEA and all of its partners.

The action of DEA's Diversion Control Division are critical with respect to addressing the licit supply. Diversion of prescription opioids by a few has a disproportionate impact on the availability of prescription opioids.

The fact remains that a majority of new heroin users stated that they started their cycle of addiction on prescription opioids.

As a result, we are constantly evaluating ways to improve our effectiveness to ensure that our more than 1.7 million registrants comply with the law.

Our use of administrative tools and legislation that changed our authorities in this area has been the subject of numerous media reports. Let me address that issue up front.

DEA has continued to revoke approximately 1,000 registrations each year through administrative tools such as

orders to show cause, immediate suspension orders, and surrenders for cause.

We have and will continue to use all of these tools to protect the public from the very small percentage of registrants who exploit human frailty for profit.

Where a licensed revocation is not necessary we have aggressively pursued civil actions and MOUs designed to ensure compliance.

Over the last decade, DEA has levied fines totally nearly $390 million against opioid distributors nationwide and entered into MOUs with each. DEA has also reprioritized a portion of its criminal investigators and embedded them in with diversion investigators and enforcement groups, referred to as tactical diversion squads.

We currently have 77 of these groups nationwide who are solely dedicated to investigating, disrupting, and dismantling individuals and organizations involved in diversion schemes.

DEA's Diversion Control Division has simultaneously worked to improve communication and cooperation with the registrant community.

As an example of this outreach, DEA offers year-round

training free of charge to pharmacists, distributors, importers, and manufacturers.

DEA just completed training more than 13,000 pharmacists and pharmacy technicians on the important role they play in ensuring they only fill valid prescriptions.

In May, DEA will initiate a similar nationwide effort to provide training on the vital role that prescribers play in curbing this epidemic.

This effort will start with specific focus on states where we have seen little decrease or, in some increases, an increase in opioid prescribing rates.

Administrative action, civil fines, and criminal cases are all important steps. Where we have fallen short in the past it is by not proactively leveraging the data that has been available to us.

Although I am happy to discuss what happened in the past, I focus my time on moving our agency forward and appreciate the opportunity to update you on where we are today and where we intend to go.

For example, in January we utilized ARCOS data overlaid with data from HHS and, when available, state PMP programs. The result was approximately 400 targeted leads that DEA was

able to send to its 22 field divisions nationwide for further investigation.

While we are working with all the federal agencies in this space -- I am sorry -- we are working all the federal agencies in the space while we continue to work well with our colleagues at ONDCP, CCD, NIDA. The mutual issues that we face today have created stronger and critical partnerships with FDA and HHS.

I'll finish up by saying I'd like to recognize the Health Subcommittee's efforts to hold a legislative hearing starting tomorrow on more than 25 pieces of legislation.

That effort not only underscores the unprecedented nature and complexity of the opioid crisis but also demonstrates that we must all take action to address this threat together.

Thank you for this opportunity and I look forward to your questions. [The prepared testimony of Mr. Patterson follows:]

**********INSERT 1**********

Mr. Harper. Thank you, Mr. Patterson. It'll now be the opportunity for members to ask you questions regarding your statement and look for solutions to the problems that we have and I will begin by recognize myself for five minutes for questioning.

Over the past year, this committee has been investigating opioid dumping and as part of this probe the committee found some disturbing examples, and I will share a couple of these, some that we have touched on.

A single pharmacy in Mount Gay-Shamrock, West Virginia, population 1,779, received over 16.5 million hydrocodone and oxycodone pills between 2006 and 2016.

Distributors sent 20.8 million opioid pills to Williamson, West Virginia, population 2,900, during the same period, and in 2006 a pharmacy located in Kermit, West Virginia, population 406, ranked 22nd in the entire country in the overall number of hydrocodone pills it received with a single distributor supplying 76 percent of hydrocodone pills that year.

Would you agree that, on its face, these distribution figures represent inordinate amounts of opioids shipped to such rural markets?

643 Mr. Patterson. I would.
644 Mr. Harper. Distributors are required to file reports
645 of shipment amounts on certain controlled substances to the
646 DEA database called the Automated Reports and Consolidated
647 Ordering System, or ARCOS. These reports are filed monthly.
648 Is that correct?
649 Mr. Patterson. Sir, either monthly or quarterly.
650 Mr. Harper. What's the distinction between when one is
651 done quarterly or monthly? Who makes that determination?
652 Mr. Patterson. It is done by, I believe, the
653 distributor or -- not by the distributor -- whether it's a
654 distributor or a manufacturer.
655 Mr. Harper. Okay. Ten years ago, would the ARCOS
656 database have been able to flag DEA diversion investigators
657 about unusual patterns such as the stunning monthly increases
658 of shipment amounts or disproportionate volume of controlled
659 substance sales at a pharmacy?
660 Mr. Patterson. Ten years ago, I think that would be
661 doubtful.
662 Mr. Harper. Okay. Did the DEA attempt to leverage the
663 data in ARCOS to help support DEA investigations of opioid
664 diversion in West Virginia?

Mr. Patterson. Back at that time frame?

Mr. Harper. Just tell me when. When did they start utilizing that?

Mr. Patterson. Sir, so ARCOS data I think pre probably 2010 was an extremely manual process. As that system has gotten more robust and, certainly, through the last handful of years we've used that in a much more proactive manner.

Mr. Harper. Would the DEA ARCOS database be able to flag such signals of opioid diversion today? Your answer is, obviously, a yes.

In 2006 and 2007, DEA sent at least there letters to wholesale drug distributors regarding their compliance obligations under the Controlled Substances Act.

The letters reminded the companies of their duties to monitor and report suspicious orders of opioids. Yet, during this time, according to DEA enforcement actions, drug distributors failed to maintain effective controls against diversion.

Why did the DEA communications with industry fail to prevent the kinds of major breakdowns apparent in West Virginia?

Mr. Patterson. I think when you go back to that time

frame on the suspicious orders reports, there was two major failures. One was either a lack of information contained therein or not filing them in this instance that they had.

I think that started the problem, quite frankly and a lot of the frustration came from chasing down the registrants and ultimately reminding them of their responsibility in this regulated area.

Mr. Harper. Over the last 10 years, the DEA reached settlements with drug distributors for failing to maintain effective controls against diversion of opioids or failing to report suspicious orders.

Yet, after these settlements, drug distributors continued to fail to comply with the regulatory requirements.

Why were these initial settlements not effective in achieving compliance from these distributors?

Mr. Patterson. And again, this goes back to the frustration of the day, and I know that the folks that were in diversion back in 2010 and 2012 struggled with the fact that these MOUs or MOAs have been put in place with these companies and they blatantly violated them again.

Mr. Harper. So how is DEA using -- utilizing ARCOS today? Is it effective today?

Mr. Patterson. So, sir, ARCOS as a stand-alone database is a good pointer. I think, as I said in my opening statement, ARCOS data and what we have learned, combined with state PMP HHS data, gives you a much better outlier problem.

In some of the cases that we have looked at, depending on the situation, ARCOS data would not have found those particular issues, right.

If it's a smaller level or a single place. So the reality is is what we need is all of these data sets essentially working in conjunction with each other.

Mr. Harper. Are there movements to improve ARCOS? Is that constantly monitored and updated and refined?

Mr. Patterson. So we are -- we are constantly working with this data now in a very proactive way. We've joined with two state coalitions of states' attorneys-general to work with data sharing in this space, especially with the PMP data as well as our counterparts at HHS.

Mr. Harper. Thank you, Mr. Patterson.

The chair now recognizes the ranking member, Ms. DeGette from Colorado, for five minutes.

Ms. DeGette. Thank you so much, Mr. Chairman, and I agree that we -- Mr. Patterson, that we do need to look

forward how we can improve things. But I don't think we can do it without examining the past, and this ARCOS system is the perfect example.

I want to spend a few minutes following up on what the chairman was asking you, because you said -- my understanding is ARCOS was in place during this whole time period, 2006 to 2016, correct?

Mr. Patterson. That's correct, ma'am.

Ms. DeGette. And but -- and so what was happening the data was just being reported in but nothing was really being done with it. Isn't that correct?

Mr. Patterson. I would say it was used in a very reactive way.

Ms. DeGette. Right. So -- so you said that a lot of times you wouldn't have been able to tell this from ARCOS.

I am going to assume, though, if we had been analyzing this data we would have found the 184,000 pills per month that McKesson was sending to Kermit if someone had looked at it. Wouldn't you think so?

Mr. Patterson. I do agree with that.

Ms. DeGette. Yes. And wouldn't you -- wouldn't you agree that in Kermit -- I think you said yes when the

chairman said this -- it was 2.2 million pills in a year in Kermit.

All you'd have to do is look at that raw data and see that, wouldn't you?

Mr. Patterson. That's correct.

Ms. DeGette. And so really the fact -- well, let me -- let me ask you another question. The Controlled Substances Act and the applicable regulations require the distributors to know their customer.

So distributors are supposed to report orders of unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency to the DEA.

Isn't that correct?

Mr. Patterson. It is, ma'am.

Ms. DeGette. So it's not just the DEA that has a burden to analyze the ARCOS data and to identify problems. But even before that, the distributors have a burden, right?

Mr. Patterson. The key burden is actual on the distributor.

Ms. DeGette. Right. Exactly. So do you -- do you think that if you were McKesson Corporation and you were looking at all these prescriptions in Kermit that you would

think that -- would you think they knew those customers?

Mr. Patterson. Well, one, the obligation was there to know their customers.

Ms. DeGette. Right. Do you think that you possibly could know the customers when you're sending that many prescriptions in there?

Mr. Patterson. I think McKesson's answer would be that, you know, they did their part on this.

Ms. DeGette. Well, what's your answer?

Mr. Patterson. Obviously, I think they should have done more.

Ms. DeGette. Well, I would think so. I mean, do you think that orders of this -- of this magnitude -- 2.2 million doses of hydrocodone to one Sav-Rite pharmacy -- do you think that that's an order of an unusual size?

Mr. Patterson. I do, ma'am.

Ms. DeGette. And do you think that it deviates from a normal pattern?

Mr. Patterson. I do.

Ms. DeGette. Okay. Let me -- let me ask you another question.

Now, looking back on this case, do you think that the

distributors in all of these situations that the chairman and I have been talking about -- do you think that they -- that they failed to adequately exercise good due diligence over what they were doing?

Mr. Patterson. Certainly, on the appearance of it. I can't tell you what their due diligence was. But --

Ms. DeGette. Oh, we are going to ask them that. Don't worry. You're not here to represent them.

Now, in December, the Washington Post and "60 Minutes" reported that McKesson distributed large volumes of opioids from its Aurora, Colorado distribution facility in 2012.

On pharmacy that received these shipments reportedly sold as many as 2,000 opioids per day. Have you retroactively applied ARCOS data to the Colorado situation to see if there were distribution patterns similar to what we saw in Kermit, West Virginia?

Mr. Patterson. I believe that's the case, ma'am, that ultimately the DEA litigated and received a settlement. I don't know if we went back currently and have looked at that same number.

Ms. DeGette. And what was the settlement?

Mr. Patterson. It was $150 million.

Ms. DeGette. From McKesson to --

Mr. Patterson. The U.S. government.

Ms. DeGette. The U.S. government. As a result of McKesson's failure to adequately follow the law on distributing those opioids. Is that right?

Mr. Patterson. That's correct.

Ms. DeGette. And so what do you think Congress can do so that we don't have a total slip-up like we did in all of these cases in West Virginia and around the country, really?

Mr. Patterson. Well, I think -- look, the fundamental change that we have already made is our recognition of how we can use the various data sets and paying attention to what we are doing.

I mean, the outreach to industry -- and I think this is a topic that I assume will come up at some point -- we have to work with the industry and the industry, obviously, has their responsibility.

But we have 1,500 people to monitor 1.73 million registrants.

Ms. DeGette. So, really, you think the initial burden to assess this is on the industry. But then the DEA has an important enforcement?

Mr. Patterson. Oversight.

Ms. DeGette. Yes, thank you.

Thank you, Mr. Chairman.

Mr. Harper. Gentlewoman yields back.

The chair will now recognize the chairman of the full committee, Mr. Walden, for five minutes for questions.

The Chairman. Thank you, Mr. Chairman.

Mr. Patterson, we need to find out whether DEA is really addressing the lessons you say DEA has learned.

Case in point is the one I raised, the questionable enforcement approach regarding the two Sav-Rite pharmacies in Kermit, West Virginia that I mentioned in my opening statement.

Sav-Rite number two was shut down in April of 2009, correct?

Mr. Patterson. I don't know the specific dates. I know there was two pharmacies. One was shut down and one wanted criminal --

The Chairman. Yes, it was -- our data show April of 2009 Sav-Rite two was shut down. Sav-Rite one was not shut down until over two years later when the owner of the pharmacy entered a guilty plea to charges that he illegally

issued prescriptions, correct?

Mr. Patterson. That's correct.

The Chairman. And in April 1st of 2009, an article in the local Herald Dispatch reported that the two Sav-Rite pharmacies and a local pain clinic were under federal investigation for operating a drug operation.

The article reported an affidavit from federal investigators who stated there were two overdose deaths linked to this network.

So my question is why did DEA shut down Sav-Rite number two but not Sav-Rite number one in April of 2009 if both pharmacies were part of a network linked to deaths?

Mr. Patterson. Sir, I would have to get back to you on that one particular issue and I will you the reason why. It's my understanding it was -- it was part of the criminal process in that case and I don't know the answer for why that was. But I would be happy to get that back to you.

The Chairman. Thank you.

So why would the DEA even consider such an arrangement when it knew the owner operated the pharmacies two miles apart, one of which the DEA claimed to be the prime reception location for the flood of pills -- that's a direct quote --

being sent to the area and linked to overdose deaths? Same owner, same operator, two miles apart?

Mr. Patterson. I agree with you, and it's something I will get back to you on.

The Chairman. During the time the DEA allowed Sav-Rite number one to remain in operation, this pharmacy received somewhere between 1 and 2 million hydrocodone and oxycodone pills.

Allowing Sav-Rite one to continue to dispense such a volume of opioids posed a continuing risk to public health and safety. Isn't that right?

Mr. Patterson. I would agree.

The Chairman. So, Mr. Patterson, what's the biggest priority? Protecting public safety or deferring to an ongoing criminal investigation?

Mr. Patterson. It should have been to protect public safety.

The Chairman. So in this case, the government originally entered a plea agreement with the pharmacy owner that didn't even call for any prison time.

The lack of any prison time troubled the judge and eventually the defendant was sentenced to six months -- six

months in prison.

What kinds of evidentiary challenges would have been involved in such a case and would putting an immediate suspension order on hold really help solve these challenges?

Mr. Patterson. So putting an immediate suspension order on hold, like, again, I don't know the particular facts of that criminal case and I would be happy to get back to you.

I will tell you that I have a very strong opinion and this has been relayed throughout our agency that whether it's an immediate suspension or whether a surrender for cause, that if we are having harm issues that that suspension needs to occur even in lieu of a criminal prosecution.

The Chairman. And have you gone back and looked? Are there any records in your possession that would speak to this issue of why that decision was made?

Mr. Patterson. I would be happy to go back and look, sir.

The Chairman. And will you provide those to us unredacted?

Mr. Patterson. I would be happy to take that back and take a look at it for you.

The Chairman. That wasn't the answer I was looking for.

Mr. Patterson. I don't want to commit to the department's files. But I would be happy to take that back and I will take your concern back about getting them unredacted.

The Chairman. Yes. I mean, we've had this discussion in private. We'll have it in public. We'll have it in private.

The long and short of it is we just want to find out what was going on, what was the thinking, why the change in operation. People died and things were not -- we don't want to see your agency repeat that.

We are beholden to the constituents we represent and I think the public has a right to know, don't you?

Mr. Patterson. I fully understand your concern and I agree with you.

The Chairman. Would this happen again today?

Mr. Patterson. Certainly, I think with our mentality, the answer would be no. Like I said, I mean, what we wish to do, sir, is stop public harm. I've had this conversation with U.S. attorneys' population, states' attorneys' population.

I see in too many instances on ISOs, current ones that I

sign off on, where there has been a delay that I don't find appropriate.

The Chairman. So how do you weigh when to proceed with an ISO versus a criminal case?

Mr. Patterson. I would take it, quite frankly, no different than what we would do in a criminal case in the field, and in this case, I find that, you know, we have the ability.

So we have certain protocols where we evaluate risk of ongoing criminal activity in traditional criminal cases. In this case, because the person has a registration, we can immediately stop that harm.

The Chairman. And how long -- what's immediate? Is that 90 days? Twenty-five days? Tomorrow?

Mr. Patterson. I think the frustration in this is it takes time to build even that ISO charge, which is the reason why, in a lot of cases, we've gone to surrenders for cause or a voluntary surrender in which we go in and try and remove that registration.

The Chairman. So the ISO -- how long are we talking about to build that case?

Mr. Patterson. I think probably, in an efficient

manner, 45 to 90 days.

The Chairman. So during that period, they can continue to dispense these drugs?

Mr. Patterson. The same way an illicit person would be out on the street as we gather the evidence we needed to present the charge.

That's why, sir, I go back to my point on surrender for cause, or a voluntary surrender. If I can walk in and lay out to that person why they need to surrender that and I can do it in a day and that's the method that we have actually been using much more aggressively than the ISO process, then we are going to do that.

The Chairman. What's the average time to go to a voluntary surrender?

Mr. Patterson. It depends. I mean, with very aggressive people it happens relatively quickly. There's always a quick balance with a criminal case and then evidence that they need to look at for that.

And, like I said, again, our conversations with prosecutors in the field have been that decision has to get made quickly.

The Chairman. All right. I know my time has expired.

I would imagine Mr. Griffith is going to have a comment or two on this as well.

With that, Mr. Chairman, I yield back, and thank you again.

Mr. Harper. Thank you, Mr. Chairman.

The chair now recognizes the ranking member of the full committee, Mr. Pallone, for five minutes.

Mr. Pallone. Thank you, Mr. Chairman.

Mr. Patterson, I want to ask you about another pharmacy in West Virginia so I can better understand why DEA was not able to stop the distributors from oversupplying certain pharmacies.

This one is the Family Discount Pharmacy in Mount Gay-Shamrock, West Virginia. Mount Gay-Shamrock has a population of just under 2,000.

DEA's data shows that distributors shipped 16.5 million opioid pills to this pharmacy between 2006 and 2016, including 2 million pills in three consecutive years.

By contrast, the Rite-Aid Pharmacy down the street received a total of about 2 million pills during this entire 11-year period.

So do you agree that over 16 million pills is an

excessive amount of opioids for Family Discount Pharmacy to have received relative to the size of the town it served?

Mr. Patterson. Especially when you compare it to the other pharmacy. Correct.

Mr. Pallone. I thank you.

One distributor has provided evidence suggesting that between May 2008 and May 2009 they sent DEA 105 suspicious order reports stating that this pharmacy regularly ordered high volumes of pills.

For example, this distributor apparently told DEA that Family Discount ordered 25 500-count hydrocodone bottles on June 16th, 2008, and that's 12,500 pills just in the one day.

On October 10th, Family Discount ordered 32 500-count hydrocodone pills -- bottles, I should say -- or 16,000 pills in a single day, again, for a town of only 2,000 people.

Now, merely reporting these suspicious orders does not absolve the distributor of its additional responsibilities. Is that correct?

Mr. Patterson. That's correct.

Mr. Pallone. So distributors still have to actually refuse shipments to suspicious pharmacies?

Mr. Patterson. They can, yes.

Mr. Pallone. Additionally, it appears that distributors continue to ship this pharmacy over a million opioid pills each year in the five years after these reports were made and even the distributor who told us they reported the pharmacy to DEA continued to supply them after submitting those reports.

So, Mr. Patterson, it would appear that, again, something broke down to allow so many opioids to be shipped to this pharmacy.

I mean, just tell us what happened here. Why are so many opioids sent to this pharmacy at the same time that DEA has received a number of suspicious order reports? What do you think happened?

Mr. Patterson. Sir, so, again, on any of these individualized cases I am going to have to go back and take a look at the specific instances of what happened.

I will give you, I think, the concern I have with the ARCOS -- not just ARCOS data but the suspicious orders, which is that is -- was a decentralized function. It would go out to our division -- those reports.

We are now bringing those in as well to our headquarters for proper deconfliction and visibility of what we see. I

will take on face value the facts that you just proffered to me and I would be happy to go back and take a look at the Family Discount scenario. As I sit here, I don't have the particulars on the case from that time.

Mr. Pallone. Well, I mean, we appreciate your following up. I mean, that's obviously why we are asking the questions. I don't expect you to know everything right off the bat.

But let me just say this. Between 2006 and 2010, did the DEA have any data analysts assigned to scrutinize information from distributors about the amount of pills shipped to particular pharmacies? Did you have any kind of data analysts, in that respect?

Mr. Patterson. So my understanding of the people that were handling the ARCOS data it was a completely manual process, meaning everything was coming in on paper or tapes, which would have to be verified.

So you have this one-month to three-month delay to begin with. They would have to have errors in their report that would go back and forth.

So what you found yourself with is a set of data that sometimes would take a year-plus to get correct, and then in

that time frame, sir, we are using it very much as a reactive tools.

In other words, someone would come in and provide some piece of information on a pharmacy or a doctor or some other impact -- or some other issue and then they would go and look at the ARCOS data. It was not done in a --

Mr. Pallone. So does that mean then, if I understand you, that there wouldn't be -- it would be too long a period of time before would they realize how excessive this was?

Mr. Patterson. Well, if it was still ongoing, obviously, it would be an ability to look at that current situation. In a lot of these cases you see where these problems occurred for either a year or two and then disappeared or they were ongoing. But --

Mr. Pallone. And is that being -- is that problem being corrected or what do you suggest we do?

Mr. Patterson. It has been corrected, sir. So, again, I think that for the committee to understand is ARCOS is an extremely different tool in 2018 than it was even in 2010 or 2011.

Mr. Pallone. So you feel that you already have the tools to correct it -- you don't need anything else?

Mr. Patterson. I feel that tool, with other data, is an important way for us to look proactively at these issues -- the very specific issues that we are talking about today.

Mr. Pallone. All right. Thank you.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentleman from Texas, Mr. Barton, for five minutes.

Mr. Barton. Thank you, Mr. Chairman.

This is a difficult hearing because I think everybody has the same bottom line. But your agency doesn't appear to be willing to aggressively try to help us solve this or at least deal with this crisis.

According to the latest numbers that this committee staff has, 115 people a day are dying of opioid overdoses and two-thirds of those are legally prescribed drugs. So about 80 people a day are dying from taking legally-prescribed prescription drugs.

Now, they may be getting that prescription in an illegal way -- in other words, they don't really need it. You're the head of the agency that's supposed to do something about it.

Now, I don't know much about you but, apparently, your background has been on the illegal side of DEA. Is that

correct?

Mr. Patterson. That is correct.

Mr. Barton. Okay. How long have you been in your current position?

Mr. Patterson. Since October of 2017.

Mr. Barton. Okay. And I doubt that you volunteered for the job. I think, you know, you don't have -- we don't have a -- we still don't have a Trump administration appointee who's been recommended to the Senate.

So for the foreseeable future in terms of drug enforcement the buck stops with you, even though you're, as I understand it, a career civil servant. Is that correct?

Mr. Patterson. That's correct.

Mr. Barton. Okay. Are you familiar with the Washington Post articles that have been running the last three to four months? One of them talks about the tension between the field enforcement offices and the Washington administrative officials?

Mr. Patterson. I have.

Mr. Barton. Okay. Do you agree or disagree with the basic thrust of those -- of those articles -- that the enforcement people were very enthusiastic and willing to

really go after the distribution centers and the drug manufacturers and the pharmacists -- pharmacies and the Washington staff, for lack of a better term, stonewalled them or toned them down?

Mr. Patterson. So I believe that's an overstatement. I think you have a number of issues that, quite frankly, play out in this space, some of which have to do with personalities.

But I don't find that the folks in the field, for the most part, had this belief that they were shut down. I do think there were people that felt that way at headquarters but not necessarily in the field.

Mr. Barton. Are you familiar with a gentleman named Clifford Lee Reeves, II?

Mr. Patterson. I am.

Mr. Barton. You don't think he stonewalled them or turned them down -- toned them down?

Mr. Patterson. Sir, as I've talked about with everybody I've met on this situation, I will simply explain this. I could put three people in a room and talk about probable cause and they could all have different opinions on --

Mr. Barton. Well, let me put it this way. You and your

associates in Washington have stonewalled this committee for the last six or seven months.

It took a threat of Chairman Walden to subpoena the attorney general of the United States to finally break loose some documents. We didn't get those documents, I understand, until yesterday.

Now, that's not the Washington Post, sir. That's your people in Washington interacting with Energy and Commerce Committee staff on a bipartisan basis. That's not hypothetical. That's real.

Now, we are as much a part of the problem as anybody because the Congress has not aggressively addressed it. But we are beginning to, and as long as you're the head of the DEA, I personally, as vice chairman of this committee, expect you to work with us and to tell your people to work with the committee staff. Can you do that?

Mr. Patterson. Sir, I took over this job in October. I met with --

Mr. Barton. Okay. I don't -- I want to know will you do what I just asked you to do? Yes or no. Will you tell your people to work with committee staff to help address this problem?

Mr. Patterson. Of course, and I have since November and we've been turning documents over since that time.

Mr. Barton. Well, you didn't turn them over until yesterday, sir, and some of the documents you turned over were so redacted that it just looked like black marks on the pages.

Mr. Patterson. Sir, we've been turning documents over since November to the tune of more than 10,000 pages of documents that have come over here in the last month.

Mr. Barton. Yes, and how many of those pages do you think are useable?

Mr. Patterson. Well, we sat down yesterday with staff to go --

Mr. Barton. Because this hearing was today.

Mr. Patterson. -- the concerns. Sir, I would respectfully disagree with that.

Mr. Barton. Well, you can -- at least you're respectfully disagreeing and I appreciate that.

Mr. Patterson. I am fully committed, sir, to working with this committee and being as transparent as I can be.

Mr. Barton. Well, you just remember, 80 people a day are dying because of legal prescription drugs that are

probably being illegally prescribed. Remember that.

I yield back.

Mr. Harper. Gentleman yields back.

The chair will now recognize the gentlewoman from Florida, Ms. Castor, for five minutes.

Ms. Castor. Thank you, Chairman Harper.

Administrator Patterson, I am sure you know about the multi-district opioid litigation in the Northern District of Ohio, which consolidates over 400 lawsuits brought by cities and counties and other states' communities against the drug distributors, manufacturers, and pharmacy chains.

The most important source of information in that major lawsuit is going to be most likely the ARCOS data, and I understand DEA initially resisted providing ARCOS data to the federal judge.

A DEA official testified in response to my question in the Health Subcommittee hearing last month that the resistance was based upon a need to protect proprietary information.

But now the court in this case has recently entered a protective order describing how the parties should treat the confidential ARCOS data when DEA disclosed it.

It's apparent to me that the ARCOS data will be pivotal in appropriately resolving the case and assigning accountability.

Do I understand now that DEA has agreed to provide nine years of data on opioid sales including the identifies of manufacturers and distributors that sold 95 percent of opioids in every state from 2006 to 2014?

Mr. Patterson. That is correct, under the protective order.

Ms. Castor. Under the protective order. So this will not be the last major challenge to manufacturers and distributors and others that are responsible.

Will DEA likely cooperate in those cases too? Have you set up a standard -- is this a decision, going forward, that other judges and litigants can count on?

Mr. Patterson. I would believe it's under the same circumstances and conditions that we would comply the same way with anyone else that came in under those same terms.

Ms. Castor. So when will that data be provided to the federal court in that -- in the northern Ohio case?

Mr. Patterson. I can get back to you on the date. I think it's very short term.

Ms. Castor. Okay. The committee's analysis of ARCOS data has been very concerning. The trends in West Virginia -- I mean, we've just really -- we've just really skimmed the surface, I think.

My colleagues have outlined some of these. I am concerned that there are other regions all across the country where distributors may have supplied pharmacies with excessive quantities of opioid pills and that that information may be overlooked.

How is DEA currently using the older ARCOS data, say, from 2006 to the present to go back and look at past crimes, and if you could explain what you're doing now.

Mr. Patterson. No, I appreciate the question and I think it's an important issue.

So the 400 packages that we just put out are current-day packages that we want to investigate -- in other words, where harm is continuing.

I shouldn't say where harm is definitely continuing but where those outliers are that we want to go back and take a look at, why is that occurring, right?

Some of these actually end up being reasonable issues. You know, there's an oncology department there. There's some

reason why there's a higher level of that medication going to that area.

I think the key is is that once we get a handle on current issues that we are dealing with we want to roll backwards and look at 2012, 2013, 2014, and 2015 where we still have the ability to take a look at that data and make it make sense.

I can tell you that there's a number of cases ongoing in DEA without going into detail on them, looking at just that issue right now with manufacturers and --

Ms. Castor. And what is the statute of limitations? If you go back and we -- the committee has seen some of this in graphical forms where 2006 it ramped up and then because now the spotlight is being shined on it that the excessive distribution has scaled down.

Do you have the ability to go back and hold them accountable for that peak dangerous distribution of opioids?

Mr. Patterson. So on the criminal side, I believe it would be five years. On civil, I would have to find out. I am not sure how far back you can go civilly.

Ms. Castor. So you are --

Mr. Patterson. As long as it is an ongoing issue, then

you fall into that time frame.

Ms. Castor. And there was a lot of criticism by the Pulitzer Prize-winning Charleston Gazette Mail that the state didn't take advantage of data at their fingertips. What are -- how are you cooperating with states in providing that data so they can hold folks accountable?

Mr. Patterson. So this gets back to the issue, I think, with PMP which -- and this is why these two data sets are so critical with each other.

We see the distribution to the pharmacy. PMP data in the states will then show you the distribution out of the pharmacy, right. So that whole connection, that's where those other outliers become very critical for us to take a look at.

Some states, and this is the issue that we have addressed throughout the members that we've met through and the states that we've talked to, some states share this data.

Some states require a subpoena, which is also fine. Some states don't share. This is a problem that we have and, frankly, I think an issue that, you know I would hope that someone looks at on a legislative fix, at a minimum to make the states cooperate with each other because you have

bordering states, in some cases, that are still not participating and cooperating with each other, which is exactly how a lot of this diversion happens.

Ms. Castor. Thank you very much. I yield back.

Mr. Harper. Gentlewoman yields back.

Before we proceed, I want to clarify for the record that the DEA has been producing documents and the vast majority of the, roughly, 9,700 pages we have received have come in during the last month.

Those documents had substantial redactions. Staff identified key documents for you and yesterday the DEA brought up some of those for us to view in camera. And I will note that those documents still contain some redactions.

So there's still much work to be done. I wanted to clarify that for the record, that the bulk of these came in after Chairman Walden's press conference and we'll continue to work with you in this effort.

Mr. Patterson. Thank you, sir.

Mr. Harper. Now the chair will recognize the vice chairman of the subcommittee, the gentleman from Virginia, Mr. Griffith, for five minutes.

Mr. Griffith. Thank you, Mr. Chairman.

Mr. Patterson, I am going to need -- I am going to need your assistance on some of this because what I am going to do is ask a series of questions which require a yes or no answer.

First, if you would take a look at the email before you dated 5/6/2011. I show it to you here, and I would ask unanimous consent to put that into the record.

Mr. Harper. Without objection.

[The information follows:]

**********COMMITTEE INSERT 2**********

Mr. Griffith. And apparently, secret DEA official wrote, because his name is blacked out, our first and most prominent social responsibility as government officials in the DEA is to protect the public.

I think that trumps all other activities. I think that's what Congress/citizens would expect us to do. You agree with that statement, don't you? Yes or no.

Mr. Patterson. Yes.

Mr. Griffith. One of the key tools for DEA to fulfil their -- this mission is through an immediate suspension order -- I will henceforth refer to those as ISOs.

This is an administrative tool used as an emergency intervention to stop a rogue doctor or pharmacist from continuing to prescribe or dispense opioids that would possibly kill drug seekers and/or put the public at risk.

You agree with that as well, don't you?

Mr. Patterson. I do.

Mr. Griffith. An essential element for requesting the ISO is concern about imminent danger to public health or safety. A pharmacy in Oviedo, Florida received an increase of oxycodone of almost 2,500 percent compared to one year earlier.

Local police arrested customers in the parking lot of this pharmacy for selling/trading pills. Police officers were concerned customers were getting high in the parking lot and getting on the roads, endangering the public.

The continued dispensing of opioids by this pharmacy with its parking lot of drug pushers and drug users who get high and then drive on the public roads would pose an imminent danger to the public, wouldn't you agree? Yes or no.

Mr. Patterson. Yes.

Mr. Griffith. You would also agree, I assume, that speed is crucial in issuing imminent suspension orders to protect the public? Yes or no.

Mr. Patterson. I would.

Mr. Griffith. And 45 -- I will just tell you, 45 to 90 days that you told the chairman of the full committee is not -- is not acceptable. Please refer to the -- another email before you and I ask unanimous consent to put that in the record and this one is dated August 22nd -- or 20th -- there's two different dates on it.

Mr. Harper. Without objection.

Mr. Griffith. 2013.

All right. The email chain in August 2013 shows that DEA lawyers were requiring the DEA field to submit an expert witness report to describe the expert's assessment of data and documents prior to submitting either or both request -- either or both request for an immediate suspension order and orders to show cause.

Are you aware of this new requirement that was imposed in 2013? Yes or no.

Mr. Patterson. No.

Mr. Griffith. And I expected that.

Regarding medical experts being required, DEA counsel Lee Reeves wrote, "To be clear, this is not a chief counsel office requirement policy. This is the requirement of the administrator and the courts."

Are you aware that the medical experts are required by the DEA administrator? Yes or no.

Mr. Patterson. No.

Mr. Griffith. Mr. Reeves also wrote that as a general matter, these cases without expert testimony are the exception rather than the rule.

So, generally, DEA is requiring medical expert testimony before the field can submit an ISO to the chief counsel's

office for review. Is this still the policy of the DEA? Yes or no.

Mr. Patterson. It is not a policy, no.

Mr. Griffith. I appreciate that. Thank you.

Mr. Reeves cites the DEA administrator's decision in the Ruben case for requiring medical experts. However, the Ruben case is a show cause case, not an ISO.

This decision basically says that if a state doesn't -- if a state doesn't provide guidance on certain medical standards, the DEA must use an expert to explain why the doctor's activities fell below the standard of care.

However, you would not need a medical expert if the state had a statute of regulations on prescribing standards. Yes or no, or I don't know?

Mr. Patterson. I don't know that.

Mr. Griffith. All right. Fair enough.

Let's discuss this policy of requiring experts, and I know that you're trying to shift from some of that but let's discuss it.

It would take some time for the DEA field to find a medical expert, wouldn't you agree?

Mr. Patterson. I would.

Mr. Griffith. And to obtain the services of a medical expert the DEA would have to issue a sole source contract and the agency and the expert would have to figure out and reach an agreement on fee and deliverables. Isn't that true?

Mr. Patterson. I don't necessarily know about the contract but it would require some type of compensation.

Mr. Griffith. And after all of that, the medical expert would need to review prescription monitoring program, data patient files, and other information. It's going to take some time for the medical expert to review and render an opinion, isn't it?

Mr. Patterson. It would.

Mr. Griffith. Yes. After the medical expert completes the review then the chief counsel's office would need additional time to review the field submission of the request for an immediate suspension order. Isn't that true?

Mr. Patterson. Yes.

Mr. Griffith. Realistically -- this scenario assumes no delays along the way, and realistically this process, in many ISO cases, will take weeks, won't it?

Mr. Patterson. I would believe so.

Mr. Griffith. And that's where you get your 45 to 90

days. If the DEA registrant sought a restraining order against the ISO, the delay in timing getting the medical expert and going through all the steps we just went through would in fact weaken the DEA's case in court for immediacy, wouldn't it?

Mr. Patterson. I would believe so.

Mr. Griffith. Yes, it would.

And so in fact, insisting on an expert medical testimony for the ISO -- I get the trial in cheap, the merits. But to protect the public, insistent on a medical expert in advance is endangering the public and endangering your case on the ISO because it takes away the immediacy factor. Wouldn't you agree?

Mr. Patterson. Yes, and I --

Mr. Griffith. Okay. I got to keep moving because I am already out of time.

All right. Maybe I can get some more opportunity later. Thank you, Mr. Chairman. I yield back.

Mr. Harper. Gentleman yields back. The chair will now recognize the gentleman from California, Mr. Ruiz, for five minutes.

Mr. Ruiz. Mr. Patterson, thank you for coming. I am a

board-certified emergency physician and I can't tell you how personally I take whenever a patient comes in overdosed, not breathing, and blue.

It's not uncommon to see a blue-colored patient being strolled in in an emergency situation, having been dumped from a car from friends who found this person overdosed, not breathing.

And as emergency physicians we cut to the chase and we start resuscitating the patient. We know exactly what to do no matter if it's from overdose of opiates or any other reason why a patient is comatose. Whether we start the ABCs -- airway breathing circulations -- and we bring them back, as much as possible.

So I am going to cut to the chase here and ask you some -- ask you to be very frank and direct.

You screwed up. The DEA knew that there was a lot of opioids being shipped, an extraordinary amount and not outliers, and when you said earlier that there's two things that you were going to do from now on it's very concerning that those two things were to recognize how to use the data, and two, pay more attention to what you're doing.

That leaves me to believe that you were collecting data

that you did not know how to use, and two, you weren't paying attention to your job within the DEA.

So I am going to be very straightforward. What are you doing different now that you're going to recognize how to use the data?

Mr. Patterson. Sir, I appreciate the concern and I think what I've tried to explain is the data -- when we are talking about a lot of these cases that you have brought up we are talking about a time period in which this data was --

Mr. Ruiz. Okay. I would rather focus -- be specific on what are the changes you're going to do now. Not giving me the reasons why or an excuse. Tell me what are you going to do now that's different.

Mr. Patterson. So let me give you a handful of the differences.

Mr. Ruiz. Yes.

Mr. Patterson. On the suspicious orders, we have regulations that are in the final stretch to deal with that. We have a website that's now been built for the distributors to understand their customers better where they can go in and see partial information on other people that distributed to that particular pharmacy for the past six months.

1534 We are working with all of our other partners both in
1535 the Health and Human Services side and the states to try and
1536 combine all this data, to look at it in a very proactive
1537 manner.
1538 Mr. Ruiz. What are your flags? What numerical
1539 equations have you used to flag something for the pharmacies
1540 and for the distributors?
1541 Mr. Patterson. I would have to get you what the
1542 specific flags are for them. I mean, they --
1543 Mr. Ruiz. Are they new flags or are they old flags,
1544 like --
1545 Mr. Patterson. No, they're our baselines for any given
1546 area as to traditional, you know, what the prescribing rates
1547 have been in those particular areas and anything that's an
1548 anomaly to that is a flag.
1549 All right. So when we've talked about these issues
1550 before we have a --
1551 Mr. Ruiz. And who's looking at that flags? Who's the
1552 one in your department who's actually putting their eyes on
1553 this computer and reporting these?
1554 Mr. Patterson. A unit within the diversion.
1555 Mr. Ruiz. Okay. And how many people are in that unit?

Mr. Patterson. I would have to get that number for you.

Mr. Ruiz. Okay, because you have --

Mr. Patterson. Again, most of it's generated by computer.

Mr. Ruiz. Okay.

Mr. Patterson. So it's not necessarily a manpower-intensive endeavor to do.

Mr. Ruiz. Okay. And so when you said that now you're going to start paying attention to what you're doing, tell me about that. What are the organizational changes that you have made to start paying attention to doing your job?

Mr. Patterson. I don't think I said now that we are doing it. I think we've been doing it for a period of time.

Mr. Ruiz. Well, you said moving forward that now -- that, you know, what you have to do is to pay attention to what you're doing. That means to imply that there was some kind of slip-up before.

So what exactly are you doing? What are the changes? I want to -- I want to practice my ABCs for a patient who's coming in. I want to know what you're doing exactly that you're going to make sure that this doesn't happen again.

Mr. Patterson. I mean, again, that's some of the issues

I just talked to you about and how we use data, community -- or not community outreach. Well, community outreach with the prescribing --

Mr. Ruiz. Have you changed any organizational structure? Is there any accountability metrics that you have included in your department? Have you increased the staffing in certain areas?

What are you doing to pay better attention to your job?

Mr. Patterson. Over the past few years, we've increased staffing and diversion. We have a new head of diversion control coming in.

He and I have sat down and spent time on this particulars issue as to other proactive ways we can look at it. I met with the U.S. attorney and states' attorneys to talk about these issues of working criminal cases or civil cases and how they impact our administrative issues for the criminal prosecutions.

They want to continue to gather evidence. If we have some harm that's being done and we can stop it, then we have to start to balance this out in a better and more proactive way.

So there -- I mean, there are dozens of things we are

doing differently. This is not just a one issue fix.

Mr. Ruiz. Well, those are the things that I am particularly concerned and want to know more about because that's what's going to create the change is by -- is by making changes in your department in order to use your data more efficiently and also to start paying attention whether it's through computers or personnel, because a computer can flag all it wants to flag but if a human is not taking those warnings and having action based on what your computer is flagging then it's just going to be a flashing flagging computer.

Mr. Patterson. Understood.

Mr. Harper. Gentleman yields back.

The chair will now recognize the gentleman from Texas, Dr. Burgess, for five minutes.

Mr. Burgess. Thank you, Mr. Chairman.

And Mr. Patterson, I want to acknowledge that I asked for you to come to my office and you complied with that, and for that I am deeply appreciative with the information that you shared with me.

Obviously, this is something about which many of us feel very, very strongly. Clearly, we want to get some answers.

The subcommittee has interest in knowing about differences between voluntary suspension orders and immediate suspension orders.

I will stipulate that both exist and that we could argue which is a more propitious path to follow. Are there other tools you have in your tool box in addition to immediate suspension order and the voluntary suspension order?

Mr. Patterson. Sure. There's a whole range. There's letters of admonition, you know, orders to show cause. There's a host of administrative tools that we have that we can use in this space, and depending on -- and to go back to an issue that Mr. Griffith had brought up, depending on, quite frankly, whether it's a doctor or a pharmacy may be a very different reaction than what we would do or evidence we would gather against maybe a distributor.

Mr. Burgess. Let me ask you a question, because I can't take credit for it -- my staff did this -- but went to your Diversion Control Division and pulled down a document that's called "Cases Against Doctors" and this is produced by the U.S. Department of Justice and Drug Enforcement Administration.

I presume it's your product. It's about a hundred pages

long. It goes back, basically, to 2002 through October 12th of 2017.

It's a hundred pages or about three cases per page, so that's 300 cases against doctors in the last 15 years. Does that sound about right?

Mr. Patterson. Sir, I don't know. That's a complete list of all doctors that cases have been worked or is that -- is it a guide to help people and where people have gotten into trouble?

Mr. Burgess. Well, I will tell you what concerns me as I look through this is that most of the dates are pre-2009. So I guess my question would be where is the data from 2010 onward and perhaps that's something we can follow up with together because I do share the provider's perspective on this. We want to be able to provide pain relief when it's required of us and it's appropriate.

At the same time, we obviously do not want to be jeopardizing public safety and the integrity of society the way the opiate crisis is endangering us currently.

But I think this could be very important information. You referenced, at the start of your testimony, that over prescribing is perhaps one of the number-one problems. Well,

if that's the case, then it's this sort of information that is, I think, going to be very helpful to us as policy makers how do we develop the correct policy.

Let me just ask you, did I understand this figure correctly? You referenced $309 million in fines at the -- at the DEA level. Is that correct?

Mr. Patterson. In civil fines, $390 million or $309 million.

Mr. Burgess. So okay, that ballpark -- $300 to $400 million.

We'd appropriated a billion dollars in cures for treatment of this problem. We are looking at another $6 billion in the appropriations bills that are coming through right now. So you see the disparity there.

Someone, whether it be suppliers prescribers is causing a problem to exist. You're finding them but it's only minuscule compared with the amount that it's actually costing society in trying to save people, salvage people, get people back to productivity.

That doesn't even address the fact that, again, people are taken out of -- out of productivity -- out of being productive citizens when they enter into this type of

behavior. Is that correct?

Mr. Patterson. I agree, sir. And may I just add? I mean, so these fines come as, again, and you -- some of the members have already mentioned this balance, right, of ensuring pain medicines for people.

So I think the fines generally come with, quite frankly, the heavier piece of that is the memoranda of understanding or memoranda of agreement of how they'll behave, moving forward.

Mr. Burgess. Correct. I get that.

Let me just ask you this, because I think it was Mr. Barton referenced 80 people a day who were dying -- was 115 was the total number but 80 per day are dying because of what you described as over prescribing.

And then we've got these lists that in my observation are not up to date. Do we know how many people were dying a day from over prescribing in 2007, 2008, 2009 in that time frame? Do you have a figure?

Mr. Patterson. I don't have it here. I would be happy to get that stat for you. It still was an alarming number, even back in that time period, sir.

Mr. Burgess. And then that begs the question. You

know, I mean -- and, again, I appreciate the effort that you're putting into it now.

But it's been right there in front of us for well over a decade, decade and a half and, clearly, it requires all hands on deck in our approach. And, again, I appreciate your being very forthcoming with my office and I appreciate that.

Mr. Chairman, I will yield back.

Mr. Harper. Gentleman yields back.

The chair will now recognize the gentlewoman from New York, Ms. Clarke, for five minutes.

Ms. Clarke. I thank you, Mr. Chairman, and I thank our ranking member.

Mr. Patterson, it's clear in many cases certain drug distributors supply very large volumes of opioids to some pharmacies in West Virginia.

But we've also seen from DEA's data that many of these pharmacies were buying from multiple distributors. For example, in 2009, the West Virginia pharmacy, Hurley Drug, received over 2 million opioid pills from six different distributors, including over 300,000 from one distributor, over 600,000 from a second distributor, and over 900,000 from a third.

So it's bad enough if one distributor over supplies a pharmacy. But when you look at the total shipments that Hurley Drug received from all distributors, it was about 2 million pills, which is over seven times what a similar pharmacy will be expected to receive, according to DEA's own data.

So DEA is the only entity that can see the volumes that multiple distributors are simultaneously sending to a single pharmacy. Is that correct?

Mr. Patterson. From the distributor level, yes, ma'am.

Ms. Clarke. So, Mr. Patterson, was DEA performing analytics a decade ago to identify these kinds of patterns at individual pharmacies?

Mr. Patterson. Again, ma'am, in a reactive manner at that time.

Ms. Clarke. Okay. So I would like to look at DEA's data on another pharmacy in West Virginia -- Sav-Rite Pharmacy in the small town of Kermit received hydrocodone from five different distributors in 2008.

A few distributors provided relatively normal amounts that don't seem to raise alarms. However, one distributor shipped 1.2 million pills and another shipped nearly 2

million.

All told this pharmacy got nearly 4 million pills that year, which is nearly 15 times what a similar pharmacy would be expected to receive, according to DEA's data.

Mr. Patterson, if you rely on distributors to report suspicious orders from pharmacies, how do you flag pharmacies trying to stay under the radar by buying from multiple distributors?

Mr. Patterson. So, ma'am, this is where, again, the data that we use today -- not the data, I shouldn't say the data -- but how we use the data is very different today, and this is also where the critical nature comes into us working with the states.

Those same pharmacies, that PMP data which show that amount of distribution from those pharmacies, so we have that distributor in and then the pharmacy out, depending on the PMP program.

So the key is for us to work together on that and, again, I can say repeatedly in 2008, 2009, and 2010 we did not use this data in the way that we are now using it and I think that's the key.

I get that we have this issue from a decade ago, that we

have to resolve, you know, in terms of how we used it. And, again, where we fell short in that we'll take responsibility for it. I think the system is much more robust and used in a much different way in --

Ms. Clarke. So can you give us a little bit more insight into how you're proactively analyzing the data to ensure that pharmacies are not being over supplied by multiple distributors? That has not come across clearly to us this morning. How are you actually doing that disruption?

Mr. Patterson. Again, we are taking this -- so as we talked about in the opening, we are proactively looking at data not just across DEA and that ARCOS database that we've talked about but HHS, PMP programs where we are sharing that information and looking to proactively target outliers.

Ms. Clarke. So how do you -- what happens once you, you know, you're flagged in this -- in this regard?

Mr. Patterson. So we --

Ms. Clarke. What exactly happens?

Mr. Patterson. We send that information out to the field for investigators -- those TDS groups or diversion groups, depending on how they're being used to go out and work those cases to find out is it a legitimate amount of

prescriptions that are going there or is there illegitimate diversion occurring in those areas.

Ms. Clarke. And has that -- has that worked thus far? Because, you know, you said this was over a decade ago. I am assuming that you have already begun sort of this new protocol. What are your findings?

Mr. Patterson. Yes, ma'am. So the interesting thing is of those 400 packages that went out, a good majority of what we saw in that data and the outliers and what they identified were ongoing cases that we already had, which shows that that data set works to develop and target those areas where we have problems.

To the extent that we didn't have cases on those other ones and they were warranted, we've opened cases on those facilities or doctors or distributors to take a look at that behavior.

Ms. Clarke. Mr. Patterson, I just want to share with you that, you know, this is an ongoing crisis. Once we are able to disrupt sort of this supply chain, we know that these supply chains become supplanted by more nefarious actors.

And so, you know, I really want to impress upon you and your agency to be as forward leaning in this regard as

possible because once those pills are cut off, we know that that's when the illicit trade picks up in velocity.

Mr. Patterson. Yes, ma'am. And as we've talked about, again, in the opening, I think that shift has already occurred.

Ms. Clarke. Thank you. I yield back, Mr. Chairman.

Mr. Harper. Gentlewoman yields back. The chair will now recognize the gentleman from New York, Mr. Collins, for five minutes.

Mr. Collins. Thank you, Mr. Chairman, and thank you, Mr. Patterson for being here.

I think you can tell and your get out of jail free card today, you have been in this particular job five months. I would hope five months from now you would not be giving many of the same answers.

Following up on what Mr. Ruiz said, I think we are just all frustrated. There seems to be the bureaucracy mind set in the DEA today, much like we've seen in the VA.

And, you know, we are finally seeing heads rolling in the VA. Not as fast as we want. I am just curious, because there's no doubt there was an abject failure of the DEA, going back the last 10 years.

Have a lot of heads been chopped off? I mean, have you got a new team in place?

Mr. Patterson. Sir, so as I said, we have a new head of Diversion Control. I think the last two people that have done that job have done and both successful in turning around that program.

Mr. Collins. Well, I just -- not to interrupt but to interrupt, you know, I think the right people can turn this around in 48 hours. I mean, I am a turn around guy. That's what I've spent my whole life doing.

You bring a new team in and people get called in the office every day and they walk out saying, somebody just hit me up the side of the head with a baseball bat. I am either going to get my act together or I am going to get out of Dodge.

This isn't a time to be polite or nice or let's do better tomorrow. No, this is an abject failure, and if I go back to -- if I am sitting in that seat and McKesson processed 1.6 million orders and only 16 were deemed suspicious, that's absurd.

I mean, I don't know what kind of computers you got but that's absurd. It means no one was watching.

And you can say well, that was being done in the district level. But it's indefensible. When we look in West Virginia and two suspicious orders so, you know, let's, you know, maybe jump ahead, and in 2008, Cardinal Health was fine $34 million for not reporting suspicious orders.

All right. So let's go forward eight years later. They're still not doing it. You know, two guesses. First -- second one doesn't count.

How much do you think you fined them eight years later for the same problem? Thirty-four million dollars, the same amount. In most places the second offense -- all right, first offense $34 million, eight years later the same problem, the same fine? Should have been tenfold. Should have been $340 million dollars.

What message did you send -- what did your agency do? And this was a year ago -- year and a half ago. I mean, you guys don't get it and if you're not -- this committee agrees on a lot.

I don't think we've ever agreed across the board on an issue as much as we are agreeing your agency needs to be turned upside down, not just a little shakeup here and there but turned upside down. It starts with you. If you can't do

it, you ought to get out.

So when I look at some of the things -- so we have distributors. We have pharmacies. We have doctors. Well, I happen to live next door -- literally, next door to one of the doctors, Dr. Gosy, in Clarence, New York, and I saw his six sports cars parked out there with all new -- I mean, his name in the community was Dr. Pain. And this wasn't something new.

So it took -- when I look back, it took the DEA a good seven years to come after my next door neighbor. By the way, he doesn't live there anymore.

But he had set up a script line in 2012 where people could call in and fill scripts with PAs under basically no supervision.

So at what point -- how could you allow a single physician -- my next door neighbor, literally, in Clarence, New York -- to write more prescriptions for opioids, millions of them, than any other doctor or in fact any other hospital in the state of New York?

There's 20 million people in New York. My particular town of Clarence has about 50,000 people, and one doctor in the town of Clarence was writing more prescriptions than any

doctor in the state of 20 million people or any hospital including New York City.

Took you guys five years to figure out there might be something suspicious? Would you agree, I mean, that's unacceptable?

Mr. Patterson. Sir, so I wouldn't have any data on a particular prescriber. DEA doesn't hold that set of data.

Mr. Collins. Well, he's now been indicted. They've seized his cars. They've seized his bank accounts.

Mr. Patterson. So at some point, whether that was a DEA case or a state local case, I don't know what it was that investigated him and --

Mr. Collins. It was a federal case.

Mr. Patterson. Okay. So at some point we learned of that and then there was --

Mr. Collins. Yes, but what's going on with your computer systems and other things? It takes you four or five years. I mean, I am -- I know how computers work, pretty much. I don't know how old yours are. I mean, maybe they're XT, you know, tabletops. I am not sure.

But this kind of data should be instantaneously available.

Mr. Patterson. And, sir, I go back to the states control prescription monitoring program, not DEA. We control into a pharmacy. The doctor --

Mr. Collins. Well, maybe you should be kicking some butt going down the chain. I mean, if I was sitting in your job and you're on the hot seat right now, and you're telling me now, I mean, placing the blame on the states, that doesn't cut it in our world here. We are not looking to place blame. We are looking for solutions.

My time has expired. We look forward to you coming back in another four or five months and having a different set of answers.

Thank you, sir.

Mr. Harper. Gentleman yields back.

The chair will now recognize the gentleman from New York, Mr. Tonko, for five minutes.

Mr. Tonko. Thank you, Mr. Chair.

I want to find out if DEA uses data gathered through its ARCOS system to game disability into how many opioid pill distributors send pills that -- distributors send to a town or region as a whole, even if the distributions are spread out over multiple pharmacies.

Administrator Patterson, one town examined by the committee was Williamson, West Virginia, population 3,000. Our committee's investigation focused on two pharmacies in Williamson. The first is Tug Valley Pharmacy.

Mr. Chair, could I ask that we please show minority exhibit three on the screen?

Okay. We have here the Tug Valley Pharmacy. According to DEA's ARCOS data, between 2006 and 2016, Tug Valley Pharmacy received over 10 million doses of opioids from 13 different distributors.

This includes over 3 million pills just in 2009. So Administrator Patterson, this is an unbelievable quantity of opioids for a pharmacy this size in a town of 3,000. Does DEA believe the amount of opioids this pharmacy received was excessive?

Mr. Patterson. In 2009 I would say so, sir.

Mr. Tonko. And, again, Mr. Chair, if we could please put minority exhibit four up on the screen. This is the second pharmacy in Williamson -- Hurley Drug -- that we see on the screen here.

ARCOS data show that Hurley received over 10.5 million doses of opioids from 11 different distributors between 2006

and 2016.

This includes over 2 million doses in both 2008 and in 2009. Mr. Patterson, again, this strikes me as an excessive amount of opioids for a pharmacy in a town of 3,000 to receive.

Do you agree that this is unreasonable?

Mr. Patterson. I would agree.

Mr. Tonko. I've mentioned that both of these pharmacies are located in Williamson and, incidentally, both of them are still in operation today.

I want to show you where they are located. So if we could please post minority exhibit five on the screen, and combined distributor shipped over 2,000 -- excuse me, over 20.8 million doses of opioids to these two pharmacies, which you can see on our screen, are located only blocks apart and they did that 20.8 million doses of opioids between 2006 and 2016.

Mr. Patterson, between 2006 and 2016, what kind of ARCOS data analyses did DEA do to alert it when distributors shipped an unwarranted amount of opioids into a town or region so that it could stop these excessive distributions?

Mr. Patterson. Again, sir, I would have to go back and

look at that specific example and look at the data set in terms of where those periods of time were.

As I already testified previously, we use the data in a very different way today than we did then. But I would want to go back and specifically look at the time frame and what was going on and I can get back to you on that.

Mr. Tonko. If the data were used today, that you have -- you know, as you use it today would it have avoided something like this?

Mr. Patterson. I would hope so.

Mr. Tonko. Well, can we have a little more of an answer? I am hoping is good, but --

Mr. Patterson. I would like to -- I would like to -- but I mean, part of the, I think, the important issue that we are talking about today is to go back and look at these specific examples.

Like I said, I have seen examples where on ARCOS data we actually can't see some of these anomalies. So I think, in taking these examples back and looking at them and we are using a time frame of 2006 to 2016, I can't tell you for the last couple of years what that ARCOS data has been, as I sit here.

Traditionally, what we've seen is very high levels of distribution into those places between 2008 to 2010 or 2011 when we started to look at this data in different ways.

Still not nearly as proactively as we do today. But that's why I would like to take this example back and look and get back to you on essentially what's happened with that.

Mr. Tonko. Thank you.

I have been dealing with this issue a great deal in my district and when I hear of opioids being the gateway to the illness of addiction, it's very disturbing, and the heartache and the pain and, unfortunately, the death associated with that illness is a crisis and we need to -- we need to do something very valuable here and I would implore that the folks at DEA be smarter in their approach.

And with that, I yield back, Mr. Chair.

Mr. Harper. Gentleman yields back.

The chair now recognizes the gentleman from Pennsylvania, Mr. Costello, for five minutes.

Mr. Costello. Thank you, Mr. Chairman.

Are you aware that the DEA's chief ALJ authored quarterly reports describing DEA's declining use of ISOs and noted in June 2014, quote, "an alarming low rate of agency

diversion enforcement activity" on a national level?

Mr. Patterson. I have read those, yes.

Mr. Costello. For the last several years, the chief ALJ has reported declining number of ISOs to the DEA administrator on a quarterly basis. This issue had also been raised in the committee's investigation.

My question -- why has the number of DEA ISOs declined significantly over the past few years.

Mr. Patterson. I think there's two things when you look at those statistics.

I think that, although warranted, the statistics were very high in 2010 and 2011 because of the issue that we were dealing with in Florida and how those ISOs were being used.

I think during this latter part we have gotten to a point of in trying to expedite the surrender of registrations we have much more gone into a posture of trying to get voluntary or surrender for cause orders.

Mr. Costello. Is there still a need today, as there was in 2011, for the DEA enforcement tool of ISOs?

Mr. Patterson. Yes.

Mr. Costello. A 2013 report by the chief ALJ stated the DEA's chief counsel had, quote, "instituted a new vetting QA

initiative" that could be slowing the progress of diversion cases.

What was this initiative?

Mr. Patterson. I don't know if it was initiative or if it was guidance. I think the --

Mr. Costello. What was the guidance? Yeah.

Mr. Patterson. I think the issue at play here was directed towards distributors, not necessarily directed at doctors and pharmacies.

Mr. Costello. Do we have -- have you provided that guidance in full to this committee?

Mr. Patterson. We have not.

Mr. Costello. Will you?

Mr. Patterson. That's a conversation that we've had with Mr. Walden and we'll continue to work forward on that --

Mr. Costello. When a state revokes the medical license of a doctor, that doctor is no longer eligible to have a DEA registration associated with that medical license, correct?

Mr. Patterson. That's correct.

Mr. Costello. When the doctor no longer has state authority to prescribe does the DEA have to conduct any further investigation or can DEA execute revocation of DEA

registration by just obtaining the certificate of the medical license revocation?

Mr. Patterson. We can do an order to show cause.

Mr. Costello. No investigation is needed?

Mr. Patterson. That's correct, because they've lost state authority.

Mr. Costello. After a state revocation of the doctor's medical license, how quickly is DEA notified about the revocation and how long does it take for DEA to revoke the doctor's DEA registration?

Mr. Patterson. That's where we need to be working with the states to essentially learn of that -- the state medical boards to learn of that information. Our field division offices are responsible for that.

Mr. Costello. Are the vast majority of DEA enforcement actions in diversion litigation cases comprised of these no state authority cases that do not involve DEA investigation?

Mr. Patterson. In terms of the orders to show cause?

Mr. Costello. That's correct.

Mr. Patterson. That's correct.

Mr. Costello. Yes?

Mr. Patterson. Yes.

Mr. Costello. Is it estimated to be about 80 percent of their actions?

Mr. Patterson. I would believe that's probably a fair number.

Mr. Costello. Mr. Chair, I would like to yield the balance of my time to you, Mr. Griffith.

Mr. Griffith. Thank you very much.

When I was asking you questions earlier, we talked about the ISOs and the apparent requirement -- I know you didn't do it but the apparent requirement for a medical expert in advance of issuing an ISO and the fact that that would take a number of weeks and you said 45 to 90 days. I went through all the different steps that might actually lead to that.

So you agree that it's the DEA's mission to protect the public safety and we agree that there's a tremendous amount of delay and part of that delay in small -- in no small measure is the requirement that before you get that administrative tool of the ISO you have to get a medical expert.

So can you, as acting administrator, agree with me today that you would be willing to reexamine the medical expert

requirement?

Mr. Patterson. Absolutely.

Mr. Griffith. And I appreciate that.

Mr. Patterson. And again, we are using the word requirement. I think these documents are in reference to distributors and not doctors and pharmacies. But I would be happy to go back and look into that further.

Mr. Griffith. Yes, it was actually reference to doctors and pharmacies. But that's okay. As long as we are working it out, that's where we want to go. We want to make things better.

And one of the reasons that I get so passionate about this is you saw Mr. Tonko's minority slide of Hurley Drug earlier.

Well, Hurley, Virginia, is 33 miles from Williamson, West Virginia, where that drug store is located. And anybody with any sense knows that a big bunch of those pills were coming into my district.

Likewise, I had some additional questions that dealt with the fact that we have problems in -- with red flags being raised that apparently takes a while to be picked up on.

So we had a doctor in Giles County who was sending his patients over to West Virginia to get drugs. We have a situation in Martinsville where they have, according to the CDC, they prescribe more opioid pain killers than anywhere else in the U.S. per capita and where another doctor was prescribing opioids for patients in North Carolina.

So I look forward to working with you to solve these problems. But these are real world problems, real world people, and real word deaths.

Mr. Patterson. I agree with you.

Mr. Griffith. I yield back. I now recognize Congresswoman Walters for five minutes.

Mrs. Walters. Thank you, Mr. Chairman.

Mr. Patterson, it's my understanding that the DEA often uses tips and information it receives from state and local law enforcement to develop cases against entities or individuals suspected of engaging in or facilitating illicit drug diversion. Is that correct?

Mr. Patterson. Correct.

Mrs. Walters. According to the DEA, the Automated Reports and Consolidated Ordering System, or ARCOS, provides the agency with retail level data regarding controlled

substance transactions. Does this mean, for example, ARCOS can show many doses of hydrocodone or oxycodone an individual pharmacy received in a given year?

Mr. Patterson. Yes.

Mrs. Walters. In fact, as part of its investigation, the committee has obtained and analyzed ARCOS data for parts of West Virginia to great effect. So we recognize how important a tool it can be.

In February of this year, DEA announced that it was adding a feature to ARCOS that will allow manufacturers and distributors to view the number of companies that have sold a particular controlled substance to a prospective customer in the preceding six months.

Mr. Paterson, does this policy enable companies to see the amount of controlled substances its current customers are receiving from other suppliers?

Mr. Patterson. Yes. Part of the suspicious orders is them knowing their customers to know when to file these concerns.

Mrs. Walters. Does the newly added features in ARCOS provide state and local law enforcement with greater access to the system's retail level data?

Mr. Patterson. I would have to find out if it provides at the state level. When we work investigations with the state level -- the state and local level, obviously, we can share that data as part of an investigation.

This is also part of the issue that we are dealing with the states' attorneys general on as to how to share these data sets to be more proactive.

Mrs. Walters. Okay. According to a letter the DEA sent to the committee in November of last year, DEA will share ARCOS data with law enforcement on a need to know basis and when they are operating in coordination with the DEA for investigative purposes.

So is it fair to say that the state and local law enforcement entities do not have access to DEA ARCOS data on a real-time basis?

Mr. Patterson. If we are working an investigation we'll share that data in a real time with them.

Mrs. Walters. Okay. Is DEA developing any proposals that will enhance state and local law enforcement's ability to access and utilize ARCOS data?

Mr. Patterson. Again, we are working jointly with them and this also goes back to the effort, I think, with our

states attorneys general.

Mrs. Walters. Okay. In order to effectively combat the opioid epidemic we need -- we need an all hands on deck approach. The DEA has data that could assist state and local law enforcement to identify potential sources of illicit drugs in their communities and I think the agency should be exploring every avenue to provide this data to law enforcement as quickly as possible.

It seems to me that providing state and local police with access to ARCOS data would be beneficial to the DEA as well, effectively providing the agency with additional eyes and ears on the ground, likely resulting in additional leads being produced to the agency.

Mr. Patterson, will you commit to examine ways to improve state and local law enforcement's access to ARCOS data so that bad actors might be able to be identified with greater frequency and effectiveness?

Mr. Patterson. Yes, ma'am.

Mrs. Walters. Thank you, and I yield back the balance of my time.

Mr. Harper. I now recognize the gentlelady from Indiana, Mrs. Brooks.

Mrs. Brooks. Thank you, Mr. Chairman.

Hello, Mr. Patterson. Since 2011, the number of immediate suspension orders issued by the DEA, as you have even noted, declined significantly from a high of 65 in 2011 down to a low of 6 in 2017. So I want to talk about that a little bit.

Are there instances in which the DEA pursues an immediate suspension order, the ISO, in parallel with related potential criminal investigation?

Mr. Patterson. So, ma'am, since October, so the administrator's position signs the ISOs when they're issued. What I have traditionally seen is because of the process of where a criminal case is being investigated there's been a delay in the ISO process as they're gathering evidence.

One of the concerns I have, and it goes back to, again, what Mr. Griffith said, is that cuts against the very argument that we have an imminent problem that we are trying to deal with.

So, again, my conversations that I've had with both U.S. and states attorneys are is that we have to act much faster in these cases in terms of if we have ongoing harm and we have the ability to stop that harm, even at the peril of a

criminal case, then that's what we should be doing.

Mrs. Brooks. And let's be clear. The U.S. don't do the immediate suspension orders. Those are done by the DEA.

Mr. Patterson. The DEA. It's an administrative action.

Mrs. Brooks. And are you saying that the U.S. attorneys were asking -- as a former U.S. attorney are you saying the U.S. attorneys were asking or telling DEA not to issue ISOs?

Mr. Patterson. In trying to gather evidence in their criminal case.

Mrs. Brooks. I understand, but that can take months if not years sometimes in criminal cases. But that is what -- do you believe that's what happened prior to you coming in October of 2017 -- that delays happened?

Mr. Patterson. I think that's been an ongoing theme of what some of these delays are caused by.

Mrs. Brooks. And why would the DEA delay that type of administrative action in pursuit of a criminal investigation? What -- why?

Mr. Patterson. Because people believe that the criminal investigation is an important endeavor towards whether it's that doctor or that pharmacy.

Mrs. Brooks. Well, very -- it is very important, no

doubt, because that person is, obviously, distributing -- or the belief is distributing illicitly. But why would an immediate suspension -- is that so that undercover operations can happen with the physician?

Mr. Patterson. Yes, ma'am.

Mrs. Brooks. And the prescriber?

Mr. Patterson. The gathering of evidence.

Mrs. Brooks. And what is the new guidance, and I appreciate the importance of gathering of evidence, but what is the new guidance relative to ISOs and criminal investigations that you are contemplating or that are in place now, and is that guidance in writing?

Mr. Patterson. So it is not formalized. This is conversations that I've been having with the AGAC, the, you know, advisory --

Mrs. Brooks. I served on the attorney general's advisory counsel.

Mr. Patterson. And to the extent that I've been meeting with states' attorneys to try and talk to them about the same issues.

So I think we have to, again, a lot of this is striking a balance. I, frankly, feel that a lot of these cases can be

worked backwards on the criminal aspect.

I understand that their desire in a lot of these cases is to be able to get contemporaneous evidence, use undercover, right, as opposed to having to use witnesses that have come in that maybe not have the best of backgrounds.

So I understand that balance. The concern I have, like I said, if we are using an ISO, it feels awful weird to be signing that ISO a year after we learned of that problem.

Mrs. Brooks. And I noticed in some of the -- in the document that Dr. Burgess had there was some of that, that the ISO was a year after the arrest even.

Mr. Patterson. Correct.

Mrs. Brooks. Although at the time of the arrest, typically that individual would be under their medical licensing procedures as well. Is that correct?

Mr. Patterson. Correct.

Mrs. Brooks. But wouldn't it make more sense to in many ways implement an ISO in the middle of the criminal investigation because those can take months if not years, and in the meantime we've got all of these people dying.

Mr. Patterson. I couldn't agree with you more and, quite frankly, even in the absence of the ISO, my concern is

is that why aren't we trying to get a voluntary surrender as quickly as we have. And we have a lot of offices that do that in a very expeditious manner.

Mrs. Brooks. And will your proposed guidelines impose a cap on the length of time it can be delayed? Is that the kind of discussion you're having. You're looking at, like, 30 days? Forty-five days?

Mr. Patterson. I think, striking that balance, we have to figure out where the days are. There will probably always be that exception that comes up and I think as long as people are willing to -- whether it's a U.S. attorney or a states' attorney that is willing to put in writing why we need to delay and we can evaluate that, I think that's something.

I mean, the process itself I think we have to work through. Like I said, we have new head of diversion control. This is an issue that has been bothering me greatly. Since October I've seen these and I've signed them and I have generally the same question every time, which is why are they taking so long.

Mrs. Brooks. And for the record, I would just like to acknowledge when I became a U.S. attorney in 2001 one of the very first huge cases we did was against a doctor, Dr.

Randolph Lievertz, for over prescription of oxycodone, and DEA in 2001, 2002 and beyond said prescription drugs were going to be the next crisis in this country.

Didn't start in 2010, didn't start in 2011. It was back in 2001, 2002, and we had a huge focus on it during that period of time and it's just really been very devastating, seeing that we fell off of that commitment it feels like in the last several years. I yield back.

Mr. Harper. Gentlewoman yields back.

The chair will now recognize the chairman of the full committee for some follow-up questions. Mr. Walden.

The Chairman. Thank you. I appreciate the indulgence of the committee.

You raise an interesting issue about the U.S. attorneys weighing in here and saying to the DEA, stop -- don't do your ISO -- we want to proceed with the criminal investigation.

One question -- do they have the authority to override your ISO authority. That would be one. And then I want to know the who, what, when, where, why.

Who are the U.S. attorneys that interceded on which cases in what areas and told the DEA suspend, and do they have that authority.

Because, to Mrs. Brooks' point, people continue to die -- die during this period, and I want to know this -- this is part of our public policy debate here is does a U.S. attorney's office somewhere have the authority to tell you don't do the ISO, don't stop the death because we got to investigate and go criminal, which will have a bigger penalty, which I respect.

But is it one agent somewhere? One U.S. attorney in one state that is -- is that why West Virginia went off the rails?

And so I would like you to get back to the committee with answers to those questions.

Mr. Patterson. I would be happy to do so, sir. And look, what I can assure this committee is I think this is a topic that we have had some robust discussion on lately as we've gone through these and I will also assure you that the direction of this administration is to stop the harm as quickly as possible.

The Chairman. But I think you should be able to answer the one question. Do the U.S. attorneys have the authority to overrule your agency's decision making?

I know you have -- you weren't there running it at the

time.

Mr. Patterson. I would believe that we could issue the ISO even against the wishes of a U.S. attorney or a state's attorney. It probably doesn't help relationships to take those kind of unilateral actions.

But, that said, I think part of this is the education of us holding up these things, why they look at either criminal or civil actions.

The Chairman. I would go back to Mr. Griffith's analogy. If you have got a drunk driver driving down the road, you don't wait until they have the fatal accident to pull them over and stop them.

Mr. Patterson. I couldn't agree with you more.

The Chairman. You can prosecute them along the way and I would think you could make the case, going backwards, because the prescriptions have been written. The pills have been sent out.

These two pharmacies we raised with you months ago are, my understanding, still operating in West Virginia. Are they not?

Mr. Patterson. I don't know. Those are the ones I have to go --

The Chairman. They're not operating. All right.

Well, if you can get back to us on the who, what, when, where, why on these U.S. attorneys that would be good.

Thank you.

Mr. Harper. Gentleman yields back.

The chair will now recognize the gentleman from Georgia, Mr. Carter, for five minutes.

Mr. Carter. Thank you, Mr. Patterson.

Mr. Patterson, I suspect you know that currently I am the only pharmacist serving in Congress, and Mrs. Brooks makes a good point. This is not something that started in 2010 or 2011. It was going on in 2001 and 2002.

I was practicing back then. Now, granted, I haven't practiced in quite a while. It's probably been four or five years since I practiced. But I still know what's going on out there.

You know, we've been kind of nibbling or you have been nibbling around the edges here. There have been great questions asked here but I want to follow up on the questions that Representative Collins asked about the alpha -- the beginning of where this problem starts and that's the doctors who are writing these prescriptions.

Now, I am not naive enough to believe that there aren't pharmacies out there that are in collusion with doctors or filling fraudulent prescriptions.

But I want to talk about the doctors who are writing these prescriptions who are obviously out of control and why it's taken DEA so long to get them in control or under control.

I will just give you an example. I served in the Georgia state legislature for 10 years. I sponsored the legislation that created the prescription drug monitoring program back in 2009.

I was jumping up and down then, saying this is a problem -- we've got to get it under control, and it was falling on deaf ears.

There are doctors right now in our community that our pharmacists won't fill prescriptions for. They just say no, that doctor's out of control -- I don't fill for that doctor.

I was working one President's Day. We were out during our session. On President's Day we are always out. I had someone come into my pharmacy, a young lady who had the holy trinity of drug abuse -- 180, oxycodone, Xanax, and Soma, three prescriptions there.

I looked at them. She gave me her driver's license from Florida. I said, I am not filling these prescriptions. She drove off in a car with Kentucky driver's license plates.

Now, I am not going to fill those prescriptions unless I have a legitimate prescription, okay, and I didn't want to fill that. But you're putting me in the position where I've got to judge whether that patient is legitimate or not.

I am not trained in law enforcement, as a pharmacist. But I want to know why, when there are doctors out there who are writing these prescriptions why can't you get them quicker?

Mr. Collins is right. You ought to be able to turn that around in 48 hours. The first time I get three prescriptions for 180 of those -- of those drugs -- of the oxycodone, Xanax, and Soma I know that doctor is out of control. Something's wrong there.

Why -- you know, I had an example -- I had a doctor who we didn't fill for, Dr. B. I went home about a year ago and some of the pharmacists were telling me, oh, they finally busted Dr. B.

I thought, wow, why did it take them five years to bust him. We never filled his prescriptions for five years but he

kept on practicing.

Well, they didn't exactly bust him. They got him for Medicare fraud. Didn't even get him for writing those prescriptions -- never did.

Another example here, Dr. D.N. He was -- he got thousands -- literally thousands of people addicted to these medications, and then he goes before the Composite Medical Board and gets slapped on the wrist, and they come back and they make him practice under the supervision of another doctor.

That's his penalty. Now he's practicing -- he lives on the waterfront, a beautiful home, beautiful cars, and yet thousands of people have been -- have been addicted because of these prescriptions that he has written.

We wouldn't fill his prescriptions. He's a rogue doctor. We are not filling those. Tell me why it takes you so long to get to the alpha, to the beginning, to the doctors who are writing these prescriptions who are out of control. Explain that to me, because I don't understand it.

All you have to do is go into a community and say, what doctors do you not fill for, and the pharmacists will tell you -- we don't fill for this doctor and we don't fill for

that doctor.

Mr. Patterson. Well, and that's, quite frankly, what we have to rely on. So, you know, again, and I am not -- look, the one thing I am not going to do in this space is shift blame anyplace.

This is a collective --

Mr. Carter. Well, it appears to me that that's what you're doing because Mr. Collins is right. You can turn this around in 48 hours. Just get those doctors out of there.

Mr. Patterson. But in the cases of these doctors, look, when we do our reviews we ask information, try and solicit people to essentially, you know, in the registrant community to come in and talk about the registrants they have problems with.

If that doesn't happen, then our next course is someone that's been arrested that says, this is what's happening in a criminal case.

Mr. Carter. But you can understand our frustration. When we don't fill prescriptions for that doctor but for years -- literally, four or five years, they continue to practice.

Mr. Patterson. I understand, and this is where PMP data

becomes absolutely critical and it's because that isn't --

Mr. Carter. But why -- what can we do to help you to be able to get these doctors under control? What can we do? Tell me what we can do in Congress.

Mr. Patterson. It's the PMP data is really what it boils down to.

Mr. Carter. You -- we've had the PDMP since 2009 in Georgia.

Mr. Patterson. But, sir, DEA doesn't have access to that data. It depends on the state.

Mr. Carter. Can you shut the doctor down? Can DEA shut the doctor down or is that up to the Composite Medical Boards of the states?

Mr. Patterson. No, if we had the -- if we had someone that was showing us that a doctor was over prescribing then --

Mr. Carter. But don't you know -- when you get this information of pill dumping you know that that pharmacy is getting those prescriptions from somewhere.

Then that ought to be -- that ought to be an indication to you. We need to -- Mr. Chairman, please -- we need to go to that community and we need to find out what's going on

here. They're coming from somewhere.

Mr. Patterson. Understood.

Mr. Carter. Thank you, Mr. Chairman.

Mr. Harper. Gentleman yields back.

The chair will now recognize the gentleman from West Virginia, Mr. McKinley, for five minutes.

Mr. McKinley. Thank you, Mr. Chairman. As not a member of this committee, I appreciate you giving me the opportunity to raise some issues with that.

Again, Mr. Patterson, thank you for being here. Are you familiar with this book written by John Temple called "American Pain?"

Mr. Patterson. No, sir.

Mr. McKinley. This is about the clinic down in south Florida that was the epicenter of the opioids. I really would suggest that you and everyone else that's paying attention to this read that book.

But anyway, because with all due respect for the way some of your testimony has gone on this about ARCOS, he was able to assemble all of this book about drug abuse without access to ARCOS.

So for someone to say that we couldn't access it, we

couldn't use it because it was manual, it was too much information, this man was able to put it together and be able to demonstrate that -- this "American Pain" clinic down in south Florida prescribed two times the amount of medicine of all the doctors combined in the state of Ohio.

He was able to put that together long hand, and he's not an agency with all the -- all the resources you have to be able to do that. He also was able to put together that -- all of the pill mills in Florida combined.

So nine times the amount of pain medicine that was issued by every state in the country. He did that long hand.

So with all due respect, I don't think you can hide behind the fact that this -- you didn't have the resources to be able to do this because it was coming in manually.

If I could, I am curious about the production quotas with it because in the book he talks about how speed pills back in the 1970s were becoming a problem, and DEA stepped up and they cut the -- they cut the production by 90 percent and the problem went away.

And then in the 1980s we had a problem with Quaaludes -- same thing. He cut -- they cut the production and it went away. Now, fast forward to today or what we've been dealing

with over the last 10 years or so, the opioids.

We continue to increase the production of opioids, continue to distribute those. Didn't we learn anything from the past experience, that we should be cutting back? And it wasn't until 2017 that we actually had our first reduction. But it's still nearly 50 percent more than we were 10 years ago in production of opioids.

How would you respond to that? Didn't we learn anything?

Mr. Patterson. No, I understand that, sir.

And look, the quota numbers are set, unfortunately, to ensure access to the patients and you can see the disturbing trend that happened with quotas. The industry said more and more people needed these prescriptions.

We worked aggressively in the last year and a half to try and work on the quota issue and pull this back. I give a lot of the credit to the states.

Mr. McKinley. If I could recover my time, because I think that perhaps I know you're meaningful to do this -- to correct it -- but it failed, because I am coming from that state that has 52 drug overdoses per 100,000 people. We are leading the nation with this. Someone has to get to this.

So I am just curious, I know you have the ability to transfer resources and funds within DEA. So my question goes back to you -- have you made any transfer back into West Virginia? Are you going to put more resources there in West Virginia as a result of your ability to do transfer?

Mr. Patterson. We have, and we are continuing to do so.

Mr. McKinley. And I know that you had -- we just put in a year or so ago down -- a tactical diversion squad in Clarksburg. I think that's the second one we have in West Virginia. Is that correct?

Mr. Patterson. That's correct.

Mr. McKinley. Leading the nation -- is that sufficient? Do you think that you have diverted enough attention into West Virginia that you don't need to divert any more funds and resources into West Virginia?

Mr. Patterson. Sir, the creation of the Louisville division, which polled three states all struggling with this same problem -- Tennessee, West Virginia, and --

Mr. McKinley. I am sorry. I am just dealing with West Virginia. It's the epicenter. You know that and I know that --

Mr. Patterson. Sir, so we --

Mr. McKinley. -- and when it -- it has been there for nearly 10 years. It's been the highest level and we've not seen the resources come in to West Virginia.

And now I appreciate very much that you put a tactical diversion squad, or your predecessor did, into Clarksburg. But I've got to think there is a lot more attention needs to go with it because if this man can do this by long hand, can put this information together, I think you all could do it. With your resources, you could do a far better job and save a lot of lives and turn some families around.

So I am asking you, please, to look at more diversion into West Virginia -- some of the funds and resources that you can to help out in this situation.

Mr. Patterson. Again, sir, we've been working on that and we are continuing to put more resources into that particular division.

Mr. McKinley. So what are the optics on this, in the 10 seconds I've got left? How am I going to be able to measure whether you're successful with what you're doing?

Because just last year in county we've already had a 50 percent increase in overdose drug -- overdose deaths in West Virginia in my county. How are we going to measure this?

Are we going to see a drop next year?

Mr. Patterson. Look, the concern we have had is that we've seen the shift into fentanyl and other illicit substances. The goal is to continue to drive down the prescription rates and the diversion of prescription pills, and we are going to have to work this licit market and, frankly, the place --

Mr. McKinley. Again, what's the -- what are the optics? Am I going to see a decline next year?

Mr. Patterson. I would hope we see declines across the board. I think some states are going to take longer than others, sir.

Mr. McKinley. Thank you. Yield back.

Mr. Harper. The gentleman yields back.

The chair will now recognize the vice chairman, Mr. Griffith, for follow-up questions.

Mr. Griffith. Thank you very much, Mr. Chairman. Appreciate it, and this question was from Mrs. Brooks, who, unfortunately, had to step out for a minute.

Do the Medicaid fraud control units run by the state AG's offices still exist in many states?

Mr. Patterson. I would have to find out, sir.

Mr. Griffith. All right, because what she was indicating was was that these particular MFCUs who are going after Medicaid fraud often can also pick up over prescribing data and that that's a collaborative unit that you all ought to be looking at in the various states to figure out who the rogue doctors are and that would help you in that regard as well.

Mr. Patterson, moving on, how can -- can you explain to me the DEA -- how can you all maintain that voluntary registration surrender can be as effective a tool in protecting the public safety as an ISO if it takes years to get the voluntary surrender as in the case of the owner of the Sav-Rite number one in Kermit, West Virginia?

Mr. Patterson. So that -- I would assume in that case and, again, I need to get the particular facts on it -- the voluntary surrender probably came as part of the criminal case.

Mr. Griffith. And so what you would do is you would move -- you would reverse that order and have the voluntary surrender or an ISO happening early on?

Mr. Patterson. Absolutely, sir.

Again, I can't go back and necessarily understand why

certain people did certain things, you know, six --

Mr. Griffith. But you can make sure, going forward, that we shorten the time?

Mr. Patterson. Absolutely, sir.

Mr. Griffith. All right. In your written testimony, you mentioned prescription drug monitoring programs as a tool that can be used to combat prescription drug diversion.

How does the DEA currently utilize the PDMP data in its investigations?

Mr. Patterson. So this varies state to state because the concern is, again, is our access to this data and how we can access this data and that is a state by state decision.

And so every state varies. This is one of the big conversations that we've had with the 48 states that are parts of these two coalitions.

Mr. Griffith. All right. Let us know how we can help.

Your written testimony also mentioned that law enforcement access to PDMP data varies widely from state to state, as you have just told us.

Can you tell me what the DEA is doing to address those concerns and to address any access barriers the agency currently faces with respect to the PDMPs?

Mr. Patterson. Again, working with all the states individually on these issues and to the extent that we can leverage the coalitions to help us in that.

Look, in a perfect world we have a federal PDMP process that we can take all this data and put together. I think in a less than perfect world at a minimum the states all need to be able to share this data with each other.

Mr. Griffith. And in your experience, are there areas -- and you just have gone over some of it -- but is there some other areas that we might be able to improve the PDMP process?

Mr. Patterson. I think that's the key piece.

Mr. Griffith. All right.

I appreciate it, Mr. Chairman. I yield --

Mr. Harper. The gentleman yields back.

Mr. Patterson, just to give you a little update, I am going to recognize Mr. Carter in just a minute for a follow-up question. Then Ms. DeGette and myself will have concluding questions and we'll be done shortly. So thank you for being here with us today.

The chair will now recognize Mr. Carter, the gentleman from Georgia.

Mr. Carter. Thank you, Mr. Chairman. I will be very brief.

I just want to follow up, Mr. Patterson. You're correct, you can't do anything about what happened years ago. But you can do a lot about what's happening now. I want to give you a sincere caution here.

What's happening with the wholesalers when they are limiting the pharmacies from getting a certain amount of drugs whereas that has all the best of intentions -- what it causes sometimes is for some of our patients not to be able to get the medications that they need and I just warn you to please be careful with that. There are patients out there, i.e., Hospice patients, who truly need these medications.

We found ourselves running out and we couldn't order it from the wholesalers because we'd already used up our limit for that month. So that put these people in a very precarious position and it's not a good position.

It's a very bad feeling for a pharmacist to have to profile and have to go out and say, oh, this patient doesn't need pain medication. Who am I to say that the long-haired tattooed body-pierced person is not in pain? That's not fair.

We've got to make sure that we get this under control and I still maintain that starting with the physicians and tell me what I can do to help you, to give you the tools that you need so that you can react quicker and get them under control when they get out of control.

That's all I am asking you to do is tell me what you need because I promise you I will do my best to get you those resources so that you can get these rogue physicians -- and they're not all of them but some of them -- a good amount of them are out of control and they get out of control quickly and it gets out of control very, very quickly.

Thank you, Mr. Patterson.

Mr. Patterson. Understood.

Mr. Harper. The gentleman yields back.

The chair will now recognize the ranking member, Ms. DeGette, for concluding questions.

Ms. DeGette. Thanks, Mr. Chairman, and I want to echo, this is a rough topic, Mr. Patterson, and we know you haven't been there that long.

But we also know that it's urgent that we get this right. It's just urgent for the safety of our constituents.

There's just a couple of areas I wanted to clarify. Mr.

Collins was asking you some questions about these -- the settlement that the DOJ has had with some of the distributors because of issues -- reporting suspicious orders and, you know, it's really important that they -- that they report these suspicious orders to you because you can't do your job unless you get this reporting. Isn't that right?

Mr. Patterson. Absolutely.

Ms. DeGette. Now, for example, the DOJ has reached two settlements with Cardinal Health. In 2008, Cardinal agreed to pay $34 million to resolve allegations that it shipped large quantities of opiates to pharmacies without reporting those orders to the DEA.

And then in 2012 again, Cardinal agreed to pay $44 million to resolve similar claims. Now, do you know, broadly speaking, why the Department of Justice decided to pursue these cases against Cardinal?

Mr. Patterson. I don't, ma'am. I know that, from the documents I have seen on the 2012 case, the frustration was is that the MOUs or MOAs in that scenario essentially they had gone back and violated again.

Ms. DeGette. Right.

Mr. Patterson. So that is probably the basis for --

Ms. DeGette. Probably what they -- that's your understanding?

Mr. Patterson. Yes, ma'am.

Ms. DeGette. Now, McKesson similarly reached two agreements with DOJ agreeing to pay $13.25 million in 2008 and again $150 million in 2017 to resolve allegations that it failed to report suspicious orders. Would you suspect it's the same kind of a situation that you talked about a minute ago?

Mr. Patterson. Yes, ma'am.

Ms. DeGette. Now, do you agree that suspicious order reports are a key part of preventing diversion?

Mr. Patterson. Absolutely, because, again, I go back to the fact that the distributors -- I should say the manufacturers and distributors are the key registrants that we need to hear from.

Ms. DeGette. Right. Right.

Now, if distributors fail to report suspicious orders, they really do undermine your ability to oversee the supply chain. Is that right?

Mr. Patterson. Yes.

Ms. DeGette. One more topic, and this is following up

on something Ms. Walters was asking you about, and I don't think maybe you understood her question.

On this website that you have been talking about that you have for distributors to look at, it does not -- it lets other distributors see if other distributors are providing in these -- to these pharmacies. But it does not tell volume. Isn't that correct?

Mr. Patterson. I would have to check it. I believe it does. It shows the six-month -- goes back a six-month window. But I would get back to you on that particular issue.

Ms. DeGette. I think so, because it's my understanding that the distributors object to disclosing volume. Here, your associate's handing you something.

Mr. Patterson. No volume.

Ms. DeGette. No volume. Okay. And, you know, from my perspective I can understand what they're saying about that impacting trade secrets and so on.

But the problem, from my perspective, is if you're just saying -- if you're just saying, okay, we are going to have a website where you can see if other distributors are providing in that area, that's really not going to -- if you don't know

the volume then it's really hard for somebody to see whether there's an abuse going on or not. Wouldn't you agree with that?

Mr. Patterson. Yes, ma'am.

Ms. DeGette. I think -- I think this website is something we should probably talk about more and maybe you can supplement your answers to see how we can use that effectively, because just knowing if other people are going in there I don't think that's going to solve our problem.

Thanks, Mr. Chairman. I yield back.

Mr. Harper. The gentlewoman yields back.

Just for clarification, it appears in 2008 that Cardinal Health paid $34 million in civil penalties and then again in 2016 an additional $10 million was paid out through one of its subsidiaries, Kinray -- if that clarifies that.

Through our investigation, Mr. Patterson, the committee has learned certainly that as early as 2008 the DEA received almost daily suspicious order reports, which received millions of opioids that had been tied to known pill mill physicians like Mr. Collins' neighbor that he referenced. Yet, most continue to remain in operation and it's unclear to what extent, if any, DEA followed up on the suspicious order

reports it received.

So tell us what is the process that the DEA takes when evaluating suspicious order reports it receives and the actions that the agency takes in response?

Mr. Patterson. So, sir, when those come in they're currently reviewed by and looked at for investigation by the divisions. This is one of the changes that we are making by bringing this into headquarters process.

Some of these companies, obviously, have districts all throughout the country. One of the reasons why we want to look at them is because we want to look at them as a corporation, not just as individual entities or other problem areas.

So that is a change that we are doing. I would be happy to go back and look at specific issues on --

Mr. Harper. Sure.

Mr. Patterson. -- any of SORS database and what was or wasn't done. I think the decentralization -- we have had structural problems, I would say, in terms of how we used not just some of this information but how we looked at it.

Those structural changes we are rapidly trying to get a handle on to make these -- especially in the suspicious

orders regulations -- I am sorry, reports -- more beneficial because, one, we need them for the registrants, but two, we have to do something with them when we get them.

And you have discussed the -- you know, implementing the process to improve and to process those suspicious orders at DEA headquarters.

Has DEA identified breakdowns in the way its field division processes suspicious order reports in the past and what corrections or adjustments have been made or do you anticipate being made?

Mr. Patterson. So, again, I think the uniformness of how we look at these things and the accountability that we hold the people to when we get these reports is critical.

So that's one of the big changes for us to make sure that as we are looking at these -- you know, I have had conversations with all of the staff in this space, whether, you know, it goes back to the ALJ or the folks in chief counsel that do it with our expectations, to go back to what Mr. Collins was talking about.

It has not been comfortable conversations. But we have to essentially do the things that we are supposed to be doing each and every day and personalities can't play a role in

this.

Mr. Harper. And when you were making decisions at DEA headquarters, the personnel at the headquarters probably have field experience in some level in DEA. Would that be a fair assessment?

Mr. Patterson. That's correct.

Mr. Harper. And as you're looking at these, are you also taking into consideration those that are in the field now maybe that have never been to headquarters to try to get their input on the actual boots on the ground?

Mr. Patterson. I think it's important and, look, I haven't spent years in this diversion world. In fact, I've really only done it for about the last 18 months as the deputy and now as acting.

What I will tell you is that fresh sets of eyes on problem sets are always critically important.

Mr. Harper. Okay.

You know, we -- you talked about well, what do we do -- prevention, education, treatment. You know, your role is really in enforcement and prosecution, at least laying the groundwork for that.

The problem that we see as we look at this in great

detail is local law enforcement does not have the capability to take care of this issue. That's why you see many of these cases coming out of rural areas.

So we would certainly want to make sure that you're doing things to pivot, to take care of the rural areas in this country as you're looking at that.

Now, there were a number of times that you referenced, you know, I will get back to you or we'll get you that information. So just know that we'll have follow-up on that.

Mr. Patterson. Absolutely.

Mr. Harper. And we'll look for that.

We should be able to work together on this, and just know that we -- we are not happy that the chairman of the full committee, Chairman Walden, had to even call for a press conference.

So we want to make sure, going forward, there are things that we need to know or things that we need to enquire on or things that you have for us. We would prefer a more openness between the committee and the DEA, going forward.

And with that we thank you for your time today, for what turned into a fairly long time for you. It's been helpful to us and we'll look forward to the follow-up questions that we

have.

I want to thank the members who have attended today and participated in today's hearing and I will remind members that they have 10 business days to submit questions for the record and I would ask, Mr. Patterson, if you would see that those are responded to promptly as you receive those.

With that, the subcommittee is adjourned.

[Whereupon, at 12:23 p.m., the committee was adjourned.]