Plaintiffs' Exhibit 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

NB, by her parent and next friend:
MICHELLE PEACOCK
2327 Green Street, S.E.
Unit #3
Washington, DC 20020,

DELILAH WYNN,
4502 Nannie Helen Burroughs Avenue, N.E.
Washington, DC 20019,

JOHN DOE,

ELAINE ANDERSON
1900 Massachusetts Avenue, S.E.
Building # 9
Washington, DC 20003,

NORMAN RUCKER
4620 Easy Place, S.E.
Washington, DC 20019,

DENISE ROBINSON,
1717 C Street, N.E.
Washington, DC 20002,

LINDA SEALS,
4301 Military Road, N.W.
Unit # 103
Washington, DC 20015,

KAHLIL TATUM,
1510 Butler Street, S.E.
Apt. #201
Washington, DC 20020,

and

ELSA MALDONADO,
318 Upshur Street, N.W.
Washington, DC 20011,

Civil Action No. 10-1511 (RJL)

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, N.W.)
Washington, DC 20004,)
)
VINCENT C. GRAY, in his official capacity)
as Mayor of the District of Columbia)
1350 Pennsylvania Avenue, N.W.)
Washington, DC 20004,)
)
and)
)
WAYNE TURNAGE, in his official capacity)
as Director of the District of Columbia)
Department of Health Care Finance)
825 North Capitol Street, N.E., Suite 500)
Washington, DC 20002,)
)
Defendants.)
_____)

FIRST 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 defendantsô policies, procedures, and practices of failing to provide Medicaid recipients in the District of Columbia (hereinafter ñMedicaid recipientsò) with adequate and timely notice, the opportunity for a fair hearing, and the opportunity for reinstated coverage pending a hearing decision, when their prescription drug coverage is denied,

terminated, reduced, or delayed. Defendantsô actions violate the Due Process Clause of the Fifth Amendment of the Constitution, Title XIX of the Social Security Act, 42 U.S.C. 1396-1396w-2, and District of Columbia law.

2. Named plaintiffs are Medicaid recipients in the District of Columbia whose prescription drug coverage has been denied, terminated, reduced, or delayed by defendants, without adequate written notice, the opportunity for a fair hearing, and the opportunity for reinstated drug coverage pending a hearing decision. As a result of defendantsô failure to provide adequate notice, the opportunity for a fair hearing, and the opportunity for reinstated drug coverage pending a hearing decision, Medicaid recipients are unable to obtain medically necessary medications that are essential to their well-being and survival.

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 written notice, the opportunity for a fair hearing, and the opportunity for reinstated drug coverage pending a hearing decision, when their requests for prescription drug coverage are denied, terminated, reduced, or delayed. Defendantsôactions 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 and Title XIX of the Social Security Act, 42 U.S.C. 1396-1396w-2. The Court has jurisdiction over plaintiffsô claims pursuant to 28 U.S.C. 1331 and 28 U.S.C. 1343. The Court has jurisdiction over plaintiffsô claims under District of Columbia law pursuant to 28 U.S.C. 1267. Venue is proper under 28 U.S.C. 1391.

PARTIES

Plaintiffs

5. Plaintiff NB is a 4-year-old Medicaid recipient. She resides with her mother, plaintiff Michelle Peacock, in the District of Columbia. She sues by her parent and next friend, Michelle Peacock.

6. Plaintiff Delilah Wynn is a 21-year-old Medicaid recipient. She resides in the District of Columbia.

7. Plaintiff John Doe is a 24-year-old Medicaid recipient. He resides in the District of Columbia.

8. Plaintiff Elaine Anderson is a 52-year-old Medicaid recipient. She resides in the District of Columbia.

9. Plaintiff Norman Rucker is a 53-year-old Medicaid recipient. He resides in the District of Columbia.

10. Plaintiff Denise Robinson is a 60-year-old Medicaid recipient. She resides in the District of Columbia.

11. Plaintiff Linda Seals is a 55-year-old Medicaid recipient. She resides in the District of Columbia.

12. Plaintiff Kahlil Tatum is a 50-year-old Medicaid recipient. He resides in the District of Columbia.

13. Plaintiff Elsa Maldonado is a 42-year-old Medicaid recipient. She resides in the District of Columbia.

Defendants

14. Defendant District of Columbia (hereafter ñDistrictò) is a municipal corporation subject to 42 U.S.C. 1983. The District is a ñstateò 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 ñDHCFò), 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).

15. Defendant Vincent C. Gray is Mayor of the District of Columbia, which through DHCF has ultimate responsibility for administering the Medicaid program in the District of Columbia.

16. Defendant Wayne Turnage is the Director of DHCF.

CLASS ACTION ALLEGATIONS

17. Named plaintiffs bring this action on behalf of themselves and all others similarly situated. Plaintiffsô class consists of all current and future District of Columbia Medicaid recipients whose prescription drugs are covered by the District of Columbia Medicaid program and who have, or will have, their prescription drug coverage denied, delayed, terminated, or reduced without timely and adequate written notice, the opportunity for a fair hearing, and the opportunity for reinstated drug coverage pending a hearing decision.

18. 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 over 140,000 Medicaid recipients in the District of Columbia. Many of these recipients do not receive or will not receive coverage of prescriptions for medically necessary drugs. Medicaid recipients do not receive timely and adequate written notice, the opportunity for a hearing, and the opportunity for reinstated drug coverage pending a hearing decision, when their coverage of drug prescriptions is denied, delayed, terminated, or reduced.

(b) There are questions of law and fact common to the class, namely whether defendants have denied class members their procedural rights under the Fifth Amendment of the Constitution, the federal Medicaid Act, and District of Columbia law by failing to ensure timely and adequate written notice, the opportunity for a fair hearing and the opportunity for reinstated drug coverage pending a hearing decision, when class membersô claims for prescription drugs are denied or not acted upon with reasonable promptness;

(c) The claims of the named plaintiffs are typical of the claims of the class in that each of the named plaintiffs is a District of Columbia Medicaid recipient whose prescription drug coverage has been denied, terminated, delayed, or reduced without timely and adequate written notice, the opportunity for a fair hearing, and the opportunity for reinstated drug coverage pending a hearing decision;

(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) Defendants have acted and continue 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

19. 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 ñMedicaid,ò 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*.

20. 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.

21. 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.

22. The Centers for Medicare and Medicaid Services (hereafter ñCMSò) of the United States Department of Health and Human Services determines whether to approve federal funding for a stateôs Medicaid program based on the information contained in the state plan. 42 C.F.R. 430.10 to 430.20. The state plan is defined as ña 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 withò federal law. 42 C.F.R. 430.10.

23. The state is required to designate a single state agency to administer and supervise the stateôs Medicaid plan. 42 U.S.C. 1396a(a)(5); 42 C.F.R. 431.10. The state agencyôs 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.

24. 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.

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

26. Federal law mandates that ñ[a] State plan for medical assistance must * * * provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.ò 42 U.S.C. 1396a(a)(3). The regulations which construe this statutory requirement define the process that is due to Medicaid recipients. *See* 42 C.F.R. 431.200, *et seq*.

27. Recipients are entitled to notice and an opportunity for a hearing whenever the state agency takes any action, which includes terminations, suspensions, and reductions of services, that affects their claims for medical services. 42 U.S.C. 1396a(a)(3); 42 C.F.R. 431.200, 431.201, 431.206(c)(2), 435.919. The state ñmust grant an opportunity for a hearing to: * * * [a]ny recipient who requests it because he or she believes the agency has taken an action erroneously.ò 42 C.F.R. 431.220(a)(2).

28. Recipients are entitled to receive timely and adequate written notice of their hearing rights. *Goldberg v. Kelly*, 397 U.S. 254, 267-268 (1970); 42 C.F.R. 435.919. The construing regulations specifically incorporate the due process standards set forth in *Goldberg v. Kelly*. *See* 42 C.F.R. 431.205(d). The written notice must describe what action the state intends to take, ñ[t]he reasons for the intended action,ò and ñ[t]he specific regulations that support, or the change in Federal or State law that requires, the action.ò 42 C.F.R. 431.210(a)-(c). The notice must also explain ñ[t]he individualôs right to request an evidentiary hearing if one is available, or a State agency hearing, ñ[i]n cases of an action based on a change in law, the circumstances under which a hearing will be

granted,ò and ñthe circumstances under which Medicaid is continued if a hearing is requested.ò 42 C.F.R. 431.210(d), (e). Defendants ñmust * * * inform every applicant or recipient in writing - (1) Of his right to a hearing; (2) Of the method by which he may obtain a hearing; and (3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.ò 42 C.F.R. 431.206(b).

29. Generally, notice must be mailed by the state agency ñat least 10 days before the date of action.ò 42 C.F.R. 431.211.

30. Medicaid recipients are entitled to a pre-termination evidentiary hearing before Medicaid benefits are discontinued. *Goldberg v. Kelly*, *supra*, 397 U.S. at 264, 267-268; 42 C.F.R. 431.205(d). If the state takes action without advance notice, it ñmust reinstate and continue services until a decision is rendered after a hearing if * * * [t]he recipient requests a hearing within 10 days of the mailing of the notice of actionò and ñ[t]he agency determines that the action resulted from other than the application of Federal or State law or policy.ò 42 C.F.R. 431.231(c).

31. The District of Columbia has codified these federal notice, hearing, and reinstatement requirements in the District of Columbia Code, making them applicable to all recipients of public assistance, including Medicaid, in the District of Columbia. *See* D.C. Code 4-205.55, 4-210.02, 4-210.04, and 4-205-59; *see also* paras. 190-194 below.

<u>District of Columbiaôs Prescription Drug Program</u>

32. The District of Columbiaôs Medicaid program provides for the coverage of prescription drugs. The District contracts with pharmacies (hereafter ñpharmacy providersò) to provide Medicaid recipients with out-patient drugs prescribed by their healthcare providers.

33. The District contracts with Affiliated Computer Services, Inc. (hereafter ñACSò) to process its Medicaid claims. Through ACS, the District has established a system to process electronic claims immediately at the time a Medicaid recipient presents a prescription to the pharmacy provider and the pharmacy provider submits an electronic claim to determine coverage. *See* 42 U.S.C. 1396r-8(h) (ñeach 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 paymentò); *see also* 42 C.F.R. 456.700, *et seq*.

34. When a physician gives a Medicaid recipient a prescription for an out-patient drug, the recipient presents the prescription to a pharmacy provider. The pharmacy provider immediately submits an electronic claim through its computer to ACS. The claims are decided immediately. The pharmacy provider receives an electronic return message from ACS 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.

35. In some cases recipients are given a substitute drug or a quantity that is different from their prescription. However, District of Columbia recipients whose prescriptions are denied and/or reduced are not provided with timely written notice of the reason for the denial, termination, or reduction, the right to request a hearing, or, if the prescription is for continuation of a course of treatment, the circumstances under which coverage of the drug can be continued pending the hearing.

36. One reason for denial of pharmacy claims is that the prescribed drug is deemed ñnon-preferred.ò The District of Columbiaôs Medicaid program utilizes a Preferred Drug List (PDL), which lists drugs that are ñpreferred agentsò and those that are ñnon-preferred agents.ò If a Medicaid recipient submits a prescription for a non-preferred drug, the claim will be denied by ACS. The pharmacy provider will receive a rejection message from ACS. District of Columbia Pharmacy Benefits Management Prescription Drug Claims System (X2) System Manual, dated March 15, 2010 (Version 0.08) (hereafter ñManualò), p. 11.

37. Another reason for denial of pharmacy claims is a lack of prior authorization. Under federal law, states may require approval, referred to as ñprior authorization,ò 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 Districtôs Medicaid program requires prior authorization in several situations. Prior authorization is required for non-preferred drugs listed on DHCFôs Preferred Drug List (ñPDLò); for medically-necessary brand-name medications with generic equivalents; for drugs classified as Schedule II narcotics and certain injectable drugs; and for some medications with quantity limits. Manual, pp. 11, 15. If prior authorization is not obtained for these drugs, coverage will be denied.

38. DHCF and its agent, ACS, have issued policies and manuals to pharmacy providers that acknowledge that claims will be denied at point-of-sale, but contain no provisions providing for notice to the recipient of state action affecting the recipientôs prescription drug coverage, the reasons for the action, the recipientôs right to a hearing, and, if applicable, continued benefits when coverage of prescription drugs is denied, terminated, or reduced.

39. The District has issued a *Medication Prior Authorization Guidance*, dated July 25, 2008. The Guidance ñencompasses policies and procedures that govern the prior authorization process * * * for the various pharmacy programs managed by [DHCF]ò and ñapplies to all [DHCF] pharmacy providers who serve DC Medicaid recipients.ò *Id.*, p. 4. The Guidance instructs: ñThe 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 ACS for prior authorization consideration.ò *Id.*, p. 27. The Guidance contains no policies or procedures regarding the provision of written notice to recipients at the time their prescriptions are denied at the pharmacy due to lack of prior authorization.

40. In cases where ACS desires additional information from a prescriber regarding a prior authorization request for a Medicaid recipient, the Guidance states that ñACS will deny the PA 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 DC MAA at 1-800-250-6950.ò *Id.*, p. 26. The Guidance contains no policies or procedures regarding the provision of written notice to the Medicaid recipient in such a situation.

41. The District has also issued to pharmacy providers ACSôDistrict of Columbia Pharmacy Benefits Management Prescription Drug Claims System (X2) System Manual, dated March 15, 2010 (Version 0.08), which provides rules regarding the submission of pharmacy claims to ACS. 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: ñNCPDP reject 76 - Plan limits exceeded.ò Manual, p.11. 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 ñNCPDP reject code 75 - Prior Authorization Requiredò or ñNCPDP Reject Code 76 - Plan Limits Exceeded.ò *Ibid*.

42. The Manual also describes a Prospective Drug Utilization Review (DUR) Program, in which ñ[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.ò Manual, p. 9. The Manual states: ñAny 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.ò *Ibid*. The Manual contains no policies or procedures regarding the provision of written notice to recipients at the time ACS responds to claims with rejection return messages.

43. In March 2009, plaintiffsô attorneys submitted an information request 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 Medicaid recipientôs request for a prescribed medication is rejected, denied, reduced, and/or not filled by a pharmacy exactly as written by the Medicaid recipientôs physician, as well as copies of any written notices provided by DHCF to Medicaid recipients in such circumstances. DHCFôs response to that request in May 2009 contained no procedures or policies providing for written notice to

Medicaid recipients when coverage of prescription drugs is denied, terminated, or reduced at the pharmacy. DHCFôs response included no written notices provided to Medicaid recipients in such circumstances.

44. ACS captures 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. 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 ñDUR Reject Error.ò For 768 denied claims, the reason for rejection was ñProduct/Service Not Covered.ò

45. DHCF contracts with a number of health plans, referred to as managed care organizations (hereafter ñMCOôsò), to provide Medicaid recipients with covered medical care. The MCOôs 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 provided by one MCO, the DC Chartered Health Plan, a significant number of Medicaid recipients enrolled in the DC Chartered Health Plan (ñhereafter Chartered Health membersò) 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 ñrejected.ò For 2,927 rejected prescriptions, the reason for rejection was ñNDC not covered; The submitted drug is not covered by the patientôs benefit plan.ò For 3,463 rejected prescriptions, the reason for rejection was ñFilled after termination date: Claimôs date of fill is after the termination date for this member or the primary card holder.ò

46. The District of Columbia statutes contain no provisions providing for notice to Medicaid recipients when coverage of prescription drugs is denied, terminated, or reduced at the pharmacy.

47. Defendants are failing to provide Medicaid recipients timely and adequate written notice when coverage of prescription drugs is denied, terminated, or reduced. Defendants are failing to inform recipients that the recipientôs claim for prescription drugs is being denied or reduced, the reason for the denial or reduction, the recipientôs right to a hearing, and the circumstances under which the recipientôs coverage may be reinstated pending a hearing.

Effects of DefendantsôActions on Named Plaintiffs

NB

48. NB has been a Medicaid recipient since birth. She resides with her mother, plaintiff Michelle Peacock. She sues by her parent and next friend, Michelle Peacock.

49. Ms. Peacockôs monthly income is $337 per month, which she receives through TANF. She cannot afford to pay for prescriptions out-of-pocket.

50. In February 2010, Ms. Peacock took NB to the hospital to treat an ear infection. The doctor prescribed the antibiotic Augmentin. Ms. Peacock went to the pharmacy and submitted the prescription. The pharmacist told her that her daughter was not eligible for Medicaid coverage. When Ms. Peacock asked the pharmacy why NB was no longer covered, the pharmacist told her that the pharmacy did not know why. At that time, Ms. Peacock had no income and did not have the

money to pay for NBôs medication out-of-pocket. Because NB needed the antibiotic immediately to treat her infection, Ms. Peacock asked her own mother, NBôs grandmother, for the money to pay for the antibiotic. NBôs grandmother provided $34 to pay for the antibiotic.

51. A week later, Ms. Peacock returned to the same pharmacy to fill a different prescription. She requested that the pharmacy check once again NBôs eligibility for Medicaid coverage. The pharmacist did so and told Ms. Peacock that NB was now showing on the computer as being eligible**.** The pharmacy reimbursed her at that time for the prior $34 payment for Augmentin.

52. In June 2010, NB was prescribed sulfamethoxazole to treat another ear infection. Ms. Peacock went to the pharmacy and submitted the prescription. The pharmacist told her that Medicaid had denied NB coverage of the medication. The pharmacist did not tell Ms. Peacock why NB was being denied. The cost of the drug out-of-pocket at the pharmacy was $40. Ms. Peacock could not afford to pay that amount. She retrieved the prescription from the pharmacy and took it to another pharmacy that charges $4 for generic medications. She paid out-of-pocket for the sulfamethoxazole.

53. Neither NB nor Ms. Peacock received written notice of the fact that coverage of NBôs prescription was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of his prescription pending the appeal. Defendantsô actions deprive NB of her due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

Delilah Wynn

54. Delilah Wynn resides with her parents. She currently attends a school that provides special education.

55. Ms. Wynnôs only income is approximately $600 per month, which she receives through social security disability insurance. Her parentsôonly income is approximately $400 per month, which they receive through public benefits. Neither Ms. Wynn nor her parents can afford to pay out-of pocket for her prescription medications.

56. Ms. Wynn has received Medicaid since she was a young child. She is disabled.

57. Ms. Wynn was recently diagnosed with diabetes. In May 2010, her doctor prescribed a glucose monitor for her. Her father, Columbus Wynn, took her prescription to the pharmacy. The pharmacy told him that it did not have the glucose monitor, but that it could order the prescription. The pharmacy took Ms. Wynnôs prescription. When Mr. Wynn returned a few days later, the pharmacy informed him that Medicaid would not cover the monitor. The pharmacy did not tell him why Medicaid would not cover it. The pharmacy told Mr. Wynn that he would have to pay for the monitor out-of-pocket. The cost of the monitor was over $110. Mr. Wynn could not afford to pay for the monitor. He eventually filled the prescription through another pharmacy.

58. Neither Ms. Wynn nor her father received written notice of the fact that coverage of Ms. Wynnôs glucose monitor prescription was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of her prescription pending the appeal.

59. Ms. Wynn also takes the medication Depakote to treat anxiety and a behavioral disorder. Ms. Wynn needs to take Depakote regularly in order to prevent anxiety episodes and regressive behavior that may require hospitalization. In March 2010, Ms. Wynnôs doctor determined that Ms. Wynn needed a different dosage formulation of Depakote and gave her a new prescription. Mr. Wynn went to the pharmacy and submitted the new prescription for Depakote. Initially, the

pharmacist accepted the prescription and told Mr. Wynn to return later for the drug. However, when Mr. Wynn returned later that day, the pharmacy told him that Medicaid would not cover the prescription for Depakote, because the different formulation that the doctor had prescribed required prior authorization from Ms. Wynnôs doctor. Mr. Wynn left the pharmacy without the medication. He immediately called Ms. Wynnôs doctor. He eventually got through to Ms. Wynnôs doctor later in the day. The doctor told Mr. Wynn that the prior authorization would be sent to the pharmacy. However, the prior authorization was not sent by the end of the day.

60. The next day, Ms. Wynnôs doctor called Mr. Wynn and informed him that the doctor had taken care of the prior authorization. Mr. Wynn returned to the pharmacy, but the pharmacy told him that the pharmacy had not received the prior authorization. Mr. Wynn called Ms. Wynnôs doctor again and informed the doctor that the pharmacy would still not give him the Depakote due to a lack of prior authorization. Because Ms. Wynn needed the drugs immediately to treat her condition, Mr. Wynn went to a pharmacy at a Department of Mental Health Service Center that day and was able to obtain an emergency supply for Ms. Wynn. Three or four days later, Ms. Wynnôs doctor called Mr. Wynn and informed him that the doctor had spoken with the pharmacy and Mr. Wynn could now get the Depakote. Mr. Wynn went to the pharmacy to obtain the Depakote for Ms. Wynn. Although the pharmacy provided Mr. Wynn with Depakote, the formulation of Depakote that the pharmacy dispensed was not the formulation that the doctor had prescribed. Instead, it was the same formulation of Depakote that Ms. Wynn had previously received.

61. Neither Ms. Wynn nor her father received written notice of the fact that coverage of Ms. Wynnôs prescription for Depakote was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of her prescriptions

pending the appeal. Defendantsô actions deprive Ms. Wynn of her due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

John Doe

62. John Doe permanently resides with his mother in Washington, D.C. During the school year, he attends graduate school in New York.

63. Mr. Doeôs motherôs monthly income is currently $20 per month. Mr. Doeôs prescription medications cost between several hundred to over one thousand dollars each month. Neither Mr. Doe nor his mother can afford to pay out-of pocket for his prescription medications.

64. Mr. Doe has received Medicaid since 2003. He is disabled. Mr. Doe returns to the District periodically throughout the school year to receive treatment for his medical conditions from his regular physicians.

65. Because Medicaid will not cover Mr. Doeôs prescription drugs at pharmacies in New York, his mother submits prescriptions at pharmacies in the District on his behalf. Once the prescriptions are filled, his mother mails the medications overnight to Mr. Doe.

66. 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.

67. Since Mr. Doe was a young child, he has been using albuterol inhalers. Because Mr. Doeôs asthma is severe, his doctor has prescribed 2 boxes of albuterol inhalers for each fill. Each box

contains one inhaler. Medicaid only permits a fill every 25 days. In March 2009, the pharmacy that dispenses Mr. Doeôs 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 2 inhalers every 30 days, his mother paid $43.99 out-of-pocket for an additional inhaler. 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. Doeôs 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 friendôs 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. Doeôs 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. Doeôs mother continued to experience problems with pharmacies reducing the quantity of Mr. Doeôs 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. Doeôs mother began experiencing prior authorization problems in refilling Mr. Doeôs prescriptions. In December 2009, the pharmacy orally informed Mr. Doeôs mother that Medicaid would no longer cover refills of the inhalers without a prior authorization for each refill requested. Therefore, even though Mr. Doeôs doctor had prescribed three refills of the albuterol inhalers, the pharmacy would not refill it.

71. Until December 2009, the pharmacy would refill Mr. Doeôs 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. Doeôs doctor and ask that the doctor request prior authorization from Medicaid for the refill. It can take the hospital three days or longer to submit a prior authorization request 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. Doeôs doctor at least four days prior to exhaustion of Mr. Doeôs 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. Doeôs 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 now experiencing problems in refilling Mr. Doeôs inhaler prescriptions. Mr. Doe continues to be denied refills of the inhalers.

74. 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 continue providing coverage of his prescription pending the appeal.

75. In addition to his asthma, Mr. Doe has also been diagnosed with potentially fatal food and environmental allergies. Mr. Doeôs 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. Doeôs 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.

76. 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.

77. 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. Doeôs mother requested a refill of the prescription at the 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. In August 2010, a paralegal at Terris, Pravlik & Millian, LLP, contacted the District of Columbiaôs Income Maintenance Administration (hereafter ñIMAò), which determines eligibility for Medicaid benefits, to inquire regarding the denial of coverage of Mr. Doeôs 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. Doeôs 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.

78. Mr. Doeôs mother cannot afford to pay for Mr. Doeôs prescriptions out-of-pocket. When she does pay out-of-pocket for his medications, she typically must forego paying a bill or another necessary living expense in order to buy the medication.

79. 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. Doeôs 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.

80. 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 continue providing coverage of his prescription pending the appeal. Defendantsôactions deprive Mr. Doe of his due process notice and

hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

81. 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 ñprint-outò of the denial. The pharmacy provided her with a document that contained an image of a ñRejection Messageò that stated, under the heading ñRejection Code/Reason,ò ñREJECTION[;] 75 - PRIOR AUTHORIZATION REQUIRED[;] 56 - Non-Matched Prescriber ID[.]ò Under the heading ñMessage,ò the document stated ñ<PDL PA REQUIRED PHARMACIST INSTRUCT MD TO CALL 800-273-4962>.ò The pharmacy also gave her an ñaction noteò that stated ñPrior Authorization Required. Contact Method: FAX. Prescriber Contacted on: 9/16/2012.ò His mother left the pharmacy without the medication.

82. On information and belief, Mr. Doeôs 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 ACS regarding its denial of his doctorôs prior authorization request. The letter was dated September 24, 2012. The letter stated that ñ[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.ò Under a section titled ñWhy is this happening?,ò the letter stated that ñDHCF did not approve the request for this medication for the following reason(s): PLEASE CONTACT HELP DESK FOR

DETAILS.ò The letter gave no further information regarding the reason for the denial. The letter also informed Mr. Doe that he could ñask for a fair hearing from the Office of Administrative hearingsò and provided information regarding how to proceed with a fair hearing.

83. On October 5, 2012, Mr. Doeôs mother was able to fill his prescription for Differin Gel without any problems.

84. 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 continue providing coverage of his prescription pending the appeal. Defendantsôactions deprive Mr. Doe of his due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

85. 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.

Elaine Anderson

86. Ms. Anderson has no source of income. She resides in a homeless shelter and receives food stamps. She cannot afford to pay out-of-pocket for her prescription medications.

87. Ms. Anderson suffers from diabetes, high blood pressure, and sinus allergies. She takes several prescription medications to treat these conditions.

88. Prior to July 2010, Ms. Anderson was receiving medical and prescription drug coverage through the District of Columbia HealthCare Alliance program, which provides medical assistance to low-income residents who are not eligible for Medicaid benefits. DC HealthCare Alliance

recipients must obtain their prescriptions drugs at one of seven Unity Health Care pharmacies in the District of Columbia. These pharmacies are not Medicaid pharmacy providers, so they do not provide prescription drugs to Medicaid recipients.

89. In July 2010, Ms. Anderson went to a HealthCare Alliance pharmacy to refill prescriptions for three drugs to treat her sinus allergies - flunisolide, Acular, and loratadine. The pharmacy informed her that she was no longer in the DC Healthcare Alliance program, that she was now covered by Medicaid, and that she needed to go to a Medicaid pharmacy provider.

90. Ms. Anderson then went to a Medicaid pharmacy provider to refill the prescriptions for the three drugs. The pharmacy told her that it could not find her Medicaid identification number in their system. The pharmacy told her to return in three or four days. Several days later, the pharmacy contacted her by telephone. The pharmacy told her again that they could find no information regarding her eligibility for Medicaid in their system and that it could not fill the prescriptions. The pharmacy suggested that she return to the HealthCare Alliance pharmacy.

91. Ms. Anderson then returned to the HealthCare Alliance pharmacy. Once again, the pharmacy told her that she was covered by Medicaid and that she needed to go to a Medicaid pharmacy provider to obtain her prescription drugs.

92. Ms. Anderson contacted a paralegal at Terris, Pravlik and Millian, LLP, to request assistance. The paralegal contacted IMA to inquire regarding Ms. Andersonôs eligibility for Medicaid. IMA verified over the telephone that Ms. Anderson was eligible for D.C. Medicaid under a new waiver program. IMA also stated that Ms. Andersonôs coverage should have been upgraded to Medicaid on July 1, 2010, but it had not been updated in the system. IMA stated that her coverage would be correctly updated in several days.

93. One week later, Ms. Anderson returned to the Medicaid pharmacy provider to fill prescriptions for the three drugs to treat her sinus allergies. The Medicaid pharmacy told her that it would not fill her prescriptions because she did not have a Member Identification Card from Unison Health Plan, the MCO contracted by DHCF to provide Ms. Anderson with her medical care under Medicaid.

94. Ms. Anderson then went to a different Medicaid pharmacy. That pharmacy also informed her that it would not fill her prescriptions because she did not a have a Member Identification Card from Unison Health Plan.

95. Ms. Anderson contacted Unison Health Plan by telephone to inquire about her Medicaid coverage. Unison Health Plan told her that it could not find her name in its system.

96. Ms. Anderson again contacted a paralegal at Terris, Pravlik and Millian, LLP, by telephone to request assistance. The paralegal connected Ms. Anderson over the telephone with a representative from Unison, who was eventually able to locate Ms. Anderson in Unison Health Planôs computer system and told Ms. Anderson her Unison Health Plan member identification number, which is different than her Medicaid identification number.

97. In early August 2010, Ms. Anderson went to a different Medicaid pharmacy provider. She submitted prescriptions for four drugs - the three drugs to threat her sinus allergies and the drug metformin to treat her diabetes. She also gave the pharmacy her Unison identification number. The pharmacy filled the prescriptions.

98. Ms. Anderson never received written notice of the fact that coverage of her prescriptions was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of her prescriptions pending the appeal. Defendantsô

actions deprive Ms. Anderson of her due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

Norman Rucker

99. Norman Ruckerôs only monthly income is $600 per month, which he receives through workerôs compensation. He cannot afford to pay out-of-pocket for his prescription medications.

100. Mr. Rucker suffers severe chronic pain related to a hernia, gout, arthritis, and carpal tunnel syndrome. He regularly takes a number of pain and other prescription medications to treat his medical conditions.

101. Mr. Ruckerôs pain medications cause him to experience itchiness as a side effect. In May 2010, Mr. Ruckerôs doctor prescribed the antihistamine diphenhydramine to alleviate the itchiness Mr. Rucker was experiencing. The diphenhydramine was effective, so Mr. Ruckerôs doctor gave him another prescription for the drug in June 2010. Mr. Rucker submitted the prescription to his pharmacy to be filled and also showed his Medical Assistance Card with his Medicaid identification number. However, the pharmacy told him that his Medicaid coverage had been denied and that he was not eligible for Medicaid. Mr. Rucker left the pharmacy without the diphenhydramine.

102. Mr. Rucker then called DHCFôs toll-free help line for Medicaid recipients. He explained the problem that he had experienced at the pharmacy. DHCF told him that he was eligible for Medicaid coverage and that the pharmacy had submitted the wrong Medicaid identification number for him.

103. The next day, Mr. Rucker called his pharmacy and informed it of what DHCF had told him. The pharmacy then tried to submit his prescription for coverage again, but the pharmacy told Mr. Rucker that he was still showing as ineligible for Medicaid coverage in its computer system. The pharmacy told him that its computer system was experiencing problems. Mr. Rucker called the pharmacy repeatedly for the next three or four days until the problem was finally fixed.

104. Mr. Rucker never received written notice of the fact that coverage of his prescription for diphenhydramine was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of his prescription pending the appeal. Defendantsô actions deprive Mr. Rucker of his due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

105. On or around January 1, 2012, Mr. Rucker was enrolled in Chartered Health Plan, an MCO, and began receiving Medicaid benefits through Chartered.

106. Mr. Rucker experiences stomach upset and stomach aches and chronic pain related to his hernia. His doctor has prescribed for him the antacid medication Nexium for a number of years. Until December 2011, Mr. Rucker had no problems with filling his prescriptions for Nexium. Around January 2012, Mr. Rucker submitted a prescription for Nexium to his pharmacy and was told that Chartered would not cover the medication. The pharmacy told him that he could purchase an antacid medication over the counter. However, Mr. Rucker could not afford to pay for an over-the-counter medication. Therefore, he has not been able to take any medications to treat his stomach upset.

107. Mr. Rucker also suffers from insomnia related to his chronic pain and sleep apnea. He has been taking prescription medications to treat his insomnia for a number of years. Around April

2012, his doctor prescribed the medication Ambien to treat his insomnia. His doctor prescribed 30 tablets a month, one per night. When Mr. Rucker submitted the prescription to his pharmacy, the pharmacy provided him with only 14 tablets and stated that Chartered would only cover 14 tablets each month. Between May 2012 and August 2012, Mr. Rucker continued to receive 14 Ambien tablets each month, instead of the 30 tablets prescribed by his doctor. In August 2012, Mr. Ruckerôs doctor submitted a Request for Emergency Non-Formulary Medication form to Chartered, requesting that Mr. Rucker be provided with Ambien and attached a prescription that specifically requested a quantity of 30 10-mg Ambien tablets. Chartered did not approve the request and instead responded to his doctor by stating that ñthis member received 14 tabs of Ambien on 08/13/12.ò

108. In September 2012, Mr. Ruckerôs doctor submitted another Request for Emergency Non-Formulary Medication form to Chartered, requesting that Mr. Rucker be provided with 30 pills of Ambien per fill so that he could take one pill each night. On the form, in a section requesting ñClinical Information,ò Mr. Ruckerôs doctor wrote: ñrequest is for 30 pills caps * * * Pt has multiple medical issues, constant pain [and] insomnia. Requires Ambien every night.ò In a section on the form requesting information regarding ñRefills and/or Anticipated length of treatment,ò Mr. Ruckerôs doctor wrote ñIndefinite.ò Chartered responded to Mr. Ruckerôs doctor that it had approved the request. In October 2012, Mr. Rucker began receiving 30 Ambien tablets each month as prescribed.

109. On or around December 1, 2012, Mr. Rucker was enrolled in Med Star Health, an MCO, and began receiving Medicaid benefits through Med Star.

110. Mr. Rucker takes the pain medication Oxycontin to treat his severe chronic pain. In January 2013, Mr. Rucker went to the pharmacy and submitted a prescription for Oxycontin to be

filled. The pharmacy told him that Medicaid would not cover the prescription for Oxycontin. Mr. Rucker left the pharmacy without the medication.

111. Because Mr. Rucker was not able to fill his prescription for Oxycontin, he ran out of the medication. Without the medication, he began to feel pain. Mr. Rucker informed his doctor that the Oxycontin was not covered. His doctor prescribed morphine as a substitute pain medication. Mr. Rucker was able to fill the morphine prescription. He took the morphine daily for about two weeks. However, the morphine caused him to feel severely depressed and to have suicidal thoughts. Therefore, he stopped taking the morphine.

112. Mr. Rucker suffers from dry, sensitive skin. His doctor prescribes Ammonium Lactate Cream. Until December 2012, Mr. Rucker was able to fill his prescription without any problems. However, in January 2013, Mr. Ruckerôs doctor called his pharmacy and submitted a prescription for Ammonium Lactate Cream. The pharmacy contacted Mr. Rucker by telephone and informed him that Med Star would not cover the medication and that he would have to pay out-of-pocket for the medication. Mr. Rucker could not afford to pay out-of-pocket for the medication, so he was not able to obtain the medication.

113. Mr. Rucker never received written notice of the fact that coverage of his prescriptions for Nexium, Ambien, Oxycontin, and Ammonium Lactate Cream was being denied, the reason for the denials, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of his prescription pending the appeal. Defendantsôactions deprive Mr. Rucker of his due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

114. Because Mr. Rucker 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.

Denise Robinson

115. Ms. Robinson is disabled and unable to work. Her only income is $1399 per month, which she receives through social security disability insurance. She also receives food stamps. She can not afford to pay out-of pocket for her prescription medications.

116. Ms. Robinson has been receiving Medicaid since 2012.

117. Ms. Robinson suffers from osteoarthritis in her hip which causes her to experience chronic pain. She receives physical therapy twice a week. Her doctor prescribes the pain medication Naproxen, which she takes daily. She has been prescribed Naproxen for approximately a year and a half.

118. Ms. Robinson has a prescription for the medication Simvastatin to control her cholesterol. She has been taking Simvastatin regularly for two to three years. She also has a prescription for the medication Amlodipine to treat high blood pressure. She has been taking Amlodipine regularly for approximately one year.

119. Around November 2012, Ms. Robinson began to suffer from painful bowel movements and bleeding. In early December, she went to see a doctor specializing in gastroenterology, who diagnosed an anal fissure or fistula. Her doctor prescribed Analpram Hydrocortisone Cream, an anti-inflammatory topical steroid medication that would alleviate the itching and inflammation caused by the fissure. Her doctor instructed her to apply the medication two to three times daily and to return in early January for a colonoscopy.

120. Ms. Robinson took the prescription for Analpram Hydrocortisone Cream to her pharmacy and submitted it for fill. The pharmacy employee told her that the pharmacy needed to call her insurance provider to determine whether the medication was covered. The pharmacy employee contacted by telephone, on information and belief, a representative of D.C. Medicaid and then told Ms. Robinson that Medicaid would not cover the medication. The pharmacy employee handed Ms. Robinson the telephone and, on information and belief, a representative of D.C. Medicaid told Ms. Robinson that payment for the medication could not be authorized. The pharmacy employee suggested to Ms. Robinson that she contact her doctor to see if another medication could be prescribed.

121. Ms. Robinson contacted the Legal Aid Society for the District of Columbia for assistance with obtaining the medication. An employee at Legal Aid contacted Ms. Robinsonôs pharmacy regarding the prescription and was told by the pharmacy that Analpram Hydrocortisone Cream was not covered by Medicaid.

122. The Legal Aid Society assisted Ms. Robinson in obtaining a D.C. Medicaid Prior Authorization request form. Her doctor filled out the form, requesting authorization for Analpram Hydrocortisone Cream to treat Ms. Robinsonôs fissure. The prior authorization request was submitted on Ms. Robinsonôs behalf on or around January 4, 2013.

123. Because Ms. Robinson was not able to obtain the Analpram Hydrocortisone Cream, she continued to experience bleeding and painful bowel movements. Because she had not been able to apply the Analpram cream and was still experiencing bleeding and painful bowel movements, she was not able to proceed with the colonoscopy in early January 2013.

124. In early January 2013, Ms. Robinsonôs doctor called in a prescription to Ms. Robinsonôs pharmacy for Hydrocortisone Pramoxine Cream. On January 8, 2013, Ms. Robinson went to the pharmacy. She was able to fill prescriptions for two other medications. However, when she inquired about the prescription for Hydrocortisone Pramoxine Cream, the pharmacy checked its computer system and informed her that Medicaid would not cover the drug. The pharmacy then spoke with, on information and belief, a representative of D.C. Medicaid on the telephone and confirmed that Medicaid would not cover the medication.

125. Between January 8 and January 20, 2013, Ms. Robinson went to her pharmacy three or four times to try to fill the prescription for Hydrocortisone Pramoxine Cream. Each time, the pharmacy checked its computer system and told her that Medicaid would not cover the drug.

126. The pharmacy informed her that she would need to pay $99.54 out-of-pocket to obtain the medication. Ms. Robinson did not have $99.54 to pay for the medication out-of-pocket.

127. Ms. Robinsonôs pain and bleeding as a result of the fissure worsened because she was unable to obtain the medication.

128. On or around January 13, 2013, she contacted a friend to request a loan of $99.54 for her medication. On or around January 20, 2013, she was able to borrow the money from her friend. She called her pharmacy and asked the pharmacy to check again whether Medicaid would cover the medication. The pharmacy told her over the telephone that it had checked again and that Medicaid would still not cover the medication. Ms. Robinson immediately went to the pharmacy and paid $99.54 out-of-pocket for the medication.

129. A week after using the Hydrocortisone Pramoxine Cream, Ms. Robinson went to a different doctor regarding her anal fissure condition. The doctor informed her that the condition had

worsened to such an extent that she now required a surgical procedure to treat the condition. She underwent surgery in February 2013.

130. On February 8, 2013, Ms. Robinson received a letter in the mail from ACS regarding its denial of her doctorôs prior authorization request for the Analpram Hydrocortisone Cream. The letter was dated January 7, 2013. The letter stated that ñ[t]he Department of Health Care Finance (DHCF) has reviewed the request submitted by your physician for: ANALPRAM HC 2.5% CREAM on 1/4/2013. This letter is to inform you that DHCF will not approve the request for this medication.ò Under a section titled ñWhy is this happening?,ò the letter stated that ñDHCF did not approve the request for this medication for the following reason(s): PLEASE CONTACT HELP DESK FOR DETAILS.ò The letter gave no further information regarding the reason for the denial. The letter also informed Ms. Robinson that she could ñask for a fair hearing from the Office of Administrative hearingsò and gave information regarding how to proceed with a fair hearing.

131. In November 2012, Ms. Robinson moved. She called the telephone number for D.C. Medicaid listed on the back of her Medical Assistance card and notified Medicaid of the move and the change in her address. The woman who answered the telephone told Ms. Robinson that she had updated Ms. Robinsonôs address in the computer system. However, the mailing address to which ACS had mailed its letter to Ms. Robinson regarding its denial of the prior authorization request for the Analpram Hydrocortisone Cream was Ms. Robinsonôs old address. Ms. Robinson had also informed the U.S. Post Office of her change in address when she moved. The U.S. Post Office had forwarded ACSôletter to Ms. Robinsonôs new address.

132. When coverage of Ms. Robinsonôs prescription for Analpram Hydrocortisone Cream was denied in early December 2012, she never received written notice of the fact that coverage of her

prescription was being denied, the reason for the denial, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of her prescription pending the appeal. Ms. Robinson also never received written notice in January 2013 of the fact that coverage of her prescription for Hydrocortisone Pramoxine Cream was being denied, the reasons for the denial, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of her prescriptions pending the appeal. Defendantsô actions deprive Ms. Robinson of her due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

133. Because Ms. Robinson 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.

Linda Seals

134. Ms. Seals is unemployed. Currently, her only income is $20 per month, which she receives through residual insurance payments. She also receives food stamps. She cannot afford to pay out-of pocket for her prescription medications.

135. Ms. Seals has been receiving Medicaid since September 2012.

136. On January 1, 2012, Ms. Seals was enrolled in Chartered Health Plan, an MCO, and began receiving Medicaid benefits through Chartered.

137. Ms. Seals suffers from chronic pain in her neck, spine, and Achilles heel. She receives medical treatment for these conditions regularly. To treat and manage her pain, her doctors prescribe the medications Diazapan, Metaxalone, Ibuprofen, and Hydrocodon-Acetaminophen. She takes these medications regularly.

138. Ms. Seals also has a prescription for the medication Hydrochlorothizide to treat high blood pressure. She also has a prescription for the contraceptive medication Medroxyprogesterone. She takes these medications regularly.

139. Ms. Seals is 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.

140. 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 the pharmacy to fill her prescription for Flucanozole. 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 ñgroup I.D. number.ò She asked the pharmacy for a ñprint-outò of the denial. The pharmacy provided her with an ñaction noteò that stated: ñWe attempted to fill this through your insurance but were unable. If you would like this filled through your insurance, please provide updated insurance information.ò Ms. Seals paid $16.00 out-of-pocket for the Fluconazole.

141. 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 continue providing coverage of her prescriptions pending the appeal. Defendantsô actions deprive Ms. Seals of her due process notice and hearing rights pursuant to the

Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

142. 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.

Kahlil Tatum

143. Mr. Tatum does not have steady employment. He relies on income from working odd jobs to pay for his living expenses. He does not receive a set monthly income. He cannot afford to pay for his prescription medications out-of-pocket.

144. Mr. Tatum has been receiving Medicaid since January 2012.

145. Mr. Tatum suffers from high blood pressure. His doctor prescribes the medications Metoprolol Tarta and Hydrochlorothiazide to treat his condition. He needs to take both medications regularly.

146. In February 2012, Mr. Tatum went to his pharmacy and filled his prescriptions for Metoprolol Tarta and Hydrochlorothiazide. He was able to obtain refills of his prescriptions the following month. However, in March or April 2012, his pharmacy called him and told him over the telephone that something was wrong with his Medicaid coverage. The pharmacy told him that his Medicaid coverage was inactive. The pharmacy was unable to give him any further information on why his Medicaid coverage was showing as inactive. The pharmacy told him that he would need to pay for his medications out-of-pocket.

147. Mr. Tatum could not afford to pay for the medications out-of-pocket. Therefore, he did not go to his pharmacy to fill his prescriptions for Metoprolol Tarta and Hydrochlorothiazide.

148. On or around April 1, 2012, Mr. Tatum was enrolled in Chartered Health Plan, an MCO, and began receiving Medicaid benefits through Chartered.

149. In April 2012, Mr. Tatum fell ill and went to the emergency room at Georgetown University Hospital. He was treated for a stomach virus and dehydration. He was prescribed three medications, Ondansetron, Metronidazole, and Ciprofloxacin, to treat diarrhea, nausea, and dehydration.

150. Since the pharmacy that had previously filled his Metoprolol Tarta and Hydrochlorothiazide prescriptions had told him his Medicaid coverage was inactive, Mr. Tatum decided to go to a different pharmacy to fill his new prescriptions for the three medications. He submitted the three prescriptions for fill. He also gave the pharmacy his Medicaid Assistance Card with his Medicaid identification number. The pharmacy checked his Medicaid coverage information in its computer system and told him that his Medicaid coverage was showing as inactive.

151. The pharmacy informed Mr. Tatum that he would need to pay $109.17 out-of-pocket to obtain the three medications. Mr. Tatum did not have $109.17 to pay for the medications out-of-pocket. Mr. Tatum left the pharmacy without his medications.

152. Mr. Tatum contacted his sister to request a loan of $109.17 to pay for his medications. He was able to borrow the money from her. Mr. Tatum then returned to the pharmacy and paid $109.17 out-of-pocket for the medications.

153. In October 2012, Mr. Tatum contacted a paralegal at Terris, Pravlik & Millian, LLP, to request assistance. The paralegal contacted IMA to inquire regarding Mr. Tatumôs eligibility for Medicaid. IMA verified over the telephone that Mr. Tatum was eligible for D.C. Medicaid and had been eligible for Medicaid continuously since January 2012.

154. Mr. Tatum never received written notice of the fact that coverage of his prescriptions for Metoprolol Tarta, Hydrochlorothiazide, Ondansetron, Metronidazole, and Ciprofloxacin was being denied, the reasons for the denials, the right to appeal, or the circumstances under which Medicaid would continue providing coverage of his prescriptions pending the appeal. Defendantsô actions deprive Mr. Tatum of his due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

155. Because Mr. Tatumôs high blood pressure is an ongoing and chronic medical condition, he needs to obtain refills of his prescription medications monthly and will need to do so as long as his doctor continues to prescribe the medications to treat his condition.

Elsa Maldonado

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

157. Ms. Maldonadoôs native language is Spanish. She has limited proficiency in English.

158. 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.

159. Ms. Maldonado suffers from asthma and sinus allergies. She has been suffering from these medical conditions for over ten 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 seven years. She takes two 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.

160. 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.

161. 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. Maldonadoôs doctor, but was unable to reach anyone at her doctorôs 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.

162. 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.

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

164. Medicaid recipients are required to renew their eligibility for Medicaid benefits annually through a process called recertification 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.

165. 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.

166. 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 Columbiaôs Department of Human Services (hereafter ñDHSò) by e-mail to inquire regarding Ms. Maldonadoôs eligibility for Medicaid. DHS responded by e-mail that Ms. Maldonadoôs 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. Maldonadoôs recertification in a timely manner. As a result, her Medicaid eligibility had been incorrectly terminated.

167. 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.

168. 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.

169. 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. Maldonadoôs 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.

170. 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.

171. 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 hospital for treatment by her doctor due to complications related to her inability to take her asthma medication.

172. 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 continue providing coverage of her prescriptions pending the appeal. Defendantsô actions deprive Ms. Maldonado of her due process notice and hearing rights pursuant to the Due Process Clause of the Fifth Amendment of the Constitution, the federal Medicaid statute, and District of Columbia law.

173. Because Ms. Maldonadoôs 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.

174. Ms. Maldonado and her husbandôs monthly income is limited. They cannot afford to pay out-of-pocket for Ms. Maldonadoôs 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.

Effects of Defendantsô Actions on Class

175. As a result of defendantsô failures to provide timely and adequate written notice, Medicaid recipients receive no notice that their claim for prescription drugs is being denied or reduced, the reason for the denial or reduction, their right to a hearing, and the circumstances under which their drug coverage may be reinstated pending a hearing decision. Therefore, recipients do not have an opportunity to prevent or challenge the termination or reduction of their prescription drug coverage. When the pharmacy provider receives an electronic return message from ACS denying prescription drug coverage, the recipientôs benefits are denied, discontinued, or reduced without warning and they are deprived of opportunities to challenge the denials and secure their reversal.

176. It is critical to recipients that their Medicaid drug coverage not be interrupted or discontinued. Their physicians have prescribed medications deemed appropriate and necessary for treatment and maintenance of illnesses and physical conditions.

177. Reductions and substitutions of prescribed medications without notice jeopardize the recipientsô health. Those who are allergic to ingredients that are included in medications are particularly at risk.

178. Medicaid recipients are especially vulnerable because of their limited income and financial resources. When defendants refuse Medicaid coverage of medications prescribed for recipients, recipients are irreparably harmed because they must forego medically necessary medications for which they can not 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.

179. Those Medicaid recipients 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 health providers for access to life-preserving medications and treatment. Defendantsôrefusal to provide coverage for prescribed medications has caused and will cause aggravation of the fears and stress such recipients already experience due to their medical condition.

180. Defendantsôactions amount to ongoing policy, pattern, practice, and/or customs that violate federal law and plaintiffsôrights under the Due Process Clause of the Fifth Amendment of the Constitution, Title XIX of the Social Security Act, 42 U.S.C. 1396a(a)(3), and District of Columbia law.

CLAIMS

FIRST CLAIM

DUE PROCESS

181. The Due Process Clause of the Fifth Amendment of the Constitution provides that ñno person shall be deprived of life, liberty, or property, without due process of law.ò

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

183. Under *Goldberg v. Kelly*, Medicaid recipients are entitled to a pre-termination evidentiary hearing before Medicaid benefits are discontinued. 397 U.S. at 264

184. Defendants have deprived plaintiffs of Medicaid benefits without complying with the due process standards set forth in *Goldberg v. Kelly*, *supra*, 397 U.S. 254.

185. Defendantsô actions violate the Due Process Clause of the Fifth Amendment of the Constitution, which is enforceable by plaintiffs pursuant to 42 U.S.C. 1983.

SECOND CLAIM

TITLE XIX OF THE SOCIAL SECURITY ACT:
FAILURE TO PROVIDE NOTICE, OPPORTUNITY FOR FAIR HEARING, AND OPPORTUNITY FOR REINSTATED COVERAGE PENDING HEARING DECISION

186. Title XIX of the Social Security Act, Medical Assistance Program, 42 U.S.C. 1396-1396w-2, requires states to ñgrant[] an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.ò 42 U.S.C. 1396a(a)(3).

187. The federal regulations at 42 C.F.R. 431.200, *et seq.*, construe the statutory requirements of 42 U.S.C. 1396a(a)(3). 42 C.F.R. 431.200(a). These regulations specifically

incorporate the due process standards set forth in *Goldberg v. Kelly*, *supra*, 397 U.S. 254. *See* 42 C.F.R. 431.205(d).

188. As set forth in paragraphs 1-180 above, defendants have a policy, pattern, and practice of failing to ensure that Medicaid recipients receive adequate written notice, the opportunity for a hearing, and the opportunity for reinstated drug coverage pending a hearing decision, when coverage of their prescription drugs is denied or is not acted upon with reasonable promptness.

189. Defendantsô actions violate 42 U.S.C. 1396a(a)(3), which is enforceable by plaintiffs pursuant to 42 U.S.C. 1983.

THIRD CLAIM

D.C. CODE

190. Under District of Columbia law, public assistance includes Medicaid benefits. *See* D.C. Code 4-201.01(6); D.C. Code 4-204.05, *et. seq.*

191. D.C. Code 4-205.55(a) requires that defendants shall provide recipients of public assistance, including Medicaid recipients, ñtimely and adequate notice in cases of intended action to discontinue, withhold, terminate, suspend, reduce assistance, or make assistance subject to additional conditions, or to change the manner or form of payment to a protective, vendor, or 2-party payment.ò D.C. Code 4-210.02 requires that defendants ñgrant a fair hearing to any applicant for or a recipient of public assistance * * * who is aggrieved by any other action or inaction of the Mayor which affects the receipt, termination, amount, kind, or conditions of his assistance.ò *See also* D.C. Code 4-210.01.

192. Under D.C. Code 4-205.55(a)(2), ñadequateò notice is defined as ñwritten notice [that] includes a statement of what action the Mayor intends to take, the reasons for the intended action,

the specific law and regulations supporting the action, an explanation of the individualôs right to request a hearing, and the circumstances under which assistance will be continued if a hearing is requested.ò ñWritten information regarding the right to request a hearing and the method of making such request shall be furnished by the Mayor to each public assistance applicant or recipient * * * whenever the Mayor notifies the applicant or recipient that it intends to take action which may or will adversely affect him or her or his or her benefits, including changes in or terminations of assistance payments.ò D.C. Code 4-210.04(a).

193. Under D.C. Code 4-205.55(a)(1), ñtimelyò notice ñmeans that the notice is postmarked at least 15 days before the date upon which the action would become effective.ò

194. Under D.C. Code 4-205.59(c), when the District takes action without timely notice and ñthe recipient requests a hearing within 10 days of the postmark of the written notice of the actionò:

> [the District] shall reinstate assistance within 96 hours of the request for a hearing and assistance shall not be discontinued, withheld, terminated, suspended, reduced or made subject to additional conditions, nor may the manner or form of payment be changed to a protective, vendor, or 2-party payment until: (1) a determination is made at the hearing that the sole issue is one of law and not of incorrect grant computation; or (2) a decision is rendered by the Mayor after a hearing and this decision upholds the Mayor in his or her action to alter the amount or conditions of the public assistance grant.

195. Defendants are violating D.C. Code 4-205.55, 4-210.02, 4-210.04, and 4-205.59, because they fail to ensure that Medicaid recipients whose prescription drug coverage is withheld, discontinued, or reduced are provided with timely and adequate notice, the opportunity for a fair hearing, and the opportunity for reinstated drug coverage while a hearing is pending.

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 defendantsô practices and procedures alleged herein violate the named plaintiffsô and the plaintiff classôs rights under the Due Process Clause of the Fifth Amendment to the Constitution, Title XIX of the Social Security Act, 42 U.S.C. 1396a(a)(3), and District of Columbia law;

(3) A permanent injunction ordering defendants, their agents, successors, employees, subordinates, and attorneys, to comply with the Due Process Clause of the Constitution, Title XIX of the Social Security Act, and District of Columbia law;

(4) Retention of jurisdiction over this action to ensure defendantsô compliance with the mandates of the Courtôs orders;

(5) An award of reasonable attorneysô 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,

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