Plaintiffs' Exhibit 1
Civ. No. 10-1511 (RJL)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ELSA MALDONADO,
318 Upshur Street, NW
Washington, DC 20011,

JOHN DOE,

LINDA SEALS,
4301 Military Road, NW
Unit #103
Washington, DC 20015,

and

BR, by her parent and next friend:
ANN ROBERTSON
1031 10th Street, NE
Washington, DC 20002,

on their own behalf and on behalf of a class of similarly situated individuals,

Plaintiffs,

v.

THE DISTRICT OF COLUMBIA,
a municipal corporation
1350 Pennsylvania Avenue, NW
Washington, DC 20004,

Defendant.

Civil Action No. 10-1511 (RJL)

SECOND AMENDED CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

INTRODUCTION

1. Plaintiffs, on behalf of themselves and others similarly situated, bring this action under 42 U.S.C. 1983 for declaratory and injunctive relief to challenge defendant's policies,

procedures, and practices of failing to provide individualized written notice to persons who present a prescription to a Medicaid-participating provider in the District of Columbia but who are denied Medicaid coverage for the prescription as written (a "denial"). Defendant's actions and inactions violate the Due Process Clause of the Fifth Amendment of the Constitution.

2. Named plaintiffs have had Medicaid coverage denied by defendant for prescriptions as written without individualized written notice. As a result of defendant's failure to provide individualized written notice, named plaintiffs were unable to obtain medically necessary medications under the District of Columbia Medicaid program.

3. Plaintiffs seek declaratory and injunctive relief on behalf of themselves and a class of similarly situated persons in the District of Columbia requiring the District of Columbia to give them timely and adequate individualized written notice when their requests for Medicaid coverage are denied for their prescriptions as written. Defendant's actions and inactions have caused substantial harm to named plaintiffs and the class they represent.

JURISDICTION AND VENUE

4. This action is brought under 42 U.S.C. 1983 to enforce the Due Process Clause of the Fifth Amendment of the Constitution. The Court has jurisdiction over plaintiffs' claims pursuant to 28 U.S.C. 1331 and 28 U.S.C. 1343. Venue is proper under 28 U.S.C. 1391.

PARTIES

Plaintiffs

5. Plaintiff Elsa Maldonado is a 46-year-old Medicaid recipient. She resides in the District of Columbia.

6. Plaintiff John Doe is a 29-year-old Medicaid recipient. He resides in the District of Columbia.

7. Plaintiff Linda Seals is a 60-year-old Medicaid recipient. She resides in the District of Columbia.

8. Plaintiff BR is a 12-year-old Medicaid recipient. She resides with her parents, Ann and Brian Robertson, in the District of Columbia. She sues by her parent and next friend, Ann Robertson.

Defendant

9. Defendant District of Columbia (hereafter "District") is a municipal corporation subject to 42 U.S.C. 1983. The District is a "state" within the meaning of Title XIX of the Social Security Act, 42 U.S.C. 1301, and, through its designated agency, the Department of Health Care Finance (hereafter "DHCF"), is charged with preparing and implementing a plan for the Medicaid program in the District of Columbia. 42 U.S.C. 1396a(a)(4),(5).

CLASS ACTION ALLEGATIONS

10. Named plaintiffs bring this action on behalf of themselves and all others similarly situated. Plaintiffs' class consists of all persons who have applied for, received, or are receiving D.C. Medicaid who present a prescription to a Medicaid-participating provider for a medication that is not completely excluded from coverage under the D.C. Medicaid program and who do not, or will not, receive timely and adequate individualized written notice when the prescription is denied or is not filled as written.

11. The requirements of Rules 23(a)(1)-(4) and (b)(2) of the Federal Rules of Civil Procedure are met as to the class because:

> (a) The class is so numerous that joinder of all members of the class is impracticable. There are currently around 281,665 Medicaid recipients in the District of Columbia. Many of these recipients do not receive or will not receive Medicaid coverage of prescriptions for medically necessary drugs and all of these recipients do not or will not receive individualized written notice when they are denied Medicaid coverage for their prescription as written;

(b) There are questions of law and fact common to the class, namely whether defendant has denied class members their procedural rights under the Fifth Amendment of the Constitution by failing to ensure timely and adequate individualized written notice when Medicaid coverage for class members' prescriptions as written is denied;

(c) The claims of the named plaintiffs are typical of the claims of the class in that each of the named plaintiffs has had Medicaid coverage denied by defendant for prescriptions as written without individualized written notice;

(d) The named plaintiffs will fairly and adequately represent and protect the interests of the class. They have no interests that are antagonistic to the class and seek relief that will benefit all members of the class. They are represented by counsel with significant experience with this type of litigation; and

(e) Defendant has acted and continues to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

FACTS

Statutory Background

12. In 1965, Congress enacted Title XIX of the Social Security Act, Medical Assistance Program, 42 U.S.C. 1396-1396w-2, establishing a cooperative federal-state program, known as "Medicaid," which was designed to provide necessary medical services to low-income people who previously had been denied access to medical care. The Medical Assistance Program portion of the Social Security Act has been implemented through the regulations found at 42 C.F.R. 430, *et seq*.

13. The program is jointly financed by the federal and state governments and is administered by the states subject to the mandates contained in federal statutes and regulations. 42 U.S.C. 1396a(a)(4),(5); 42 C.F.R. 430.0.

14. Medicaid is available to low-income people who are in one of several categories or groups specified in the federal statute, such as children and pregnant women whose incomes are below federal poverty level standards and people who are aged, blind, or disabled. 42 U.S.C. 1396-1, 1396a(a)(10)(A). The Medicaid program typically does not provide health care services directly

to eligible individuals or provide beneficiaries with money to purchase health care directly. Rather, Medicaid is a vendor payment program, wherein Medicaid-participating providers, including doctors and pharmacies, are reimbursed by the program for the services they provide to recipients.

15. The Centers for Medicare and Medicaid Services (hereafter "CMS") of the United States Department of Health and Human Services determines whether to approve federal funding for a state's Medicaid program based on the information contained in the state plan. 42 C.F.R. 430.10 - 430.20. The state plan is defined as "a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with" federal law. 42 C.F.R. 430.10.

16. The state is required to designate a single state agency to administer and supervise the state's Medicaid plan. 42 U.S.C. 1396a(a)(5); 42 C.F.R. 431.10. The state agency's responsibilities include the determination of which groups are eligible for Medicaid, the types of services to be provided, payment levels for services, and administrative and operating procedures. 42 U.S.C. 1396a(a)(4),(5); 42 C.F.R. 430.0.

17. The District of Columbia has elected to participate in the Medicaid program. The District has designated DHCF as the single state agency responsible for the administration of all aspects of the District of Columbia Medicaid program. D.C. Code 7-771.07.

18. The District has submitted a state plan under Title XIX of the Social Security Act ("State Plan"). In that plan, the District agreed, among other things, to administer the program in accordance with applicable federal laws and regulations.

19. The Fifth Amendment to the Constitution guarantees that "[n]o person shall * * * be deprived of life, liberty, or property, without due process of law." U.S. Const., amend. V. Plaintiffs have a protected property interest in prescription drug benefits for any drug that is not

completely excluded from coverage by Medicaid. *See NB ex rel. Peacock v. District of Columbia*, 794 F.3d 31, 42 (D.C. Cir. 2015). The due process required includes timely and adequate individualized written notice informing individuals of, *inter alia*, defendant's action, the basis of defendant's action, and the individual's hearing rights. *See Goldberg v. Kelly*, 397 U.S. 254, 267-268 (1970); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950); *Gray Panthers v. Schweiker*, 652 F.2d 146, 168-69, 172 (D.C. Cir. 1980).

District of Columbia's Prescription Drug Program

20. The District of Columbia's Medicaid program provides for the coverage of prescription drugs. The District pays pharmacies (hereafter "pharmacy providers") to provide Medicaid recipients with out-patient drugs prescribed by their healthcare providers.

21. The District contracts with a Pharmacy Benefits Manager ("PBM"), currently Magellan Medicaid Administration, Inc., to process Medicaid claims in its Fee-for-Service Program. Through the PBM, the District has established a system to process electronic claims immediately at the time a person presents a prescription to the pharmacy provider and the pharmacy provider submits an electronic claim to determine Medicaid coverage. *See* 42 U.S.C. 1396r-8(h)(1) ("each State agency [is encouraged] to establish, as its principal means of processing claims for covered outpatient drugs * * *, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists * * * in applying for and receiving payment"); *see also* 42 C.F.R. 456.700, *et seq*.

22. DHCF currently contracts with four health plans, referred to as managed care organizations (hereafter "MCOs"), to provide Medicaid recipients with covered medical care. By contract, DHCF engages the MCOs as its agents to provide Medicaid pharmacy services to the

recipients enrolled with the MCO. An electronic claims processing system is also used for processing Medicaid claims in the District's Managed Care Program. Each MCO contracts with a PBM to facilitate claims processing at pharmacies. Each PBM operates an electronic claims management system that immediately informs persons seeking Medicaid coverage for prescriptions whether they will be covered as written or denied.

23. When a physician gives a person a prescription for an out-patient drug, the person presents the prescription to a pharmacy provider. If the person represents that they are a Medicaid recipient, the pharmacy provider immediately submits an electronic claim through its computer to a PBM. The claims are decided immediately. The pharmacy provider receives an electronic return message from the PBM indicating whether the prescription will be covered by Medicaid. If the claim is denied, the pharmacy provider receives an electronic return message with a rejection code that corresponds to a reason for the denial of the claim.

24. In some cases, these persons are given a substitute drug or a quantity that is different from their prescription. Both when the claim is denied in its entirety and when the prescription is filled differently than as written, persons seeking Medicaid coverage are not provided with individualized written notice of the denial, the reason for the denial, the right to request a hearing, or the circumstances under which temporary Medicaid coverage of the prescribed drug can be provided.

25. One reason for denial of Medicaid coverage is that the prescribed drug is deemed "non-preferred." The District of Columbia's Medicaid program utilizes a Preferred Drug List ("PDL"), which lists drugs that are "preferred agents" and those that are "non-preferred agents." *See* https://dc.fhsc.com/downloads/providers/dcrx_pdl_listing.pdf. If a Medicaid recipient submits a prescription for a non-preferred drug, the claim will be denied by the PBM unless "prior

authorization" has been requested by a prescriber and approved by the District. *See* D.C. Mun. Regs. tit. 29, § 2706.2. When the claim is denied, the pharmacy provider will receive a rejection message from the PBM.

26. Under federal law, states may require approval, referred to as "prior authorization," before dispensing covered out-patient drugs to Medicaid recipients. 42 U.S.C. 1396r-8(d)(1),(5). Prior authorization can only be requested by the prescribing Medicaid provider; it cannot be requested by the Medicaid recipient. The District's Medicaid program requires prior authorization in several situations. Prior authorization is required for non-preferred drugs listed on DHCF's Preferred Drug List ("PDL"); for medically-necessary brand-name medications with generic equivalents; for drugs classified as Schedule II narcotics and certain injectable drugs; for any drug requiring medication therapy management; for any drug requiring closer utilization monitoring; and for some medications with quantity limits. *See* D.C. Mun. Regs. tit. 29, § 2706.2. If prior authorization is not obtained for these drugs, Medicaid coverage will be denied.

27. DHCF and its agents, including the PBMs and MCOs, have issued policies and manuals to pharmacy providers and Medicaid beneficiaries that contain no provisions providing for individualized written notice describing the state action affecting the person's prescription drug coverage, the reasons for the action, the person's right to a hearing, and, if applicable, continued benefits when coverage of prescription drugs is denied.

28. The District has issued a *Medication Prior Authorization Guidance*, dated July 25, 2008. The Guidance "encompasses policies and procedures that govern the prior authorization process * * * for the various pharmacy programs managed by [DHCF]" and "applies to all [DHCF] pharmacy providers who serve DC Medicaid recipients." *Id.*, p. 4. The Guidance instructs: "The prescriber should initiate prior authorization requests. Ideally, this occurs at the point in time that

the prescription is being written. If this does not occur, the claim will deny at Point of Sale (POS) with a message that the prescriber should contact [the Pharmacy Benefits Manager] for prior authorization consideration." *Id.*, p. 25. The Guidance contains no policies or procedures regarding the provision of individualized written notice to persons at the time their prescriptions are denied Medicaid coverage at the pharmacy due to lack of prior authorization.

29. In cases where the PBM desires additional information from a prescriber regarding a prior authorization request for a Medicaid recipient, the Guidance states that the PBM "will deny the [Prior Authorization] request if the doctor does not respond to a request for information within three (3) working days. The pharmacy is notified when this type of denial occurs due to lack of response from the physician. No denial letters are issued. The physician or pharmacist may appeal a decision in writing and fax to [the District's designated Medicaid agency] at 1-800-250-6950." *Id.*, p. 26. The Guidance contains no policies or procedures regarding the provision of individualized written notice to the person seeking Medicaid coverage for the prescription medication in such a situation.

30. The District has also issued to pharmacy providers manuals regarding claims processing. For example, the District of Columbia Pharmacy Benefits Management Prescription Drug Claims System (X2) System Manual, dated September 1, 2010 (Version 0.08), provides rules regarding the submission of pharmacy claims for Medicaid coverage. The Manual describes numerous circumstances and reasons for which pharmacy claims will be rejected and the corresponding rejection codes. For instance, the Manual states that if the pharmacy provider submits a claim for a drug with quantity limits and the prescription exceeds the limits, the pharmacy provider will receive an electronic return message stating: "NCPDP reject 76 - Plan limits exceeded." Manual, p. 12. If the pharmacy provider submits a claim for a drug requiring prior

authorization and no prior authorization has been submitted by the prescriber, the pharmacy provider will receive an electronic return message stating either "NCPDP reject code 75 - Prior Authorization Required" or "NCPDP Reject Code 76 - Plan Limits Exceeded." *Id.*, p. 11.

31. The Manual also describes a Prospective Drug Utilization Review (DUR) Program, in which "[t]he system will automatically review each drug claim submitted by a pharmacist (prior to dispensing) to identify problems such as drug-drug interactions, therapeutic duplication, and incorrect dosage." Manual, p. 9. The Manual states: "Any claim submitted that could potentially be a problem will either deny and require pharmacy overrides or pay with a message returned on the response indicating the potential problem. The following ProDUR exceptions that will result in a denial are: Drug-Drug interaction with severity level 1; Therapeutic Duplication for CII controlled substances; Early Refill." *Ibid.* The Manual contains no policies or procedures regarding the provision of individualized written notice to persons seeking Medicaid coverage for the prescription at the time the PBM responds to claims with rejection return messages.

32. In March 2009 and March 2016, plaintiffs' attorneys submitted information requests pursuant to the District of Columbia Freedom of Information statute to DHCF, requesting regulations, procedures, manuals, policies, guidances, transmittals, and bulletins, issued by DHCF and any of its contractors, regarding procedures that agency employees, contractors, and pharmacy providers are to follow when a person's request for Medicaid coverage of a prescription is denied or is not filled as written by a pharmacy, as well as copies of any written notices provided by DHCF in such circumstances. DHCF's responses to those requests contained no procedures or policies providing for individualized written notice when Medicaid coverage of a prescription as written is denied at the pharmacy. DHCF's responses included no individualized written notices provided in such circumstances.

33. The District's PBMs capture data regarding the number of electronic claims submitted daily by District pharmacy providers, the number of those claims that are denied, and the rejection code corresponding to each denial. According to these data for the time period of April 30, 2008 to March 31, 2009 (DCMEDI Daily Statistics and Reject Analysis Reports), a significant number of point-of-sale electronic claims submitted by pharmacy providers are denied on a daily basis. For example, on March 31, 2009, a total of 6,641 electronic claims were submitted under the District's Fee-for-Service Program. Of those claims, 3,300 claims, comprising 49.7 percent of the total number of claims, were denied. Of these claims, 1,437 were denied due to "DUR Reject Error." For 768 denied claims, the reason for rejection was "Product/Service Not Covered."

34. The MCOs are required to provide DHCF with data regarding prescription drug claims, including the number of prescription drug claims submitted, the number of denied claims, and the reasons for the denial. According to data for 2009 provided by one MCO, the DC Chartered Health Plan, a significant number of Medicaid recipients enrolled in the DC Chartered Health Plan (hereafter "Chartered Health members") have been denied coverage of prescription drugs. For example, during May 2009, 17,291 Chartered Health members submitted prescriptions for fill. Of those members, 5,609 members were denied prescription fills. A total of 61,704 prescriptions were submitted for fill. Of those prescriptions, 14,333 prescriptions, comprising 23.2 percent of the total number of prescriptions, were "rejected." For 2,927 rejected prescriptions, the reason for rejection was "NDC not covered; The submitted drug is not covered by the patient's benefit plan." For 3,463 rejected prescriptions, the reason for rejection was "Filled after termination date: Claim's date of fill is after the termination date for this member or the primary card holder."

35. In response to plaintiffs' attorneys' May 2018 information request submitted pursuant to the District of Columbia Freedom of Information statute to DHCF, the District reported

that between January 1, 2017 and May 31, 2018, around 92,927 individuals submitted one or more prescriptions for medication to a pharmacy, requested coverage under the District's Medicaid program, and were denied such coverage.

36. Between January 1, 2017 and May 31, 2018, the MCO Health Services for Children with Special Needs had an enrollee denial rate of 90 percent (4,770 enrollees submitted prescriptions and 4,295 of those were denied coverage for at least one prescription). Between January 1, 2017 and May 22, 2018, the MCO Trusted Health Plan had an enrollee denial rate of 71 percent (29,157 enrollees submitted prescriptions and 20,802 of those were denied coverage for at least one prescription).

37. The District of Columbia statutes contain no provisions providing for individualized written notice when Medicaid coverage of a prescription as written is denied at the pharmacy.

38. Defendant is failing to provide timely and adequate individualized written notice when Medicaid coverage of prescription drugs is denied for a prescription as written. Defendant is failing to inform individuals that their claim for Medicaid coverage of their prescription as written is being denied, the reason for the denial, the right to a hearing, and the circumstances under which Medicaid would provide a temporary supply of the medication.

Effects of Defendant's Actions and Inactions on Named Plaintiffs

Elsa Maldonado

39. Ms. Maldonado has been a Medicaid recipient for over eleven years. She resides with her husband and three children. Her husband and two of their children are also Medicaid recipients.

40. Ms. Maldonado's native language is Spanish. She has limited proficiency in English.

41. Ms. Maldonado is currently enrolled in AmeriHealth, an MCO, and is receiving Medicaid benefits through AmeriHealth. Until May 2013, Ms. Maldonado was enrolled in a different MCO, Chartered Health Plan, and was receiving Medicaid benefits through Chartered.

42. Ms. Maldonado suffers from asthma and sinus allergies. She has been suffering from these medical conditions for over fifteen years. She regularly takes prescription medications to treat both conditions. She takes Advair daily to treat her asthma condition. She has taken Advair regularly for the past fifteen years. She takes two other prescription medications, Loratadine and another sinus medication, daily to treat her allergies. Her doctor writes prescriptions for these medications once a year to cover the monthly fills she needs for the entire year.

43. To ensure that she does not run out of her prescription medications, Ms. Maldonado is enrolled in an automatic prescription refill program with her pharmacy.

44. Around July 2012, Ms. Maldonado went to her pharmacy to obtain refills of her medications. Instead of providing Advair as her doctor had prescribed, the pharmacy gave Ms. Maldonado a different medication, ProAir, to treat her asthma. The pharmacy did not tell her that she was receiving a different medication. Ms. Maldonado read the prescription label and noticed that it was not Advair. She had previously taken ProAir and it had not been effective in treating her asthma. She told the pharmacy that it was not the correct medication. The pharmacy told her that Medicaid would only cover ProAir. The pharmacy then called Ms. Maldonado's doctor, but was unable to reach anyone at her doctor's office. Ms. Maldonado attempted to return the medication to the pharmacy, but the pharmacy refused to take back the medication. She took the medication with her but did not use it.

45. Ms. Maldonado called her doctor to explain that the pharmacy had given her ProAir instead of Advair, and that she had previously taken ProAir and it had not been effective in treating

her asthma. She believes that her doctor then called the pharmacy and instructed the pharmacy to provide her with Advair.

46. Ms. Maldonado was able to obtain the Advair a week later.

47. Medicaid recipients are required to renew their eligibility for Medicaid benefits annually through a process called recertification or renewal by completing and submitting a recertification form to the District of Columbia. Ms. Maldonado is required to submit her recertification at the end of October each year. In October 2012, Ms. Maldonado timely submitted her Medicaid recertification form to the District of Columbia.

48. On November 9, 2012, Ms. Maldonado went to her pharmacy to obtain refills of her three medications. The pharmacy told her that Medicaid would not pay for her medications, because the system was showing her as ineligible for Medicaid.

49. On November 13, 2012, Ms. Maldonado contacted a paralegal at Terris, Pravlik and Millian, LLP, to request assistance. On that same day, the paralegal contacted the District of Columbia's Department of Human Services (hereafter "DHS") by e-mail to inquire regarding Ms. Maldonado's eligibility for Medicaid. DHS responded by e-mail that Ms. Maldonado's recertification had been processed that day and attached a copy of a notice to Ms. Maldonado, dated November 13, 2012, which stated that her recertification had been received on October 25, 2012, and had been approved. Thus, DHS had failed to process Ms. Maldonado's recertification in a timely manner. As a result, her Medicaid eligibility had been incorrectly terminated.

50. On information and belief, on or around February 2013, Ms. Maldonado began experiencing problems with obtaining automatic refills of her prescription for Advair. During those months, she had to contact the pharmacy and her doctor to obtain refills of her prescription for Advair.

51. During the week of April 15, 2013, Ms. Maldonado went to her pharmacy to obtain a refill of her prescription for Advair. Instead of providing Advair as her doctor had prescribed, the pharmacy again gave Ms. Maldonado ProAir. The pharmacy did not tell her that she was receiving a different medication. Ms. Maldonado picked up the medication and only later read the prescription label and noticed that it was ProAir, not Advair. She returned to the pharmacy and informed the pharmacy that it was not the correct medication. The pharmacy told her that Medicaid would not cover Advair. She informed the pharmacy that she needed to take Advair and asked the pharmacy what she could do to obtain the correct medication. The pharmacy told her that she would need to pay approximately $300 out-of-pocket to obtain the Advair. Ms. Maldonado attempted to return the medication to the pharmacy, but the pharmacy refused to take back the medication. She took the medication with her but did not use it.

52. The following week, Ms. Maldonado contacted a paralegal at Terris, Pravlik and Millian, LLP, to request assistance. On that same day, the paralegal contacted a representative for Chartered Health Plan by telephone to inquire regarding Ms. Maldonado's problems with obtaining Advair. The Chartered representative stated that Ms. Maldonado needed an override from her physician in order for Advair to be covered. The representative stated that Ms. Maldonado previously had an active override on her account, but that the override expired at the end of January 2013 and that Ms. Maldonado would have to speak with her physician to get the override activated again.

53. Ms. Maldonado called her doctor to explain that the pharmacy had again given her ProAir instead of Advair. Her doctor then faxed a document to the pharmacy.

54. Ms. Maldonado was not able to obtain the Advair at the pharmacy until over three weeks after the pharmacy filled her Advair prescription with ProAir. Her supply of Advair ran out

during that time period and she had to go without taking her asthma medication for one week. During that time, she had to go to The George Washington Hospital for treatment by her asthma specialist due to complications related to her inability to take her asthma medication.

55. In June 2018, Ms. Maldonado went to the pharmacy to obtain a refill of her Advair prescription. A pharmacy employee submitted the prescription and told her that Medicaid would not cover it. The employee offered her a substitute medication called Armonair RespiClick 232. Ms. Maldonado did not take the substitute medication. Ms. Maldonado called her doctor to ask for help getting the prescription. Her doctor contacted the pharmacy directly. Several days later, Ms. Maldonado received a call from the pharmacy indicating that her prescription for Advair was ready to be picked up.

56. Ms. Maldonado never received written notice of the fact that coverage of her prescriptions was being denied, the reason for the denials, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication. Defendant's actions and inactions deprive Ms. Maldonado of her due process notice rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution.

57. At all times during the above-described events, Advair was not completely excluded from coverage under the D.C. Medicaid program.

58. Because Ms. Maldonado's asthma and sinus allergies are ongoing medical conditions, Ms. Maldonado obtains refills of her prescription medications monthly and will need to do so as long as her doctor continues to prescribe the medications to treat her conditions.

59. Ms. Maldonado and her husband's monthly income is limited. They cannot afford to pay out-of-pocket for Ms. Maldonado's prescription medications. In order to pay out-of-pocket

for her medications, they would have to forego another necessary living expense in order to buy the medication.

60. The above-described denials have caused Ms. Maldonado stress and she has begun foregoing her medication when she feels well enough to do so, in order to maintain a backup supply in case of an emergency.

John Doe

61. John Doe resides with his mother in Washington, D.C. He attended graduate school in New York from 2011 to 2014.

62. Mr. Doe's mother currently does not have an income. Mr. Doe's prescription medications cost several thousand dollars each month. Without Medicaid coverage, his prescription medications would cost approximately $60,000 per year. Neither Mr. Doe nor his mother can afford to pay out-of-pocket for his prescription medications. In order to pay for his prescriptions out-of-pocket, Mr. Doe and his mother would have to forego another necessary living expense, or forego paying a bill. Even then, they could only afford to do so if the prescriptions were under $100.

63. Mr. Doe has received Medicaid through its Fee-for-Service program since 2003. He is disabled. When he attended graduate school, Mr. Doe returned to the District periodically throughout the school year to receive treatment for his medical conditions from his regular physicians.

64. Because Medicaid would not cover Mr. Doe's prescription drugs at pharmacies in New York, his mother submitted prescriptions at pharmacies in the District on his behalf. Once the prescriptions were filled, his mother mailed the medications overnight to Mr. Doe.

65. Mr. Doe suffers from severe and chronic asthma. To prevent and treat asthma attacks, he takes a number of medications. When he is at home, he takes an inhalation solution, which is administered through a medical device called a pulmoaide in the form of a mist inhaled

into the lungs. When he is not at home, he administers inhalers orally. Because an asthma attack can occur at any time, he carries an inhaler with him at all times that he is not at home.

66. Since Mr. Doe was a young child, he has been using albuterol inhalers. Because Mr. Doe's asthma is severe, his doctor has prescribed two boxes of albuterol inhalers for each fill. Each box contains one inhaler. Medicaid only permits a fill every 25 days. In March 2009, the District of Columbia pharmacy that dispenses Mr. Doe's inhalers reduced the quantity of albuterol inhalers from two inhalers per fill, as prescribed, to one inhaler. The pharmacist orally informed his mother that Medicaid would only cover one inhaler per fill. Because Mr. Doe must have two inhalers every 30 days, his mother paid $43.99 out-of-pocket for an additional inhaler. The pharmacy did not tell his mother why Medicaid would not cover two inhalers, and she was unable to communicate effectively with her son's healthcare providers to remedy the situation, as she did not know the reason for the denial.

67. His mother contacted DHCF to fix the problem. For the next few months, Mr. Doe was able to receive two inhalers per fill. However, starting in June 2009, the pharmacy again began reducing the quantity of albuterol inhalers from two inhalers per fill, as prescribed, to one inhaler. Mr. Doe's mother again contacted employees of DHCF to fix the problem. However, the pharmacy continued to reduce the prescription quantity. In early July 2009, his mother again had to pay out-of-pocket for an additional albuterol inhaler.

68. In late July 2009, Mr. Doe was staying overnight at a friend's house in Virginia. He had an asthma attack and his inhaler ran out. Because he did not have an additional inhaler, he had to page his mother in the middle of the night. Mr. Doe's mother rushed to the pharmacy and requested a rush fill. The pharmacy told her that Medicaid would only cover one inhaler, so his mother paid out-of-pocket for the additional inhaler. She immediately drove out to Virginia with

the inhalers and a pulmoaide. When she arrived, she found Mr. Doe wheezing and having great difficulty breathing. He was taking very shallow, spastic breaths and walked forward towards her in a tilted position. Once he administered his inhaler, he was able to recover from the attack.

69. From June 2009 until February 2010, Mr. Doe's mother continued to experience problems with pharmacies reducing the quantity of Mr. Doe's prescription for albuterol inhalers. In February 2010, the problem was fixed, and Mr. Doe started consistently receiving two inhalers per fill as prescribed.

70. Meanwhile, Mr. Doe's mother began experiencing prior authorization problems in refilling Mr. Doe's prescriptions. In December 2009, the pharmacy orally informed Mr. Doe's mother that Medicaid would no longer cover refills of the inhalers without a prior authorization for each refill requested. Therefore, even though Mr. Doe's doctor had prescribed three refills of the albuterol inhalers, the pharmacy would not refill it.

71. Until December 2009, the pharmacy would refill Mr. Doe's albuterol inhaler prescription without requiring prior authorization. If his physician prescribed a given number of refills in the original prescription, the pharmacy would refill his prescription every 30 days until the given number of refills was exhausted. This ensured that Mr. Doe could receive his inhalers continuously without interruption.

72. Because Medicaid will no longer cover refills without prior authorization, Mr. Doe can no longer depend on continuous access to his albuterol inhalers, which he needs whenever he is outside his home or dormitory. Instead, each time Mr. Doe needs a refill of the inhalers, his mother must contact Mr. Doe's doctor and ask that the doctor request prior authorization from Medicaid for the refill. It can take three days or longer for the prior authorization request to be submitted to Medicaid. Once Medicaid gives prior authorization, it takes an additional day for the

inhalers to get to Mr. Doe by overnight delivery. Therefore, his mother must make sure to call Mr. Doe's doctor at least four days prior to exhaustion of Mr. Doe's inhaler. She is constantly worried that Mr. Doe may run out of his current supply of inhalers without having a refill, exposing him to serious health risk from an asthma attack when he is ambulatory.

73. When the pharmacy orally informed Mr. Doe's mother in December 2009 that Mr. Doe could no longer receive refills without prior authorization, she contacted employees of DHCF again to notify them that she was experiencing problems in refilling Mr. Doe's inhaler prescriptions. Mr. Doe continues to be denied refills of the inhalers.

74. At all times during the above-described events, albuterol inhalers were not completely excluded from coverage under the D.C. Medicaid program.

75. Mr. Doe never received written notice of the fact that his prescription for albuterol inhalers was being denied and/or reduced, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

76. In addition to his asthma, Mr. Doe has also been diagnosed with potentially fatal food and environmental allergies. Mr. Doe's food allergies are extensive. The foods to which he is allergic include dairy, eggs, nuts, legumes, sesame seeds, breads, beef, seafood, wheat, gluten, flour, pasta, and certain fruits. Because of these extensive food allergies, Mr. Doe's diet is severely restricted. He must be very careful about what he intakes and inhales. He must carry an epinephrine injector with him at all times. When he suffers an acute allergic reaction, he has to administer the injector to prevent and treat the onset of anaphylactic shock.

77. Mr. Doe also suffers from adverse or allergic reactions to certain medications. He is allergic to the antibiotic drug amoxicillin and the drug Rondec. Because he is allergic to milk

and nuts, he is also allergic to medications that contain any milk or nut-based ingredient. One such drug is the inhaler Atrovent which contains peanut in its propellant.

78. Mr. Doe is also prescribed the nasal spray Flonase. The pharmacy has typically filled the prescription for Flonase with its generic equivalent, fluticasone propionate. Prior to May 2010, Mr. Doe had been able to obtain fluticasone propionate at the pharmacy without any problems. In May 2010, when Mr. Doe's mother requested a refill of the prescription at a District of Columbia pharmacy, the pharmacy told his mother that Medicaid would not cover the medication. The pharmacy did not tell his mother the reason for the denial of coverage. His mother paid $75.99 for the fluticasone propionate out-of-pocket. Mr. Doe's mother contacted a paralegal at Terris, Pravlik and Millian, LLP, to request assistance. In August 2010, the paralegal at Terris, Pravlik & Millian, LLP, contacted the District of Columbia's Income Maintenance Administration (hereafter "IMA") (now known as the Economic Security Administration), which determines eligibility for Medicaid benefits, to inquire regarding the denial of coverage of Mr. Doe's prescription for fluticasone propionate in May 2010. The IMA explained that because fluticasone propionate is not included in the Preferred Drug List, Medicaid requires prior authorization before dispensing the drug. The IMA stated that the reason for the denial of coverage was that the prior authorization for the drug had expired and that another prior authorization was required. Mr. Doe's mother was unaware that the drug required prior authorization. The drug had been covered by Medicaid on at least five prior occasions, and the issue of prior authorization had never arisen.

79. At all times during the above-described events, Flonase and fluticasone propionate were not completely excluded from coverage under the D.C. Medicaid program.

80. Around this time, Mr. Doe was also prescribed the drug Prevacid to treat an upset stomach. When his mother submitted the prescription at the pharmacy, the pharmacy filled the

prescription with a different drug, ranitidine. Because of Mr. Doe's severe and potentially fatal allergies to foods and other substances, it is dangerous to his health for him to take medications that have not been specifically prescribed by physicians who are familiar with his complicated medical history.

81. At this time, Prevacid was not completely excluded from coverage under the D.C. Medicaid program.

82. Neither Mr. Doe nor his mother received written notice of the fact that his prescriptions for Flonase and Prevacid were denied and/or reduced, the reason for the reductions, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

83. Mr. Doe takes several prescription steroid medications regularly to treat his asthma. These medications cause him to experience severe facial and body acne as a side effect. He uses a number of prescription medications regularly to treat his acne. On or around September 16, 2012, his doctor prescribed the topical medication Differin Gel. When his mother submitted the prescription at the pharmacy, the pharmacy told her that she could not obtain the medication. She asked the pharmacy for a "print-out" of the denial. The pharmacy provided her with a document that contained an image of a "Rejection Message" that stated, under the heading "Rejection Code/Reason," "REJECTION[;] 75 - PRIOR AUTHORIZATION REQUIRED[;] 56 - Non-Matched Prescriber ID[.]" Under the heading "Message," the document stated "<PDL PA REQUIRED PHARMACIST INSTRUCT MD TO CALL 800-273-4962>." The pharmacy also gave her an "action note" that stated "Prior Authorization Required. Contact Method: FAX. Prescriber Contacted on: 9/16/2012." His mother left the pharmacy without the medication.

84. On information and belief, Mr. Doe's doctor submitted a prior authorization request to DHCF on or around September 21, 2012. On or after September 24, 2012, Mr. Doe received a letter in the mail from the District's PBM regarding its denial of his doctor's prior authorization request. The letter was dated September 24, 2012. The letter stated that "[t]he Department of Health Care Finance (DHCF) has reviewed the request submitted by your physician for: DIFFERIN 0.3% GEL on 9/21/2012. This letter is to inform you that DHCF will not approve the request for this medication." Under a section titled "Why is this happening?," the letter stated that "DHCF did not approve the request for this medication for the following reason(s): PLEASE CONTACT HELP DESK FOR DETAILS." The letter gave no further information regarding the reason for the denial. The letter also informed Mr. Doe that he could "ask for a fair hearing from the Office of Administrative hearings" and provided information regarding how to proceed with a fair hearing.

85. On October 5, 2012, Mr. Doe's mother was able to fill his prescription for Differin Gel without any problems.

86. At all times during the above-described events, Differin Gel was not completely excluded from coverage under the D.C. Medicaid program.

87. Neither Mr. Doe nor his mother received written notice from DHCF of the fact that his prescription for Differin Gel was denied on September 16, 2012, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

88. On or about September 5, 2016, Mr. Doe broke his wrist and was in great pain. His treating physician prescribed hydrocodone-acetaminophen for his pain.

89. This was a new prescription.

90. Mr. Doe's mother went to a District of Columbia pharmacy to fill his prescription for hydrocodone-acetaminophen. The prescription was denied and a pharmacy employee told his mother that Medicaid would not cover it because it was a new prescription and he had never been prescribed hydrocodone-acetaminophen before.

91. Mr. Doe's mother opted to pay out-of-pocket in order to obtain the medication he had been prescribed, because Mr. Doe would be in excruciating pain and unable to function without the medication. The cost of the medication was under $100. Mr. Doe's mother paid for the medication using money that otherwise would have paid her heating bill that month. Mr. Doe's mother is part of the Low Income Home Energy Assistance Program (LIHEAP) through the District of Columbia Department of Energy and the Environment. Because she is a part of this program, she was able to reallocate money from her heating bill to her son's prescription medication that month without foregoing heat. This decision caused Mr. Doe and his mother a great deal of stress.

92. At all times during the above-described events, hydrocodone-acetaminophen was not completely excluded from coverage under the D.C. Medicaid program.

93. Neither Mr. Doe nor his mother received written notice of the fact that coverage of hydrocodone-acetaminophen was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

94. Defendant's actions and inactions deprive Mr. Doe of his due process notice rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution.

95. Because Mr. Doe suffers from multiple chronic and ongoing medical conditions, he obtains fills of his prescription medications monthly and will need to do so as long as his doctor continues to prescribe medications to treat his conditions.

Linda Seals

96. Ms. Seals is unemployed and does not have an income. She receives heating assistance. She cannot afford to pay out-of-pocket for her prescription medications.

97. Ms. Seals has received Medicaid since June 2012 through either the District's Fee-for-Service program or one of its managed care organizations. Currently, she receives Medicaid benefits through the District's Fee-for-Service program.

98. Ms. Seals suffers from high blood pressure and has a prescription for three blood pressure medications. She takes these medications regularly and is required to take these medications at regular intervals in order for them to be successful.

99. Ms. Seals is also highly susceptible to infection. Before receiving dental treatment, she takes the prescription medications Azithromycin and Clindamycin to prevent bacterial infections. These anti-bacterial medications make her susceptible to yeast infections, for which she takes the prescription medication Fluconazole.

100. On January 1, 2013, Ms. Seals was enrolled in Chartered Health Plan, an MCO, and began receiving Medicaid benefits through Chartered.

101. Ms. Seals received dental treatment on January 1, 2013. Prior to the treatment, Ms. Seals took Azithromycin and Clindamycin. The medications caused her to suffer a yeast infection, for which she was prescribed Fluconazole. On January 11, 2013, Ms. Seals went to a District of Columbia pharmacy to fill her prescription for Fluconazole. Ms. Seals handed her Medical Assistance card with her Medicaid identification number to the pharmacy employee. The pharmacy told Ms. Seals that her insurance had changed and that her information could not be processed without a "group I.D. number." She asked the pharmacy for a "print-out" of the denial. The pharmacy provided her with an "action note" that stated: "We attempted to fill this through your

insurance but were unable. If you would like this filled through your insurance, please provide updated insurance information." Ms. Seals paid $16.00 out-of-pocket for the Fluconazole.

102. At all times during the above-described events, Fluconazole was not completely excluded from coverage under the D.C. Medicaid program.

103. Ms. Seals never received written notice of the fact that coverage of her prescription for Fluconazole was being denied, the reasons for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

104. On August 1, 2017, Ms. Seals was enrolled in the District's Medicaid Fee-for-Service program.

105. In August of 2017, Ms. Seals went to fill her prescription for her usual blood pressure medication, Hydrochlorothiazide, at a District of Columbia pharmacy. Her prescription was denied Medicaid coverage and a pharmacy employee told her that she was not covered by Medicaid. She left the pharmacy without the medication.

106. She contacted a paralegal at Terris, Pravlik and Millian, LLP, to request assistance. The paralegal contacted the District of Columbia and confirmed that her recertification application had been timely submitted, but that due to an error in the computer system with the spelling of her name, she was not appearing as active in the system. The District of Columbia had incorrectly entered a hyphen in between Ms. Seals' middle and last name, causing the system to reflect that she was no longer enrolled in Medicaid under her legal name.

107. The paralegal sent the District of Columbia a letter clarifying the correct spelling of Ms. Seals' name and she was eventually able to obtain her prescribed medication.

108. At all times during the above-described events, Hydrochlorothiazide was not completely excluded from coverage under the D.C. Medicaid program.

109. At no time during the above-described events did Ms. Seals receive written notice of the fact that coverage of the prescribed medication was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

110. In November of 2017, Ms. Seals began experiencing severe pain in her mouth due to an infection following an earlier root canal. She consulted with an oral surgeon, who determined that she would need surgery to remove the tooth and biopsy the dense matter beneath the tooth. Ms. Seals' doctor prescribed her Vicodin to treat pain. Without that medication, she would have been in severe pain in her mouth and jaw and she would have suffered from debilitating headaches.

111. Ms. Seals does not regularly take painkillers. Her prescription was a new prescription.

112. She went to a District of Columbia pharmacy to fill her prescription for Vicodin. Her prescription was denied and a pharmacy employee told her that Medicaid would not cover it because it was a new prescription and she had never been prescribed Vicodin before.

113. She opted to pay out-of-pocket for the medication, because without it she would have been in severe and debilitating pain. The cost of the medication was under $100. In order to pay for this medication, it was necessary for her to use money that she otherwise would have put toward her heating bill that month. She is a part of the Low Income Home Energy Assistance Program (LIHEAP) through the District of Columbia Department of Energy and the Environment. This program provides assistance towards her energy bill, paid directly to the utility company. Therefore, Ms. Seals was able to reallocate money from her heating bill to her prescription medication that month without foregoing heat. This decision caused Ms. Seals a great deal of stress

and she would not have been able to pay for the medication out-of-pocket and would have suffered a great deal of pain if she was not part of LIHEAP.

114. At all times during the above-described events, Vicodin was not completely excluded from coverage under the D.C. Medicaid program.

115. At that time, Ms. Seals did not receive written notice of the fact that coverage of her prescribed medication was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

116. Defendant's actions and inactions deprive Ms. Seals of her due process notice rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution.

117. Because Ms. Seals suffers from ongoing and chronic medical conditions, she obtains refills of her prescription medications monthly and will need to do so as long as her doctors continue to prescribe the medications to treat her conditions.

BR

118. BR is 12 years old. She resides with her parents, Ann and Brian Robertson. She sues by her parent and next friend, Ann Robertson.

119. BR is severely disabled and has a complex diagnosis of Down Syndrome, Childhood Apraxia of Speech, Gastroesophageal Reflux Disease, and Pervasive Development Disorder – Not Otherwise Specified.

120. BR is a Medicaid recipient through the Tax Equity and Fiscal Responsibility Act (TEFRA)/Katie Beckett Waiver. BR receives Medicaid through the managed care organization Health Services for Children with Special Needs, Inc. ("HSCSN"). BR has been enrolled with HSCSN since December 1, 2011. D.C. Medicaid has been BR's sole form of health insurance since 2015.

121. D.C. Medicaid provides BR with health insurance to cover a range of in-home health services that enable her to live at home with her parents, rather than in a hospital or institution. BR has a care manager through HSCSN who assists her with getting the health care and services she needs. The care manager does not fill prescriptions for BR. Instead, BR's mother, Mrs. Robertson, personally manages all of BR's prescriptions and her parents take turns filling the prescriptions.

122. BR takes several prescriptions on a daily basis, including Citalopram, Trileptal, Prevacid, fluoxetine, and Risperdal. Although BR has had changes in prescriptions or medications throughout her life, she has been on most of these medications for several years.

123. In January 2018, BR and her parents began experiencing problems filling BR's prescriptions at their usual District of Columbia pharmacies.

124. Between January and February 2018, BR's requests for Medicaid coverage of her regular prescription medications through HSCSN were denied on three separate occasions. BR was unable to obtain her necessary medications in a timely manner.

125. On all three occasions, when BR's prescriptions for medication were denied Medicaid coverage at the pharmacy in January and February 2018, neither BR nor her parents received any written notice of the fact that coverage of the medication was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

126. After the first denial in January 2018, Mrs. Robertson contacted HSCSN to determine the reason Medicaid would not cover the prescription. A representative told Mrs. Robertson that HSCSN would not cover the medications because BR had a secondary form of insurance. However, BR has not had a secondary form of insurance since 2015 when HSCSN

became her primary and sole form of insurance. Mrs. Robertson explained this to the representative who responded that it would be corrected in the system. Nonetheless, BR's medications were denied two more times.

127. On or about March 13, 2018, BR became ill and was sick for several days. After she had been sick and unable to eat or drink for three days, on or about March 16, 2018, a home health nurse practitioner came to BR's home. The nurse practitioner diagnosed BR with strep throat and wrote her a prescription for an antibiotic to treat the illness.

128. At all times during the events described in this section, this antibiotic medication was not completely excluded from coverage under the D.C. Medicaid program.

129. The nurse practitioner was familiar with BR and the fact that she sometimes refuses to eat or drink when she has a sore throat. The nurse practitioner emphasized that it was important to get BR on the antibiotics right away because of this history and the fact that BR had already been ill and not eating or drinking for three days. BR was dehydrated and at risk of hospitalization.

130. BR's father, Mr. Robertson, brought BR's prescription for antibiotics to the nearest District of Columbia pharmacy at Harris Teeter. The Robertsons have used this pharmacy several times in the past to fill BR's prescriptions.

131. However, the Harris Teeter pharmacy would not give Mr. Robertson BR's medication. The pharmacist told him that BR was not "active" in the system, but did not provide any further clarifying information as to why BR was not "active" in the system. Mr. Robertson was forced to leave the pharmacy without the prescription.

132. At this denial, Mr. Robertson did not receive any written notice of the fact that coverage of the medication was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

133. On this same day, Mrs. Robertson called the Harris Teeter pharmacy to speak directly to the pharmacist. Mrs. Robertson requested that the pharmacist run the prescription through the system another time and provided the pharmacist with BR's Medicaid ID and prescription ID numbers to help them locate BR within the system. However, when the pharmacist realized that BR received Medicaid through HSCSN, she informed Mrs. Robertson that it would be very difficult for the pharmacy to bill for BR's prescription.

134. Mrs. Robertson was gravely concerned for her daughter's health and well-being and desperate for her to have the medication she needed.

135. Mrs. Robertson was not informed that BR may have been entitled to a 3-day emergency supply of the medication.

136. Mrs. Robertson called the nurse practitioner and requested that BR's prescription be sent electronically to the Walgreens pharmacy at Children's National Medicaid Center. The Robertsons have often used the pharmacy at Children's National in the past to fill BR's prescriptions after she receives care there.

137. The pharmacist at Children's National informed Mrs. Robertson that BR's "number" was incorrect and that the pharmacist could not fill the prescription. The pharmacist did not provide further clarifying information about whether it was BR's Medicaid ID number or prescription ID number that was incorrect. Instead, the pharmacist suggested that Mrs. Robertson call HSCSN to determine the reason for the denial.

138. At this time, Mrs. Robertson did not receive written notice from the pharmacy at Children's National of the fact that coverage of the medication was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

139. Mrs. Robertson then called HSCSN and spoke with a representative who was unable to determine the reason for the denial. That representative told Mrs. Robertson that she should try contacting the pharmacy benefits manager Caremark.

140. Mrs. Robertson then called Caremark and spoke with a representative who told her that Caremark had all the necessary information to approve Medicaid coverage for BR's prescription as written and did not know why the denial was happening at the pharmacies.

141. Mrs. Robertson then called BR's HSCSN care manager, Jalima Caulker, and informed her of what was happening with BR's prescription. Mrs. Robertson said that BR was not showing up as an active Medicaid enrollee when the pharmacies ran her identifying numbers (prescription ID and Medicaid ID numbers). Ms. Caulker determined that when BR's Medicaid renewal had been processed at the beginning of the year, BR had been issued a new prescription ID number. However, the Robertsons had not received a new card for BR with the new prescription ID number on it.

142. Mrs. Robertson requested that the care manager bring an updated card that day so that BR could obtain her medication and avoid further complications, including hospitalizations. Ms. Caulker brought the updated card that day.

143. Later that evening, Mrs. Robertson brought the updated card to the Walgreens at Children's National and was able to fill the prescription and begin BR on her prescribed antibiotic medication.

144. However, because it had taken so much longer than it should have to start BR's antibiotics, BR went several additional hours without food or water. As a result, the next day BR was severely dehydrated and Mrs. Robertson had to take her to the Children's National emergency room. When there, BR received intravenous fluids to restore her hydration levels.

145. This entire ordeal caused BR to suffer unnecessarily. At the time, BR was a severely ill child in desperate need of antibiotic medication. For an extended period of time, her and her parents were unable to ascertain the reason she was being denied Medicaid coverage and were unable to obtain the necessary medication to begin treating her worsening strep throat. Throughout this experience and after, BR and her parents experienced high levels of stress.

146. Throughout the events described above, neither BR nor her parents received written notice of the fact that coverage of BR's medication was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would provide a temporary supply of the medication.

147. Defendant's actions and inactions deprive BR of her due process notice rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution.

Effects of Defendant's Actions and Inactions on Class

148. As a result of defendant's failures to provide timely and adequate individualized written notice, persons receive no notice that their claim for Medicaid coverage of prescription drugs is being denied, the reason for the denial, their right to a hearing, and the circumstances under which their drug coverage may be reinstated pending a hearing decision. Therefore, these persons do not have an opportunity to prevent or challenge the denial of their prescription drug coverage. When the pharmacy provider receives an electronic return message from a pharmacy benefits manager denying prescription drug coverage, the person's prescription drug benefits are denied without warning and they are deprived of opportunities to challenge the denials and secure their reversal.

149. It is critical that Medicaid drug coverage not be interrupted or discontinued. Physicians have prescribed medications deemed appropriate and necessary for treatment and maintenance of illnesses and physical conditions.

150. Reductions and substitutions of prescribed medications without notice jeopardize these persons' health. Those who are allergic to ingredients that are included in medications are particularly at risk.

151. Persons seeking Medicaid coverage for their prescription medications are especially vulnerable because of their limited income and financial resources. When defendant refuses Medicaid coverage of medications prescribed for the Medicaid population, these persons are irreparably harmed because they must forego medically necessary medications for which they cannot afford to pay out-of-pocket or they are forced to spend money needed for other necessities, such as food and shelter, on medical care.

152. Those Medicaid recipients and applicants suffering from serious medical conditions and illnesses already confront fears and stress due to the fragility of their health and lives, the side effects of medications they must take, and their dependence on bureaucracies and healthcare providers for access to life-preserving medications and treatment. Defendant's refusal to provide coverage for prescribed medications and individualized written notice when a prescription is denied or is not filled as written has caused and will cause aggravation of the fears and stress such persons already experience due to their medical conditions.

153. Defendant's actions and inactions amount to ongoing policy, pattern, practice, and/or custom that violate plaintiffs' rights under the Due Process Clause of the Fifth Amendment of the Constitution.

CLAIM

DUE PROCESS

154. The Due Process Clause of the Fifth Amendment of the Constitution provides that "no person shall be deprived of life, liberty, or property, without due process of law."

155. Plaintiffs have a protected interest in the Medicaid benefits guaranteed by Title XIX of the Social Security Act and District of Columbia law.

156. Defendant has deprived plaintiffs of Medicaid benefits without complying with the due process standards set forth in *Goldberg v. Kelly*, *supra*, 397 U.S. 254, and *Mullane v. Central Hanover Bank & Trust Co.*, *supra*, 339 U.S. 306.

157. Defendant's actions and inactions violate the Due Process Clause of the Fifth Amendment of the Constitution, which is enforceable by plaintiffs pursuant to 42 U.S.C. 1983.

RELIEF

Plaintiffs, on behalf of themselves and all other persons similarly situated, request that this Court grant the following relief:

(1) Certification of this action, as a class action, pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure;

(2) A declaratory judgment pursuant to 28 U.S.C. 2201 and Rule 57 of the Federal Rules of Civil Procedure that defendant's policies, practices, and procedures alleged herein violate the named plaintiffs' and the plaintiff class's rights under the Due Process Clause of the Fifth Amendment to the Constitution;

(3) A permanent injunction ordering defendant and defendant's agents, successors, employees, subordinates, and attorneys, to comply with the Due Process Clause of the Fifth Amendment of the Constitution;

(4) Retention of jurisdiction over this action to ensure defendant's compliance with the mandates of the Court's orders;

(5) An award of reasonable attorneys' fees and costs pursuant to 42 U.S.C. 1988; and

(6) Such other relief as may be deemed proper by the Court.

Respectfully submitted,

/s/ *Stephanie A. Madison*

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